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Healthcare leaders under the age of 40: successful strategies and practices for leading healthcare organizations

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HEALTHCARE LEADERS UNDER THE AGE OF 40 - SUCCESSFUL STRATEGIES AND

PRACTICES FOR LEADING HEALTHCARE ORGANIZATIONS

A dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Education in Organizational Leadership

by

Rizalyn Reynaldo

September, 2017

Farzin Madjidi, Ed.D. – Dissertation Chairperson

This dissertation, written by

Rizalyn Reynaldo

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

Doctoral Committee:

Farzin Madjidi, Ed.D., Chairperson

Lani Simpao Fraizer, Ed.D.

Gabriella Miramontes, Ed.D.

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DEDICATION

To my loving husband and best friend, Brian, who believed in me every step of this doctoral journey, through the triumphs and the struggles. Faithful. Scholarly. Skillful. Courageous. Ambitious. You are my perfect match. Thank you for loving me unconditionally.

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VITA

EDUCATION

2017	Doctor of Education (Ed.D.) Organizational Leadership	Pepperdine University Malibu, CA
2011	Master of Health Administration (M.H.A)	University of Southern California Los Angeles, CA
2011	Master of Science in Gerontology (M.S.G.)	University of Southern California Los Angeles, CA
2011	Certificate in Long Term Care Administration	University of Southern California Los Angeles, CA
2007	Bachelor of Science (B.S.) Health Promotion and Disease Prevention	University of Southern California Los Angeles, CA
2007	Minor in Health Policy and Management	University of Southern California Los Angeles, CA

PROFESSIONAL HISTORY

2016- Present	Regional Director, Methodist Transplant Specialists Methodist Medical Group/Methodist Health System	Dallas, TX
2015-2016	Regional Director, Operations Adventist Health Physicians Network/Adventist Health System	Glendale, CA
2011-2015	Clinical Administrator, Maternal-Fetal Medicine University of Southern California, Department of Obstetrics and Gynecology	Los Angeles, CA
2009-2011	Coordinator, Vendor and Client Relations University of Southern California, Department of Business Services	Los Angeles, CA
2005-2009	Purchasing Assistant University of Southern California, Department of Business Services	Los Angeles, CA
2007-2011	Administrator, Residential Care Facility for the Elderly R&R Majestic Assisted Living, Inc.	Canoga Park, CA

ABSTRACT

As millennials and young adults under the age of 40 become the growing majority, it is critical to understand their leadership profile, the workplace challenges they face, and their strategies for overcoming obstacles as young leaders. Specifically, in healthcare, the rapidly changing industry presents internal and external environmental challenges that must be handled in the most professional and proficient manner to be an effective leader. As such, the purpose of this study is to gather best strategies and practices that healthcare leaders under the age of 40 can adopt for their respective organizations. There are 4 research questions that address the research study's purpose: (a) strategies and practices employed by healthcare leaders under 40, (b) challenges faced by healthcare leaders under 40, (c) definition and measurement of leadership success and organizational performance, and (d) recommendations for young aspiring leaders. 15 healthcare leaders under the age of 40 participated in the research study and responded to 12 questions in a semi-structured interview format. The results of the phenomenological qualitative study yielded 62 themes. In particular, the following emerged as top themes with regard to strategies and practices: servant leadership, authentic leadership, transformational leadership, emotional intelligence. Challenges faced by healthcare leaders included regulatory changes, healthcare reform, competing priorities, managing financial and human capital, and managing change. In terms of managing resistance to change, a four-part framework was developed through the following themes: educate people on the change, engage people in the process, listen and empathize, build a guiding coalition. As for obstacles experienced by young leaders, themes included proving credibility, perceptions of youth, lack of experience or knowledge. 60% stated that their definition of leadership success would be based on team development and success, followed by organizational success, personal achievement, and reduced staff turnover. A high

performing organization focused on quality, engaging the workforce, patient experience, cost savings, financial growth and stability, and community outreach. To measure and track organizational performance, key performance indicators, dashboards, and balance scorecards were mentioned. The research study wrapped up with advice for young aspiring leaders with emotional intelligence emerging as a top theme.

Keywords: millennials, leadership, healthcare, phenomenological, qualitative, servant leadership, authentic leadership, transformational leadership, emotional intelligence, regulatory changes, healthcare reform, competing priorities, managing human capital, and managing change, resistance, high performing organization, employee engagement, patient experience, key performance indicators, dashboards, balanced scorecards.

Chapter 1: Introduction

Introduction

Leaders in the healthcare industry have endured constant change over the last decade. Episodic changes in the healthcare industry have advanced into continuous transformations driven by significant innovations in technology, increased transparency and accessibility of hospital and physician ratings, emergent research on clinical outcomes and operational performance, and the expectation for integrated and coordinated care of patients (Studer, 2013). Since 2009, the Center for Medicare and Medicaid Services (CMS) under the United States (U.S.) Department of Health and Human Services (HHS) has instituted guidelines to increase the use of electronic health record (EHR) systems in hospitals and private physician practices to augment coordination of care, develop a common infrastructure, and improve provider productivity (Slavitt & DeSalvo, 2016). The shift and reliance on technology has become an increasingly daunting undertaking for healthcare organizations and physicians. Furthermore, healthcare organizations are held to standards aimed at achieving improved quality of care and healthier patient outcomes all at reduced costs (Stefl, 2008). The expectation of a greater patient experience while simultaneously balancing continuous changes in adopting federal mandates necessitates strong healthcare leadership to advocate hardwiring behaviors that deliver better patient outcomes while minimizing costs.

The current state of the United States health industry parallels the observation made by Peter Drucker back in 2002 when he highlighted the major complexities of large healthcare organizations, and further recognized the challenges faced by small healthcare institutions (Drucker, 2002). Many of the challenges have been incited by healthcare legislation passed by Congress. President Barack Obama signed into law the Affordable Care Act (ACA) on March

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23, 2010 (U.S. Department of Health & Human Services, 2016), which has insured approximately 20 million people between 2010 and early 2016 (U.S. Department of Health & Human Services, 2016). As millions of Americans gained health insurance who previously were uninsured, there was an evident increase in demand for healthcare services, which subsequently exacerbated the ongoing shortage of healthcare professionals (Anderson, 2016).

The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) developed shortage designation criteria for Health Professional Shortage Areas (HPSAs), which are noted as geographic locations that exhibit a shortfall of primary care, dental, or mental health providers. As of June 19, 2014, the following HPSAs were identified along with a total number of providers needed to eradicate the HPSA designation (Health Resources and Services Administration, 2016):

- An estimation of 6,100 Primary Care HPSAs was made based on a physician to population ratio of 1: 3,500. In geographic areas with 3,500 or more people per one primary care provider, the area is designated as a HPSA. To remove the primary care HPSA designation, 8,200 primary care physicians would need to join the healthcare workforce.

- An approximation of 4,900 Dental HPSAs was made according to a dentist to population ratio of 1: 5,000. In geographic areas with 5,000 or more people per dentist, the area becomes a designated HPSA. To remove the dental HPSA categorization, 7,300 dentists would need to be added to the healthcare workforce.

- An estimation of 4,000 mental health HPSAs was made based on a psychiatrist to population ratio of 1: 30,000. In geographic areas with 30,000 or more people per psychiatrist, the geographic location becomes a designated HPSA. To remove the mental

health HPSA designation, 2,800 psychiatrists would need to be added to the healthcare workforce.

The ACA is meant to bring access and quality care to the American people, yet the insurmountable healthcare workforce shortage and increased demand for services has created additional stress for health professionals, resulting in burnout, dissatisfaction and even resignation of healthcare providers (Anderson, 2016). This prevailing employee and physician engagement issue represents only one facet of a healthcare leader's portfolio of challenges to overcome. As healthcare leaders are called to lead with fewer resources (Stefl, 2008, p. 361), they are constantly navigating through complicated social and political conditions (Stefl, 2008), decreasing and fluctuating reimbursements rates (Anderson, 2016; McAlerney, 2006; Stefl, 2008), ongoing shortages in human capital (Anderson, 2016; Health Resources and Services Administration, 2016; Stefl, 2008), pervasive regulations related to performance and safety standards with penalties for non-compliance (Anderson, 2016; McAlearney, 2006), and a greater expectation for transparency (Stefl, 2008).

To overcome these operational challenges is what separates a high-performing organization from a low performing organization. The *Organizational Change Processes in High Performing Organizations* study by the Alliance for Health Care Research (2005) funded by the Studer Group revealed that high performing healthcare organizations share five influential factors. Growth from previous year is more than 5%; operating income is more than 6%; patient satisfaction scores fall in or above the 85th percentile; quality indicators benchmark above 25% of outcomes; and turnover is below 12% (Alliance for Health Care Research, 2005). These five criterion represent common operational responsibilities and challenges of healthcare leaders within their respective organizations.

There were seven hospitals in Indiana, Illinois, Florida and New Jersey whose senior leaders participated in in-depth interviews regarding their consistently high performing organizational excellence in service, quality, staff retention, operating income, and growth (Alliance for Health Care Research, 2005). Through qualitative data gathered from interviews with senior leaders from these high performing hospitals, five main influential themes emerged regarding the organization's success. These success factors include open communication and employee forums, commitment of executive and senior leadership, evaluation and accountability of leadership, leadership training opportunities, and providing the workforce with a connection to a common purpose (Alliance for Health Care Research, 2005). The underlying theme among these five influential factors of a high performing organization is leadership's participation and ownership in delivering on each factor.

There are a number of environmental factors instituted by the government that contribute to the increasing complexity of the role of leaders in the healthcare industry. These factors, such as government regulations and dwindling reimbursements, may prevent attainment of high performing recognition as competing environmental and organizational priorities create yet another obstacle for healthcare leaders (McAlearney, 2006). Reimbursements from federal and state sponsored programs impose regulatory demands from the CMS. The ACA implementation has led to the CMS decreasing payments to healthcare organizations that do not satisfy requirements of certain CMS initiatives (Page, 2013). For example, CMS began requiring medical practices of 100 or more eligible professionals under one tax identification number to report patient satisfaction scores and other quality measures to Medicare through the Physician Quality Reporting System (PQRS) in 2015 (Press Ganey, 2016). Those eligible professionals or medical group practices who failed to satisfactorily report quality data through PQRS in 2015

would be penalized by a negative Medicare payment adjustment in 2017 (Press Ganey, 2016). Providing quality of care to patients and reporting such quality metrics to Medicare is paramount in avoiding financial penalties.

On an organizational level, there are several hierarchies of leadership comprised of clinical and administrative professionals, which presents unique challenges for directing and coordinating the flow of work and responsibilities within the organization (McAlearney, 2006). Healthcare institutions are "notorious for seemingly chaotic internal coordination" (McAlearney, 2006, p. 968). In fact, there often exists a prominent cultural divide between administrative leaders and clinicians of a healthcare organization (McAlearney, Fisher, Heiser, Robbins, & Kelleher, 2005). The fiduciary responsibilities and quality expectations of administrative leaders often does not complement the physician expectations, thus causing the "cultural chasm" between the two professional levels (McAlearney, 2006, p. 968).

Clinicians have a tremendous impact on the patient experience and therefore understanding their satisfiers is integral to the success of any healthcare organization. The Studer Group, a notable healthcare consulting firm, conducted research to determine what physicians desire in the workplace. Four themes about the wants and needs of physicians emerged: quality (the assurance that patients are delivered exceptional clinical care), efficiency (the opportunity to complete their clinical tasks quickly and effectively), input (their perspective is taken into account when making organization's decision) and follow-up and appreciation (a demonstration of recognition of their contributions Studer, 2013). Administrative leaders have the added responsibility of finding ways to incorporate these physician satisfiers while balancing all other environmental and organizational priorities.

Physicians represent one major group of constituents of healthcare organizations with specific perspectives on the care delivery model; however, there are several other constituencies that include other members of the healthcare workforce (i.e. nurses, medical assistants, pharmacists, etc.), patients, their families, regulators and insurers who all have varying viewpoints on how healthcare should be delivered (McAlearney, 2006). The divergent perspectives lead to greater intricacies around what is considered organizationally effective, which inherently contributes to an additional challenge for healthcare leaders to navigate. With conflicting needs of internal and external stakeholders, healthcare leaders must possess the suitable skills in finance and human resources to ensure the highest service is delivered to patients, communities and constituents (McAlearney, 2006).

The type of leadership characteristics and behaviors of a successful healthcare leader varies in the literature. As the competitive healthcare marketplace has become focused on producing quality healthcare services at lower costs, there has been a growing trend towards the adoption of Toyota's Lean production practices, which emphasizes the elimination of waste and reduction of operational expenses (Shah & Ward, 2007). From Toyota's Lean model, Liker and Convis (2011) developed the Lean Leadership model that is comprised of four stages: (a) be dedicated to personal development; (b) develop a vision with corresponding goals; (c) drive continuous improvement of working practices, also known as kaizen, and (d) mentor and train peers and subordinates (Poksinska, Swartling, & Drotz, 2013). These four stages of the Lean Leadership model share commonalities with contemporary leadership theories such as servant leadership (Greenleaf & Spears, 2002) and transformational leadership (Bass & Riggio, 2006).

Servant leadership and transformational leadership both underscore an appreciation of individuals and the significance of coaching and developing the workforce (Stone, Russell, &

Patterson, 2004). Both theories also reflect the leadership style of demonstrating emotional and behavioral intelligence, which is considered the most efficacious leadership style for the ever-changing landscape of the healthcare marketplace (Delmatoff & Lazarus, 2014). Self-awareness and social awareness are two key characteristics that an emotionally and behaviorally intelligent leader possesses (Delmatoff & Lazarus, 2014). A self-aware leader objectively and accurately assesses one's emotional and behavioral makeup (Delmatoff & Lazarus, 2014) and understands the impact on relationships in the work environment (Goleman, 2000). The socially aware leader demonstrates empathy, organizational awareness, and service orientation by identifying and delivering internal and external customers' needs (Goleman, 2000). In healthcare, there is an emphasis on leaders realizing the behavioral tendencies of the internal customers, or employees, who are largely responsible for ensuring the changes initiated by healthcare reform are implemented efficiently. Unfortunately, there will be a cadre of individuals who are resistant to change (Delmatoff & Lazarus, 2014). In order to excel and survive in a labor intensive, fast paced, and highly service focused industry, strong healthcare leaders must embody certain characteristics and employ certain strategies to consistently motivate, empower and support the workforce in delivering quality services in an industry where change is the norm.

Statement of the Problem

Leaders in healthcare play a significant role in their respective communities in dealing with the complexities of the current healthcare industry. The leadership styles, best practices and strategies of a general population of healthcare leaders is evident in empirical research, however, there is a unique, exemplary group of healthcare leaders who have risen to leadership roles fairly quickly in their careers who are not adequately represented in research.

Becker's Healthcare is a renowned source for healthcare industry leaders searching for leading-edge business and legal information. One of Becker's widely read trade publications is *Becker's Hospital Review*, which publicizes a yearly list of *Rising Stars: 25 Healthcare Leaders Under Age 40*. Roney (2012) describes this elite group of talented and driven men and women who, before the age of 40, have earned executive positions within their respective health system or organization. Through peer nomination and editorial research, these respectable leaders are recognized for spearheading organizational initiatives and improving the performance and financial health of the institution. Roney (2012) states that many of these nominated leaders hold records as the youngest executives within their respective organizations. Considering the accomplishments of these fairly young executives before reaching the age of 40, a promising future is in the midst for these leaders.

Modern Healthcare is another prominent source of information for healthcare leaders as it provides weekly updates on healthcare trends, policies, and research through a print magazine, a web presence, and electronic newsletters. Similar to Becker's list of *Rising Starts: 25 Healthcare Leaders Under Age 40, Modern Healthcare* has been publishing an annual "Up & Comers Award" for over a decade, which recognizes 12 healthcare leaders who are 40 years and younger, and have demonstrated substantial work in healthcare administration, management, or policy (Modern Healthcare, 2016). Winners of this prestigious award are chosen based on four main criteria: (a) leadership roles and accomplishments, (b) operating and financial performance of organization under the healthcare leader's purview, (c) participation in community service, and (d) additional leadership positions outside of the nominee's main organization (Modern Healthcare, 2016).

According to the American College of Healthcare Executives (ACHE), "an international professional society of more than 40,000 healthcare executives who lead hospitals, healthcare systems, and other healthcare organizations," (American College of Healthcare Executives, 2014, para. 1), 73% of the 35,320 leaders who provided their age were over the age of 40. Given most healthcare executives are 40 and older, and due to few studies exploring younger healthcare leaders' experiences in the literature, a phenomenological study devoted to understanding lived experiences and best practices of healthcare leaders is necessary to enrich the body of research centering around a minority group of healthcare leaders.

Furthermore, the number of millennials and young adults under the age of 40 in the workplace represent a growing majority in the current labor workforce. According to the United States Census Bureau (2015), those born between 1982 and 2000 represent 83 million of the nation's population, which surpasses the population of 75 million baby boomers. Young adults and millennials under the age of 40 represent the majority, yet do not share the same protection against employment discrimination compared to individuals who are 40 years of age and older under the Age Discrimination in Employment Act (1967). As the healthcare leaders under the age of 40 experienced rapid progressions in their careers, it could be likely that their promotion may be viewed as undeserved by some.

Studies exist that corroborate the under-studied phenomenon that younger employees are discriminated against by employers and by society at large (Johnson & Neumark, 1997; Nelson, 2005). Potential attitudinal consequences of age discrimination include diminished organizational commitment in the form of affective and continuance commitment (Snape & Redman, 2003). The environmental and organizational challenges faced by healthcare leaders, in general, can be further amplified for young healthcare leaders who potentially may face the

unfortunate act of discrimination based on age. As such, the need exists to determine whether younger healthcare leaders have experienced age discrimination and other forms of conflict due to age or other prejudices, and if so, what strategies they have found useful to overcome and rise above such injustice in the workplace.

Purpose Statement

Accordingly, the purpose of this study was to explore best strategies and practices that healthcare leaders under the age of 40 can adopt for their respective organizations amidst a rapidly changing industry. The purpose was achieved by identifying the challenges and successes that current healthcare leaders under the age of 40 have experienced while leading the workforce and managing the complexities and demands of the field. The study also examined how healthcare leaders under 40 measure their leadership success. Finally, aspiring young leaders can gain fundamental knowledge and wisdom from the lived experiences of healthcare leaders who earned leadership positions early in their careers.

Research Questions

The following research questions (RQ) were addressed in this study.

RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?

RQ2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?

RQ3: How do healthcare leaders under the age of 40 measure their success and the performance of their respective organizations?

RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?

Significance of the Study

The findings of this study elicited valuable practices and strategies that current healthcare leaders can utilize in leading their respective organizations. More specifically, healthcare leaders under the age of 40 will gain insightful information on the challenges faced by fellow peers of the same age category. As age discrimination is a factor among younger healthcare leaders, there are recommendations shared on how to overcome such unjust discernments in the workplace. This body of research can help contribute to policy efforts to amend the Age Discrimination in Employment Act to remove the minimum age requirement of 40, therefore granting federal protection for all ages, young and old.

The research revealed specific leadership styles and strategies of healthcare leaders under the age of 40 that have proven to be successful when handling the various needs of the internal and external constituents of a healthcare organization. As the healthcare industry undergoes continuous change due to spontaneous environmental and organizational factors, it will be beneficial to understand the specific practices and methodologies that young healthcare leaders employ to overcome the challenges related to change management. Change is often accompanied by resistance and the demoralization of employees and physicians (Delmatoff & Lazarus, 2014). Therefore, when seeking to mollify different levels of stakeholders with varying perspectives, it would be worthwhile to understand effective conflict resolution and negotiation techniques among healthcare leaders in the research study. Findings can apprise healthcare organizations of influential employee, leadership, and clinician training and development policies, and initiate a thorough review and potential revision of existing leadership training. A similar argument can be carried forward to other industries, such as business and education. Furthermore, findings will enable leadership development training to include evidenced-based leadership behaviors and

strategies that would be instrumental in cultivating a high performing organization with an engaged workforce. Additionally, personal lived experiences and recommendations provided by leaders under the age of 40 will help aspiring young leaders with career planning assistance. As some hold records as the youngest leaders or executives within their respective healthcare organization, these elite group of leaders can serve as role models for students in graduate programs focused on health administration and leadership. The educational path, internships, residencies, or mentoring opportunities that helped the participants reach executive level roles early on in their careers will provide exemplary guidance for future leaders, especially in the healthcare industry.

Assumptions of the Study

1. It was assumed that the participants of the study could speak knowledgeably and genuinely about their leadership experiences, and express first-hand what types of best practices and strategies are necessary to successfully lead healthcare organizations.

2. The leaders in this study, although from various healthcare organizations, would share a fair amount of commonalities with regard to best practices and strategies to justify this research study.

3. The researcher would not convey any suggestive bias or influence any responses of the participants.

4. The lived experiences of a representative sample of 15 healthcare leaders under the age of 40 would contribute to a body of knowledge that is underrepresented in the literature.

Limitations of the Study

1. The researcher's professional and personal experiences in a leadership positions in healthcare may pose a potential bias to the qualitative research executed.

2. This study was limited to healthcare organizations such as hospitals, ambulatory centers, and rehabilitation centers that receive federal sponsorship from CMS in the United States.

3. Participants responded based on their personal memories, which could pose some minor issues with accuracy on recollecting lived experiences.

Definition of Terms

The purpose of definition of terms is to offer more clarity on how select terms are used in this research study. The following terms will be mentioned throughout this study:

- *Age Discrimination*: Unfavorable treatment of an individual in the workplace based on his or her age. The individual can be an applicant of a job, or a current employee. The Age Discrimination in Employment Act protects those age 40 or older (U.S. Equal Employment Opportunity Commission, 2016), however, in the context of this research study, the focus will be potential age discrimination of those under the age of 40.

- *Aspiring Young Leader*: Individuals in the Generation X and Millennial population who are preparing to step into leadership roles in their organizations and their respective communities (Coleman & George, 2011).

- *Change Management*: In healthcare organizations, there are several practices that are noted to be critical in business and organizational transformations. The first practice is to deliver a business justification and vision for change. The second practice is to evaluate the organization's readiness for change, and correspondingly the risk involved. The third practice is to align the organization with the vision and goals by mobilizing the healthcare leaders who will raise awareness and engender commitment of the workforce towards change. Finally,

the change effort should be measured and tracked for performance improvement and benefits (Giniat, Benton, Biegansky, & Grossman, 2012).

- *Healthcare Leader*: The sample of interviewees will consist of current healthcare workforce members under the age of 40 in director or above roles. If one is under the age of 40 and a member or fellow of the American College of Healthcare Executives (2016), he or she is placed in the Early Careerist Network. The roles above the director position include senior directors, executive directors, senior administrators, vice presidents, presidents, chief executive officers, chief operating officers, chief financial officers, or chief information officers.

- *Healthcare Organizations*: According to the American College of Healthcare Executives (2016), positions for healthcare leaders or executives are available in multiple settings: ambulatory care facilities, consulting firms, healthcare associations, home health agencies, hospices, hospitals and hospital systems, integrated delivery systems, long-term care facilities, managed care organizations, medical group practices, mental health organizations, public health departments, and university or research institutions.

- *High Performing Organization*: In healthcare organizations, high performance is marked by superior results in the following indicators: patient satisfaction, quality benchmarks, staff retention, operating income, and growth (Alliance for Health Care Research, 2005).

- *Phenomenology*: A research design that highlights the lived experiences of participants regarding a particular phenomenon as discussed by the participant (Creswell, 2014). Interviews are typically conducted to elucidate the "essence of

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the experiences" (p.14) of several participants who share similar experiences with a particular phenomenon (Creswell, 2014).

- *Quality*: The term quality in the healthcare industry refers to patients receiving appropriate and timely care on a consistent basis (Clancy, 2009).

Chapter Summary

Healthcare leaders play vital roles in the performance of their respective organizations (Alliance for Health Care Research, 2005; Chassin & Loeb, 2013; Garman, McAlearney, Harrison, Song, & McHugh, 2011; Studer, 2013; Taylor, Clay-Williams, Hogden, Braithwaite, & Groene, 2015). There are trends (DeVore & Champion, 2011; Iglehart, 2011; James, 2012; Santilli & Vogenberg, 2015) within the United States healthcare system that provide a dynamic marketplace that commands strong thought leaders who can handle risks, decision making, and relationship building. The ultimate goal of healthcare leaders is to achieve high performance status through engaging the entire workforce to meet or exceed metrics in growth, operating income, patient satisfaction, safety and quality indicators. The main focus of this study is leaders under the age of 40 who will continue to experience the complex challenges and changes occurring in the healthcare environment. Young, aspiring healthcare leaders will be stepping into similar roles and responsibilities that make it essential to provide research that shares experiences, common themes, and best practices for excelling in a leadership role. Furthermore, any healthcare leader, regardless of age, can benefit from successful strategies and practices for leading healthcare organizations.

Chapter 1 provided an outline of this qualitative research study, illuminated background information to support the problem, highlighted a problem statement, and elucidated the purpose of this study. Four research questions were identified, which focused on the challenges of

healthcare leaders under the age of 40 in overseeing their respective organizations as well as their strategies, best practices, and measurements of success. The significance of the study was described, which is primarily to leave a long lasting informational legacy for future young leaders to address organizational challenges. Chapter 2 will deliver a review of relevant literature that will serve as theoretical and foundational context for the research.

Chapter 2: Literature Review

Healthcare leaders serve a fundamental role in the performance and success of the organizations they lead. As exemplified by the following review of literature, the strategies, practices, and behaviors of leaders in healthcare yields key information for transferrable knowledge that can be valuable in many leadership positions, including roles outside of the healthcare industry. The review of literature speaks to the objective of this study, which is understanding the particular challenges of the healthcare environment and the leadership style and strategies necessary to overcome obstacles for leading high performing organizations.

This comprehensive review will elucidate the current state of healthcare affairs within the United States, which impacts the organizational level wherein healthcare leaders must possess the skills and knowledge to mobilize the workforce to meet certain performance expectations. The distinction between high and low performing healthcare organizations will be discussed, followed by strategies and best practices to attain high performance status. Two different change management and performance-driven frameworks, High-Reliability Health Care Maturity Model (Chassin & Loeb, 2013), and Studer Group's Evidenced Based Leadership Framework (Studer, 2013), commonly used in the healthcare environment will be the main focus. The balanced scorecard (Kaplan & Norton, 2007) and pillar framework (Studer, 2013) are two methods for measuring performance in healthcare organizations. Additionally, leadership styles, behaviors, and practices that are generally recognized in the service-oriented healthcare industry will be shared, including Lean leadership (Liker & Convis, 2011), transformational leadership (Bass & Riggio, 2006), servant leadership (Greenleaf, 1977), and leadership in self-managed teams (Yukl, 1997).

As the focus of this research study is leaders under the age of 40, an overview of the Age

Discrimination in Employment Act (ADEA) will be provided, along with information on Social

Dominance Theory (Sidanius, Pratto, van Laar, & Levin, 2004), which is foundational to issues

related to age discrimination and intergenerational issues in the workplace. This literature review

will inform the research study and will provide a solid foundation for conducting qualitative

interviews, analyzing the data, and discussing the findings.

The Healthcare Landscape

      Affordable care act. As this study serves to understand the challenges faced by

healthcare leaders overseeing their respective organizations, it is beneficial to understand the

current healthcare market trends (DeVore & Champion, 2011; Iglehart, 2011; James, 2012;

Santilli & Vogenberg, 2015) that impact the organization's operations and bottom line. The role

of healthcare leaders across the United States has become more crucial and challenging with the

passing of the Affordable Care Act, which was a significant milestone for providing healthcare

to the masses (Keehan et al., 2011). There are several venues for which Americans could obtain

health coverage through the ACA. First, uninsured Americans enrolled through the on-line health

insurance marketplaces (Blumenthal, Abrams, & Nuzum, 2015). Second, states could have

expanded their Medicaid programs to cover individuals who are at or below 138% of the federal

poverty level (Blumenthal et al., 2015). Third, young adults under the age of 26 could now be

covered by their parents' health insurance as dependents (Blumenthal et al., 2015). Finally,

insurers can no longer discriminate against those with preexisting conditions, therefore

prohibiting the termination of policies due to illness (Blumenthal et al., 2015). While the intent

of the historic healthcare reform initiative granted millions of uninsured individuals health care

coverage (Blumenthal et al., 2015; Keehan et al., 2011), it increased health care spending

nationally to $2.6 trillion in 2010, and is expected to increase healthcare costs by 5.8% annually from 2010 to 2020 (Keehan et al., 2011). Additionally, the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) underscored the consequence of a shortage of healthcare providers to serve the millions of Americans with insurance (Health Resources and Services Administration, 2016). Due to the growth in national spending perpetuated by the ACA and the subsequently larger population of insured Americans (Keehan et al., 2011), healthcare organizations and their respective leaders must foster strategic thinking to remain competitive and financially viable in an industry where constant change and cost cutting have become the norm.

Triple Aim. The Triple Aim initiative introduced back in 2007 by the Institute for Healthcare Improvement (IHI) gained restored traction in recent years since the passing of the ACA (McCarthy & Klein, 2010). The objective of the Triple Aim is to improve the overall status of the American healthcare system through three main goals. These goals include improving quality outcomes for patients, enhancing patient satisfaction, and decreasing costs for the population served (Berwick, Nolan, & Whittington, 2008). As healthcare organizations work to achieve the difficult feat of balancing the three components of the Triple Aim, problems such as poor management of care and overutilization of medical services can be addressed (McCarthy & Klein, 2010). There is an underlying need to balance the execution of each aim effectively as focusing more heavily on one aim may cause an unintended ripple effect on one of the other aims (McCarthy & Klein, 2010). Leaders of healthcare organizations have to be aware that a greater emphasis on quality initiatives can impact spending, while a sole focus on reducing costs through workforce reductions, for example, can lead to an unsatisfactory patient experience (McCarthy & Klein, 2010).

Accountable care organizations. The ACA has also commanded strategic trends in the healthcare marketplace that has created additional factors that influence decision making and relationships among key stakeholders and healthcare leaders (DeVore & Champion, 2011; Iglehart, 2011; Santilli & Vogenberg, 2015). One common trend promoted by the Obama administration and Congress is the development of accountable care organizations (ACOs Iglehart, 2011), which is a network of health systems and hospitals that partner with one another with the common goal of improving the health of Americans by emphasizing primary care and preventive care measures (DeVore & Champion, 2011; Santilli & Vogenberg, 2015). To become an ACO, the network of health care providers and hospitals must demonstrate the capability of providing the full spectrum of care to a minimum of 5000 Medicare beneficiaries while simultaneously controlling costs and exhibiting quality care for a defined patient population (Iglehart, 2011; Santilli & Vogenberg, 2015). Private health plans can also partner with ACOs to encourage more efficient utilization of care resources (Iglehart, 2011). Essentially, the concept of ACOs challenges leaders to partner with other healthcare systems and to strategize methods that demonstrate accountability for delivering quality healthcare at a low cost (DeVore & Champion, 2011; Igleart, 2011).

Pay-for performance. Besides ACOs, there are other market trends (DeVore & Champion, 2011; James, 2012; Santilli & Vogenberg, 2015) that govern the current healthcare system. These are key initiatives that healthcare leaders must keep themselves apprised of to remain current and competitive in the industry. First, hospitals and healthcare providers are financially enticed to meet pay-for-performance (P4P) measures, also known as value-based reimbursement (Santilli & Vogenberg, 2015). P4P is a payment methodology to incentivize

healthcare providers and hospitals to improve quality of care provided to patients and achieve population health and wellness (DeVore & Champion, 2011).

The evolution of defined quality indicators for P4P measures, including process, outcome, patient experience, and structure measures, as determining factors of provider compensation is another market trend (James, 2012). Managing the P4P payment system within an organization is a key responsibility of healthcare leaders, which entails monitoring and partnering with physicians to ensure performance metrics are met. Process measures evaluate certain clinical decisions and actions that can impact health outcomes for patients (James, 2012). An example is whether providers counsel patients on the health risk of smoking. Outcome measures assess the impact care has on patients' health status (James, 2012). One common outcome measure is controlling for diabetes, which is monitored through patient laboratory results. Patient experience measures evaluate patients' discernments regarding the care delivered by healthcare providers and staff (James, 2012). Patients have the ability to make more informed decisions about their health due to the accessibility of information on the internet, which allows patients to be active participants in their diagnosis and treatment. (Santilli & Vogenberg, 2015) Lastly, structure measures refer to the infrastructure used during the treatment, which breaks down to the facility, equipment, and personnel involved (James, 2012).

Electronic health records. As for equipment in healthcare organizations and physician practices, health systems have been working arduously to meet the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) instituted by President George W. Bush (DesRoches & Miralles, 2011). The HITECH Act imposed the adoption of electronic health records (EHR) by 2014 in healthcare organizations (DesRoches & Miralles, 2011). EHR, also known as Electronic

Medical Records (EMR), organizes a patient's medical record into a computerized information system that is accessible throughout a health system. ARRA permitted the Centers for Medicare and Medicaid Services (CMS) to offer financial incentives between 2011 and 2014 in order to encourage the implementation of an EHR to improve the quality of patient care (DesRoches & Miralles, 2011). Moreover, the CMS was given authority to financially penalize physicians and health organizations for not deploying an EHR by 2015 (DesRoches & Miralles, 2011). Implementing and training the healthcare workforce to transition from paper charts to an EHR has been a tremendous financial investment for healthcare organizations, and continues to require effort by leaders, physicians, and staff to keep up with updates and government mandates related to the EHR systems. EHRs are key to gathering and storing data related to P4P measures, which are submitted to government agencies such as CMS.

There has been notable resistance by physicians to adopt the EHR despite the quality benefits and financial incentives associated with adopting an EHR (Clarke, Belden, & Kim, 2014). The intended quality benefits of utilizing an EHR include the following: reduction in paperwork, the ability to remotely access a patient's medical record, accurate and updated patient information, alerts to critical lab results, and improved patient satisfaction (Clarke et al., 2014). EHR technology allows for added transparency, thus empowering patients through patient education resources and creating a mechanism for better coordination of care (Santilli & Vogenberg, 2015). Despite the unprecedented growth in the number of EHR users, there remain late or resistant adopters who report challenges to adopting EHRs. The perceived disadvantages include implementation costs, workflow issues, increase in doctors' time in training and learning the system, and decrease in productivity (Clarke et al., 2014). The loss in productivity is related to usability challenges of having to adhere to predetermined workflows and being accountable to

a computerized technology (Nelson, 2005). These and other factors of resistance have led to

negative attitudes toward the usefulness and efficiency of the EHR (Meinert & Peterson, 2009).

According to Lakbala and Dindarloo (2014), physicians play the most significant role in

attaining quality improvement and financial return in implementing EHRs. As the primary user

group, physicians' support or lack thereof heavily influences adoption by other important user

groups, such as administrative and clinical staff (Lakbala & Dindarloo, 2014). In order to

successfully implement any new system for physicians, healthcare leaders must gain physician

buy-in and participation in the planning of workflow changes and utilization of the EHR.

   Other market trends. Additional market trends further impact the financial viability of

healthcare organizations (Santilli & Vogenberg, 2015). As baby boomers continue to age with

several chronic conditions, there is greater economic risk for organizations that take care of an

aging population, which then places added pressure on maintaining consistent revenue streams

(Santilli & Vogenberg, 2015). To respond to narrowing operating margins, hospital mergers and

acquisitions, also known as horizontal integration, is another healthcare trend that allows health

systems to expand in scale and to spread the financial risk and operating costs throughout a

larger enterprise (Santilli & Vogenberg, 2015). As health systems unite into ACOs, insurers face

the pressure of maintaining low premiums, which is achieved by excluding costly healthcare

providers and hospitals from the network (Santilli & Vogenberg, 2015). Inherently, the narrower

networks lead to issues with patient access and satisfaction as consumers of healthcare have

fewer options when choosing a provider (Santilli & Vogenberg, 2015).

   The healthcare market trends since the passage of the ACA in 2010 has created a

multitude of challenges faced by leaders in the industry (DeVore & Champion, 2011; Igleart,

2011). The Triple Aim approach of satisfying patient needs through quality care while reducing

costs sums up a facile concept in theory, yet complexities arise when leaders attempt to implement the IHI approach (McCarthy & Klein, 2010). With the healthcare landscape undergoing rapid change on a daily basis (Studer, 2013), competing priorities often derail process improvement plans. With growing collaborations in ACOs and narrowing networks (Santilli & Vogenberg, 2015), economic (DeVore & Champion, 2011; Igleart, 2011) and clinical risks (Santilli & Vogenberg, 2015) are spread among varying stakeholders. The role of healthcare leaders will continue to be impacted as current and evolving market trends affect stakeholder relationships, decision making and strategic thinking (DeVore & Champion, 2011; Iglehart, 2011; Santilli & Vogenberg, 2015). It is the innovative strategies and practices developed and implemented by healthcare leaders that differentiates the struggling low performing organizations from the high performing organizations that will maintain stability during times of constant change (Studer, 2013).

High Performing Organizations: Conceptual Framework

The extant literature on high performing organizations conveys overlapping and varying themes and measures to define performance in institutions. High performing organizations are referred to in the literature by different nomenclature (Chassin & Loeb, 2013; Garman et al., 2011; Harley, Allen, & Sargent, 2007; Harmon et al., 2003; Taylor et al., 2015; Weick & Sutcliffe, 2007). The other comparable terms include high performing hospitals (Taylor et al., 2015), high performance work systems (Harley et al., 2007), high performance work practices (HPWP Garman, et al., 2011), high-involvement work systems (HIWS Harmon et al., 2003), and high-reliability organizations (HROs Chassin & Loeb, 2013; Weick & Sutcliffe, 2007). These terminologies in the literature are described in various ways, either by definition, a set of themes, or by specific measures. As this study serves to explore the path to success of healthcare leaders

who strive for excellence in their respective organizations, it is beneficial to be informed by what constitutes "high performance" in existing literature.

High performing organizations. In Chapter 1, high performing organizations were originally defined through the "Organizational Change Processes in High Performing Organizations" study by the Alliance for Health Care Research (2005). To qualify for this research study, hospitals needed to demonstrate a certain level of achievement in five measures: service, quality, staff retention, operating income, and growth (Alliance for Health Care Research, 2005). Senior leaders from high performing hospitals were asked to provide their perspective regarding the organization's success (Alliance for Health Care Research, 2005; Studer, 2013). The emerging themes of high performance include open communication and employee forums, commitment of executive and senior leadership, evaluation and accountability of leadership, leadership training opportunities, and providing the workforce with a connection to a common purpose (Alliance for Health Care Research, 2005). The common thread among these five success factors of a high performing organization is leadership's involvement and ownership in fostering an environment that values each of the themes (Alliance for Health Care Research, 2005).

High performing hospitals. Several research studies distinguish high performing hospitals from low performing hospitals (Curry et al., 2011; Jha & Epstein, 2010; Kane, Clark, & Rivenson, 2009; Taylor et al., 2015). One comprehensive study reviewed 19 studies and facilitated a qualitative process of data abstraction, contextual analysis, and thematic synthesis for recognizing high performing hospitals (Taylor et al., 2015). Similar to the P4P measures mentioned previously (Santilli & Vogenberg, 2015), process, output, and outcome factors were utilized in the identification of the characteristics displayed by top performers. The systematic

synthesis of literature revealed seven themes apparent in high performing hospitals, which will be described in more detail in the following subsections (Taylor et al., 2011).

   Positive organizational culture. Through the systematic review of 19 studies by Taylor et al., (2015), five common characteristics emerged under the theme of positive organizational culture. The first characteristic is the clear respect between varying levels of the healthcare teams, both clinical and non-clinical, across departments and disciplines (Bradley et al., 2006). Second, high-performing hospitals exhibited a strong belief in attaining excellence through acts of consistency and ongoing quality improvements (Keroack et al., 2007). Third, employee achievements were recognized by leadership and financially compensated in a timely fashion (Keroack et al., 2007). Fourth, employees received encouragement to share concerns and ideas to improve work culture and processes, which fostered a safe and comfortable environment (Adelman, 2012). Lastly, the different hierarchical levels of high performing hospitals bought into the same mission, vision, and values that encouraged quality, safety, and continuous improvement (Adelman, 2012).

   Senior management support. Taylor, Clay-Williams, Hogden, Braithwaite, and Groene (2015) detected four characteristics that contributed to the second theme of high performing hospitals. The first characteristic revealed employee appreciation of the support demonstrated by senior management in facilitating relationships between healthcare providers and non-clinical team members. Second, senior management demonstrated active participation and constant interaction with staff during implementation of hospital initiatives. Third, high visibility of senior managers and ease of communication in resolving problems also contributed to a consensus of senior management support apparent in high performing hospitals. Lastly, senior managers exhibited unwavering commitment to achieving exceptional quality care (Taylor et al., 2015). As

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senior management support has an apparent impact on healthcare organizations' performance, it is imperative for leaders to lead by example by displaying the same level of support to senior management and to every level of the organization, thereby creating a potential cascading effect downstream.

Effective performance monitoring. Four characteristics were representative of the third theme, *effective performance monitoring* (Taylor et al., 2015). Employees value having set goals and effective monitoring of progress through transparency of accurate data. To promote reliable performance monitoring, high performing hospitals instituted robust technical infrastructure to track clinical and financial data. Information obtained from data systems would then be utilized to detect issues, encourage change, apply new processes, and support constant feedback and improvement initiatives. A culture of accountability was the final characteristic under effective performance monitoring. The notion highlighted in the systematic review of literature indicates the importance of "upward accountability" through the sharing of data sources that provide a distinction between poor performers versus high performers (Taylor et al., p. 15). As effective performance monitoring is critical to meeting high performance standards in hospitals, healthcare leaders play an important role in goal setting, sharing performance results, and obtaining feedback on improvement initiatives, which should foster a culture of accountability at all levels of the organization.

Building and maintaining a proficient workforce. Four characteristics related to human resource functions contributed to the fourth theme of high performing hospitals, which healthcare leaders must instill in their senior management and middle management involved in the management of frontline staff (Taylor et al., 2015). First, there is a fundamental emphasis on selecting high performers, retaining them, and developing staff through training opportunities.

Second, in high performing organizations, recruitment involves choosing staff who are aligned with the company's vision. Additionally, ongoing evaluations with current staff focuses on their commitment to the organization's vision. Third, an effective workforce thrives on evidenced-based and established policies and procedures to ensure consistent and safe practices are used across the continuum of care. Lastly, high-performing hospitals invest in staff by supplementing their development through mandatory educational initiatives and training sessions for staff, for which healthcare leaders can dictate the dollars to be allocated.

Effective leaders across the organization. The fifth theme, *effective leaders across the organization*, is composed of three characteristics exhibited by healthcare leaders. Leaders exemplify quality-focused values of commitment and ownership for attaining excellent organizational outcomes in quality, patient satisfaction and costs (Bradley et al., 2006). Healthcare leaders also genuinely care for staff performance and development, which manifests in leaders' openness to providing and receiving feedback, and willingness to provide key resources to enhance processes (Puoane, Cuming, Sanders, & Ashworth, 2008). As mentioned in the first theme, positive organizational culture, mutual respect is a highly revered characteristic exhibited on multiples levels of leadership, from medical leaders, to nurse leaders, and administrative leaders (Bradley et al., 2006).

Expertise-driven practice. Two characteristics are emblematic of the sixth theme, *expertise-driven practice*, which is another indicator of a high performing hospitals (Taylor et al., 2015). The first characteristic is flexibility granted to frontline staff to allow them the autonomy to refine processes incrementally with the goal of accomplishing optimum results (Bradley et al., 2006). All changes are based on quick feedback loops among the care team, as well as staff expertise in recommending best practices. The second characteristic is the organization's' trust in

employees' capabilities empowering them to be innovative in problem solving and creative in decision making (Robbins, Garman, Song, & McAlearney, 2012).

Interdisciplinary teamwork. Three thematic ideas were combined to create the overarching seventh theme of high performing hospitals, *interdisciplinary teamwork* (Taylor et al., 2015). The first characteristic is a collaborative environment in which different levels and disciplines of the internal healthcare workforce communicate effectively with a common purpose of meeting performance goals as a team (Bradley et al., 2006). The second thematic idea that emerged was sharing of evidenced-based knowledge and resources on certain diseases and treatments with external hospital providers (Landman et al., 2013). Third, to ensure timely and effective services are provided to patients during the continuum of care, there is notable collaboration between providers, administrators, social services and other departments to deliver coordinated services to the patient with the intent of achieving optimal outcomes (Taylor et al., 2015).

High-performance work systems. Management practices in the field of human resources is the definition of a high-performance work system (HPWS). The human resources practices in HPWS are employee-centric, including a systematic recruiting and selection process, professional development opportunities, encouragement of creativity in problem solving, and a rewards system for achieving organizational goals (Harley et al., 2007). Previous research has been centrally focused on HPWS' impact on organizational performance in the manufacturing setting (Appelbaum, Bailey, Berg, & Kalleberg, 2000), but not in the service sector (i.e. the healthcare setting Harley et al., 2007). Empirical research on HPWS has been predominantly written from the management perspective versus the employee perspective (Becker & Huselid, 1998). Research published in the *British Journal of Industrial Relations* provides the employee

perspective of HPWS' in the healthcare setting in a study that brings to light an academic debate between the "mainstream" and "critical" approaches of HPWS (Harley et al., 2007, p. 607). The "mainstream" approach postulates a positive association between HPWS practices and employee outcomes (i.e. employee satisfaction, organizational commitment), which leads to productive contributions to the organization. Conversely, the "critical" approach is derived from the "labor process theory" (Ramsay, Scholarios, & Harley, 2000), which posits that any organizational performance successes related to HPWS practices is achieved through increased employee responsibility and workload. The heightened intensity of work then results in greater stress and pressure in the workplace (Ramsay et al., 2000).

Registered nurses (highly skilled workers) and personal care workers (lower skilled workers) participated in a research study in Victoria, Australia to test whether there is an association between HPWS practices and the mainstream approach versus the critical approach that supports the labor process theory (Harley et al., 2007). The independent variables included key measures of HPWS practices such as the level of autonomy within teams, the employee selection process, areas of performance management, performance based pay, employee training, and employee inclusion in decision making regarding organizational changes (Harley et al., 2007). The dependent variables of the study included three factors that tested outcomes of the "mainstream" approach, and three outcome variables that tested main suppositions of the labor process theory approach. The "mainstream" variables are (a) employee's level of control for job performance, (b) job satisfaction, and (c) organizational commitment. The labor process theory indicators include the following variables: (a) intention of employees to quit, (b) psychological stress, and (c) work effort (Harley et al., 2007). Essentially, the study revealed strong corroboration of the "mainstream" approach that HPWS practices are positively associated with

constructive employee outcomes (e.g. employee satisfaction, organizational commitment), versus

negative employee outcomes (e.g. intention to leave, stress, low commitment). Therefore, human

resource practices play a vital role in employee engagement, which in turn contributes to

enhanced commitment and performance in achieving organizational goals.

High-performance work practices. High-performance work practices (HPWP) is

another term used in relation to high performing organizations (Garman et al., 2011). HPWPs

refer to a set of key practices that drive positive organizational outcomes by focusing on

initiatives that improve the quality and efficiency of employee performance (Garman et al.,

2011). Similar to the definition of high performance work systems by Harley, Allen, and Sargent

(2007), HPWPs consist of human resource practices such as selective recruitment, staff

development and involvement in decision making, and incentive compensation (Robbins et al.,

2012). Garman and colleagues (2011) derived the conceptual model through the realist approach

of synthesizing and reviewing literature (Pawson, 2006). By starting with a pool of 114 articles,

Garman and colleagues retained only 52 articles, which were used to develop the HPWP model

through which the EBL Framework (Studer, 2013) will be analyzed.

Organizational factors influencing adoption, impact, and sustainability of HPWPs are

demonstrated in the HPWP model. Adoption of HPWPs requires senior leadership support and

human resources involvement in order to successfully facilitate the implementation of the

HPWPs (Galang, 1999). Capabilities of implementers (those who establish and facilitate the

HPWPs in the workplace Murphy & Southey, 2003), number of network affiliations (e.g.

quantity and quality of organizational associations and coalitions Erickson & Jacoby, 2003),

financial condition (Delaney & Godard, 2011), and lower union density (Galang, 1999) are also

factors in healthcare organizations that influence adoption of HPWPs. The impact and

sustainability of the HPWPs over time are influenced by the quality of the local labor market, the organization's financial status, and degree of leadership support (Garman et al., 2011). The main component of the HPWP model that provide healthcare leaders some guiding practices are the HPWPs grouped into four subsystems (Garman et al., 2011):

HPWP subsystem #1: engaging staff. The HPWP model by Garman and colleagues (2011) identifies four key practices for staff engagement. These four practices include the following: (a) communicating mission and vision, (b) information sharing, (c) employee involvement in decision-making, and (d) performance driven reward/recognition (Garman et al, 2011). Organizational leaders in high performing organizations do not automatically assume employees understand the "why" behind certain decisions or actions. Conversely, leaders expend time to share the reasons behind decisions and purposefully elucidate employee's valuable purpose in carrying out the mission and vision of the organization. High performing organizations share information down the chain of command in cascading fashion from senior leadership to directors, to managers, to supervisors, to frontline employees (Garman, et al., 2011). Information is also shared via report cards, which display quality or patient experience metrics throughout the facilities. Employees at every level are encouraged to partake in process improvement projects (i.e. Lean projects), which demonstrates involvement in decision making. Lastly, high performing organizations tie achievement of goals to recognition or incentive programs (Garman et al., 2011).

HPWP subsystem #2: aligning leaders. Leadership alignment and development entails three practices that are evident in high performing organizations: (a) providing leadership training, (b) linked to organizational goals, (c) succession planning, (d) performance-contingent rewards (Garman et al., 2011). The first practice, *leadership training*, is exemplified through

new manager training, formal leadership development educational opportunities for senior leaders and emerging leaders, and management training for physicians. *Succession planning* in organizations looks to internal candidates to develop and promote them into leadership roles. Lastly, there is complete transparency around individual leaders' progress on their key objectives, which drives the performance-contingent compensation as outlined in the HPWP model (Garman et al., 2011).

   HPWP subsystem #3: acquiring & developing talent. According to the HPWP model, staff acquisition and development includes four key practices: rigorous recruiting, selective hiring, extensive training, and career development (Garman et al., 2011). *Rigorous recruiting* is demonstrated through communicating appealing characteristics of the organization including competitive compensation and benefit packages and exceptional employee engagement scores (McAlearney et al., 2011). With *selective hiring*, organizations emphasize selecting the right talent aligned with the mission and organizational culture. (McAlearney et al., 2011) Additionally, employees participated in peer interviewing to select new team members. While the selection process is key, there is added emphasis on training and developing existing human capital. *Extensive training* at every level exists for new employees, senior leaders, managers, and clinical staff (i.e. nurses). Finally, the high performing organizations provided mentoring programs, employees subsidies for professional development courses, and leadership development opportunities for "high potential managers," physicians, and nurses (McAlearney et al., 2011, p. 223).

   HPWP subsystem #4: empowering the frontline. There are four key practices under the fourth subsystem of the HPWP model. These include employment security (policies and practices that support employment stability), employment safety (frontline staff being able to

speak up about safety concerns), reduced status distinctions (a formal hierarchy is de-emphasized), and teams/decentralized decision-making (empowering teams to decide on how to organize their day-to-day operations Garman et al., 2011). Leaders visibility on the floor and open communication practices with employees demonstrates leadership's willingness to work side by side with staff and to promote approachability of leaders, which is atypical in organizations with hierarchical distinctions. As leaders make rounds throughout the organization, employees have the ability to communicate any operational or safety issues and ideas to create more efficient systems. By having the opportunity to voice opinions about organizational improvements, employees take part in the decision-making process and impact safety outcomes since they feel more comfortable reporting errors or near-misses from which the rest of the organization can learn.

High-involvement work systems. Healthcare leaders and managers are tasked with two key imperatives: decreasing patient related costs, and selecting and retaining a competent healthcare workforce dedicated to helping patients improve their health outcomes. A research study featuring 146 Veterans Health Administration (VHA) facilities illustrated the significance of high-involvement work systems (HIWS) in meeting the two leadership requirements that ultimately improves organizational performance (Harmon et al., 2003). HIWS is defined as "a holistic work design that includes interrelated core features such as involvement, empowerment, development, trust, openness, teamwork, and performance based rewards" (Harmon et al., 2003, p. 393). This definition represents overlapping human resource themes found in HPWS (Harley et al., 2007) and HPWP (Garman et al., 2011).

While staff development and competitive salaries and benefit packages are instrumental to retaining high potential employees, these areas of HIWS may counteract cost-saving

initiatives. Conversely, Fortune 1000 firms that have introduced HIWS to their human resource processes have seen positive results in customer and employee satisfaction, financial performance, productivity, and quality (Harmon et al., 2003). The VHA study demonstrated similar organizational improvements experienced by the Fortune 1000 firms. HIWS practices in 146 VHA facilities enhanced employee satisfaction, which led to cost-cutting outcomes such as decreased stress levels, reduced turnover, less leaves of absence, and fewer work related disability claims. Consequently, financial performance improved immensely with an average of $1.2 million in savings per VHA facility, which was made possible by "unleashing and leveraging the human potential that resides with all organizations" (Harmon et al., 2003, p. 403).

      High-reliability organizations. The science of high-reliability looks at organizations that are at risk for hazard and deadly failure, yet have extremely safe track records with rare instances of accidents. Examples of high-reliability organizations (HROs) are the aviation industry and nuclear power plants, which are two industries that demonstrate far greater levels of safety and reliability than the healthcare industry (Chassin & Loeb, 2013). Weick and Sutcliffe (2007) expound on five principles that serve as exemplary practices of safety and quality among high-reliability organizations that health care facilities can adopt. First, HROs remain vigilant to the potential of failure or threat, and do not take for granted the absence of accidents over months or years (Weick & Sutcliffe, 2007). Second, employees in HROs do not downplay or simplify any concerning observations in the field. Instead, they are mindful and consistent in differentiating between the small subtleties of threats to safety, reporting them, and correcting the threat before they magnify into a larger threat. Third, HROs demonstrate a "sensitivity to operations" (Chassin & Loeb, 2013, p. 462), which indicates acknowledgement that minimal changes in process or operations poses immediate potential threats; therefore, any aberration from the expected task or

process should be reported immediately (Weick & Sutcliffe, 2007). Furthermore, employees in HROs take ownership of the obligation to voice any concerns or potential hazards. Fourth, HROs demonstrate profound resilience in employees' abilities to identify errors rapidly, resolve them, and mitigate further risks of those errors spiraling into bigger problems. The fifth and final principle of HROs is deferring to experts in light of new threats. Depending on the situation and type of threat posed, HROs have structures in place, regardless of organizational hierarchy, to determine which experts should have complete autonomy and decision-making authority to rectify the situation (Weick & Sutcliffe, 2007).

Discussion. High-performing organizations were discussed from different angles through a deep dive into varying terminologies, measures, and practices of what is considered "high performing" in existing literature. There is major emphasis of human resource functions and leadership and management interactions that directly impacts employee engagement and organizational performance. The review culminated in a discussion regarding "high-reliability organizations," which are organizations that value and strive for "near-perfect safety" (Chassin & Loeb, 2013, p. 462). With safety as a priority, quality becomes a complementary objective. Unfortunately, healthcare organizations, in particular hospitals, have been reported to fall short in terms of meeting safety and quality goals, which precludes these healthcare organizations from being labeled as highly reliable based on empirical research. To be labeled as high performing or reliable stands as a major challenge for healthcare leaders throughout the United States.

Applying some of the five principles of high reliability posited by Weick and Sutcliffe (2007) could improve healthcare organizations, propelling them to the highly reliable designation. For example, HROs are preoccupied with preventing failure, while healthcare

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organizations present as "[accepting] failure as an inevitable feature of their daily work" (Chassin & Loeb, 2013, p. 463). A prime example is an estimated 99,000 hospital deaths in the United States caused by hospital-acquired infections (Klevans, et al., 2007), which is further compounded by research demonstrating the infection prevention practice of hand hygiene compliance to be less than 50% in organizations (Erasmus, et al., 2010).

While incremental improvements have been made in healthcare, there still remains a gap in the workforce's sensitivity to deviations in operations and willingness to communicate potential errors or hazards (Weick & Sutcliffe, 2007). Unsafe behaviors, conditions, and practices are often witnessed by healthcare employees, however, they frequently do not report these issues upward to management (Chassin & Loeb, 2013). This reluctance to communicate in the team environment and with superiors is further exacerbated by the intimidating behaviors demonstrated by physicians, mainly towards nurses (Leape, et al., 2012). The unapproachable demeanor of physicians further intensifies the poor communication prevalent in healthcare organizations. Finally, HROs defer to expertise regardless of status in the chain of command when responding to safety and quality issues; Conversely, healthcare organizations operate through hierarchical layers when resolving threats or problems regardless of who holds the expertise in the organization (Chassin & Loeb, 2013). Healthcare leaders must break down the barriers of hierarchy within the organization, bridge the relationship between healthcare providers and the frontline staff, and inspire a team environment committed to attaining high reliability status. The following section presents previous research on strategies and practices that healthcare leaders may adopt in their respective organizations to achieve performance goals related to safety, quality, finance, and patient satisfaction.

Strategies and Practices of Healthcare Leaders

In 2001, the Institute of Medicine (IOM) Committee on Quality of Health Care in America published groundbreaking information that brought patient safety to the forefront of healthcare topics. The IOM stressed six aims of quality: safe, effective, patient-centered, timely, efficient and equitable care (Institute of Medicine Committee on Quality of Health Care in America, 2001). For patients and their families, their expectation is compassionate and consistent care delivered in a safe and error-free environment. More than a decade since IOM's seminal work, healthcare organizations and practitioners have battled cases of medical malpractice and the fallout of human errors. In 2014, the National Practitioner Data Bank (NPDB) administered by the United States Department of Health & Human Services (HHS) recorded $3.9 billion dollars in medical malpractice payments in the United States with 30% of the malpractice cases resulting in death (Diederich Healthcare, 2016). Such statistics demonstrate the enormous, glaring gap between current state of healthcare and the six aims of the Institute of Medicine. Therefore, exemplary practices and strategies in existing literature is beneficial to the role of healthcare leaders in catalyzing efforts of the entire workforce to ensure patients receive a "safe, effective, patient centered, timely, efficient and equitable" experience on a consistent basis (Institute of Medicine Committee on Quality of Health Care in America, 2001, p. 7)

Two models to improve the delivery of healthcare will be explored in the following sections. The first model, Evidenced Based Leadership (EBL) Framework, is an execution framework that serves to align goals, behaviors, and processes to transform healthcare organizations into high performers and ultimately improve patient experience (Studer, 2013). The second model, high-reliability healthcare maturity model, is comprised of three major domains of change: leadership, safety culture, and robust process improvement (RPI Chassin &

Loeb, 2013). RPI is comprised of three methodologies used to resolve quality and safety problems: lean, six sigma, and change management.

Evidenced-Based Leadership Framework

Studer Group, a Huron Healthcare solution, partners with healthcare organizations in the United States, Canada, Australia and other countries, to accomplish cultural transformations in the healthcare marketplace amidst continuous change. Studer Group was originally founded by Quint Studer, an embedded healthcare figure with more than 30 years of experience in the field. One of Studer's (2003) first leadership books, *Hardwiring Excellence*, outlines the healthcare leadership tools and key behaviors of the Evidenced-Based Leadership framework (Studer, 2003). The Studer Group established the "Hardwiring Excellence" Framework (the predecessor to EBL), which evolved into a coined phrase to define the act of instituting consistent behaviors among leaders, physicians, and frontline staff that breed a culture of accountability and high performance. There are three key components to the EBL Framework: aligned goals, aligned behaviors, and aligned process (Studer, 2013). The framework and the tactics and tools under each component that are crucial to developing a high performing healthcare organization will be described in the following sections.

Aligned goals. Aligned goals ensure that individuals at every level of the organization can connect to the same goals and objectives for increasing patient satisfaction and quality of care while reducing costs. The Objective Evaluation System and Leader Development are crucial to influencing a culture of alignment and accountability. Healthcare leaders must buy into the significance of participating in development opportunities, and must take ownership in disseminating information and objectives back to the workforce, which will further foster alignment to the organizational goals.

Objective Evaluation System. The objective evaluation system covers one of the factors (e.g. leadership evaluation and accountability) of a high performing healthcare organization as mentioned in the study by Alliance for Healthcare Research (2004). Studer Group developed an electronic evaluation system for clinical and administrative leaders to track performance on weighted organizational goals. The theoretical framework that supports an objective evaluation system is known as management by objectives (MBO), which was first advocated by Peter Drucker as a systematic methodology to establishing and employing objectives that would result in enhanced organizational performance and employee satisfaction in both public and private sector organizations (Drucker, 1976). Leadership and middle management participates in goal setting, which impacts the frontline employees through continuous feedback on an individual's performance in accomplishing a particular goal (Earley, 2005). Continuous feedback on the results of each of the goals is associated with the improved quantity and quality of performance and increased employee satisfaction with leadership, which was evident in a field study wherein MBO was implemented in a human services agency (Thompson, Luthans, & Terpening, 1981).

The evaluation tool provided by Studer Group is one that provides a method for setting goals that are objective and weighted. The Leadership Evaluation Management (LEM) system is used by health care organizational partners of the Studer Group. Within LEM, the Chief Executive Officer sets eight to ten key metrics that he or she would like the organization to achieve within an assigned performance period. These key metrics then cascade down to leaders or middle management who then develop between four and eight metrics that are relevant to their area in which they will be evaluated. Weights are assigned to the key goals, which determine a leader or manager's priority and focus (Studer, 2013). There is complete

transparency around individual leaders' progress on their key metrics, which keeps an individual accountable to driving results for one's particular department or area of oversight.

Leader development. Leader development under aligned goals relates to the Leadership Institutes and training that influences high performing organization. Studer group provides quarterly Leadership Development Institutes (LDI) to physician leaders and organization leaders to deliver the tools, training, and resources to improve the patient experience and organizational performance (Studer, 2013). Approximately 64 hours of training a year is typically executed off-site. The training sessions focus on skills identified as requiring improvement and necessary to accomplish the organization's goals (Studer, 2013). Managing change is an example of a topic of a LDI led by a Studer coach.

Martineau, Hoole, and Patterson (2009) discuss how leadership development results in four positive outcomes of organization success, which include financial performance, talent attraction and retention, development of a performance culture, and increased organizational agility. Bersin and Associates (2015) deliver their opinion on leadership development as catalyst for creating a gravitating force of high-performing employees that are driven to achieve organizational goals. Organizations with high-performing leaders have the ability to attract and motivate great individuals to foster a culture of performance.

The Studer Group's emphasis on leadership development and training underscores a fundamental relationship between human capital investment and organizational performance. Human capital investment represents the "total value of human resources" (p. 1013) in an organization (Wang & Shieh, 2008). Wang and Shieh (2008) hypothesized a positive correlation between human capital investment and organizational performance. In particular, they focused on three dimensions of human capital investment: staff recruitment and selection, staff

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inspiration, and staff training and development (Wang & Shieh, 2008). In the arena of training and development, ongoing professional development opportunities for staff are critical to achieving goals and improving organizational performance (Schuler, 2000). While Wang and Shieh's (2008) correlation analysis for human capital investment and organizational performance was partially significant, the conclusion was that training for managers was beneficial to organizational performance. The focus of the training should be on "the predictive ability of foresight, the precise ability of analysis, and the determined ability of decision making" (Wang & Shieh, 2008, p. 1021). The intended outcome of this type of management development would be for the managers to nurture the potential of staff and mentor them to advance their professional skills to be able to achieve the goals of the organization (Wang & Shieh, 2008). These two sub-components of aligned goals (objective evaluation system and leadership development) can be connected back to the some of the key success factors of high performing organizations identified by the Alliance for Health Care Research (2005). The objective evaluation system provides a mechanism for promoting leadership evaluation and accountability, while an emphasis on leadership development coincides with Leadership Institutes and training. The investment in human capital, leadership evaluation, accountability, and development fosters the third success factor of high performing organizations per the Alliance for Health Care Research study (2005), which is executive and senior leadership commitment.

Aligned behavior. The second component of the EBL framework, aligned behaviors, includes Studer Group concepts of "Must Haves" and Performance Management. "Must Haves" are defined as the "tactics, tools, and techniques that need to be implemented in order to achieve the desired outcomes as set by the organization or leader" (Studer, 2013, p. 176). Performance management involves selecting and retaining talent, and training and development to better

manage high, middle, and low performers. The combination of employing the "Must Haves" and performance management tools of the Studer approach result in employees and physicians becoming more engaged, therefore reaching their highest potential, and patients receiving excellent quality care. The following sections will review the various "Must Haves" activities and the Studer prescribed methodology for working with high, middle, and low performers.

"Must haves." "Must haves" are the actions and behaviors that three different categories of individuals value in a healthcare organization. Employees have their set of expectations of their managers and leaders (Studer, 2013). Physicians have their desired needs, and therefore the Studer Group highlights the leadership tactics to engage physicians (Studer, 2013). Additionally, patients desire specific behaviors from the clinical team and staff that will result in a more valuable patient experience (Studer, 2013). The various must-have activities for employees, physicians, and patients will be discussed further.

Employee "must haves." **"**Hardwiring excellence" is a process that touches different levels of the organization. Evidenced-based tactics are employed by organizations that partner with the Studer Group to elicit employee input into decisions and continuous improvement opportunities (Studer, Hagins, & Cochrane, 2014). The following employee "must haves" are the main initiatives to improve patient satisfaction, employee engagement and overall organizational performance (Spaulding, Gamm, & Griffith, 2010). Studer et al. (2014) express the following implication of employee engagement: "Organizations that work to engage employees also provide safer care environments for patients" (p. S79).

Rounding for Outcomes: Rounding with employees is a process wherein leaders and managers actively engage in conversations with frontline staff in the work setting (Studer, 2004). Leaders and managers ask employees five questions during rounding that will elicit the

following feedback: (a) what works well; (b) individuals who should be recognized for doing something well; (c) physicians who should be recognized; (d) what can be done better; and (e) whether the employees have the tools and equipment to do their job (Studer et al., 2014). This discourse between leaders and employees promotes engagement in several ways, such as building relationships with leaders by fostering approachability, recognition of positive work, rewarding individuals, and ascertaining opportunities for improvement in clinical processes, training and development, and tools and equipment that are lacking (Studer, 2004; Studer et al., 2014).

Thank You Notes: After rounding is completed by a leader or manager, those who were recognized during the rounding would receive a hand-written thank-you note from the employee's manager that is sent to one's home address. This action contributes to employee's sense of purpose, serves as encouragement, reinforces behaviors that align with organizational goals, and ultimately drives employee retention and patient satisfaction (Studer, 2004; Studer et al., 2014).

Employee Selection: The selection process for a position vacancy involves employee participation. A decision matrix and behavior based questions allows employees to compare potential candidates and choose individuals who would be the best fit for the organization (Spaulding et al., 2010). According to the Studer Group (2003), employee participation in the selection process increases employee retention, physician and staff engagement, decreases turnover, and improves clinical outcomes.

First 90 Days: After a new employee has been on boarded, the employee meets with his or her supervisor after the first 30 days and 90 days of employment. There are six key questions that are asked during these scheduled meetings: (a) How is the organization performing (b) Is it

living up to employee expectations (c) What areas could be improved? (d) Any ideas for improvement based on previous experiences? (e) Are there any individuals that have proved very helpful? (f) Is there anything that might cause them to leave? (Studer, 2004). These 30 and 90-day touch points with a new employee has the same outcomes as rounding, establishes a solid supervisor-employee relationship from the beginning, demonstrates a willingness to work in tandem with the employee, and obtains feedback from an employee with a fresh perspective (Studer, 2004).

Key Words at Key Times: AIDET is the Studer acronym that signifies five essential communication behaviors for staff, as well as for physicians. The "A" stands for "acknowledge," which involves making eye contact with the patient and his or her family member(s) and making them feel welcome. The "I" stands for "introduce", which involves introducing oneself, one's skillset, experience and certification, any colleagues or physicians. The "D" stands for "duration." This communication tactic calls for the employee to consistently inform the patient of wait time. The "E" stands for "explanation," which is communicating the reason behind the procedure or visit, what to expect, any discharge instructions, any medication side effects, and asking if the patient has any additional questions. Finally, the "T" is a simple "thank you" for choosing the organization, for waiting patiently, or for trusting the care team. When AIDET is executed properly and with consistency, it is proven to "reduce patient anxiety and increase patient compliance" (Studer, 2013, p. 198).

Physician "must haves." Physicians have a tremendous impact on the patient experience and therefore understanding their satisfiers is integral to the success of any healthcare organization. The Studer Group conducted research to determine what physicians desire in the workplace. Four themes about the wants and needs of physicians emerged: quality (the assurance

that patients are delivered exceptional clinical care), efficiency (the opportunity to complete their clinical tasks quickly and effectively), input (their perspective is taken into account when making organization's decision) and follow-up and appreciation (a demonstration of recognition of their contributions Studer, 2013). To meet these four "wants and needs" of physicians, the following physician "Must Haves" were devised by the Studer Group:

Involve Physician in Goal Setting and Skill Building: Physicians embrace the idea of individuals being held accountable to achieving clinical goals. Involving physicians (in particular medical leaders) in setting the goals that affect clinical outcomes is most beneficial. To complement the idea of goal setting with physicians, the Provider Feedback System (PFS) was engineered by the Studer Group as an "alignment tool" where relevant data regarding clinical metrics and physician goals are housed (Studer, 2013, p. 188). Organizational goals cascade down to affiliated and employed physicians through PFS system. Studer (2013) provides a four-step process for medical leadership to set goals with clinicians: (a) Review organizational goals (b) Select physician goals and weights (c) Communicate the goals and baselines, and (d) Provide continuous feedback on their progress. Examples of physician feedback goals include those related to clinical quality, cost and patient satisfaction scores. It is equally essential to develop the skills of physicians, especially when a new change or behavior is being introduced into the clinical workflow. Providing an explanation of the importance of adopting a new behavior and giving physicians the opportunity to observe and practice the behavior will also lead to better acceptance of the new skill or behavior and improved quality care provided to patients.

Round on Physicians: Similar to rounding on employees, leaders can round on physicians by following four steps: (a) Make a personal connection; (b) Ask "What is working well?" (c) Ask "Do you have everything you need to provide excellent care? (d) Ask "Anybody to reward

and recognize?" (Studer, 2013, p. 205). With every subsequent rounding session with a physician, leaders begin to develop a "human connection" that leads to greater physician engagement. Research by the Studer Group demonstrates better physician engagement with greater frequency of rounding (Studer, 2013). Monthly rounding with physicians is the suggested frequency for top results in physician engagement.

Focus, Fix, and Follow Up: After rounding with physicians, Studer Group recommends leaders to "*focus* on their unique drivers, *fix* their concerns, and *follow up* afterward to capture the win" (Studer, 2013, p.196). Based on the physician's' level of support for change, leaders divide physicians into four categories, which enables leaders to concentrate on specific key actions for the following physician categories: "loyal," "want to be aligned," "skeptical," and "naysayer" (Studer, 2013). For the "loyal" physician who supports organizational changes, expressing gratitude for his or her support during a group or individual meeting is a "must have." Additionally, it is suitable to gain feedback from a "loyal" physician on what the organization does well and can improve upon. A physician who "wants to be aligned" is amenable to changes, however, is held back from being fully aligned with leadership due to a particular reason (e.g. political or operation challenge). These physicians would appreciate the same actions as a "loyal" physicians, however, when a concern cannot be rectified immediately, a direct response is better than being left in limbo. A "skeptical" physician has several issues and concerns. Moving these individuals would need to be an eventual organizational objective. A key action with the skeptic includes persistence in capturing wins and communicating them to these physicians. Finally, the "naysayer" who represents a small percentage of the medical staff will likely never support organizational change, and therefore resists attempting to make believers out of these physicians (Studer, 2013).

Teach AIDET: Physicians can be trained on the same AIDET fundamentals of patient communication that are expected of employees. Getting physicians aligned with employee patient communication strategies can improve their effectiveness, clinical outcomes, and patient satisfaction scores (Studer, 2013). The American Association of Orthopedic Surgeons (AAOS) is a proponent of effective communication in developing the patient-physician relationship. In an advisory statement to fellow surgeons, the AAOS endorsed the concept of patient-focused communication that is open, honest, and promotes trust and healing (American Academy of Orthopaedic Surgeons, 2016). The AAOS (2016) corroborates the positive impact of good communication on patient behavior, patient care outcomes, patient satisfaction, and subsequently decreases the incidence of malpractice lawsuits (Huntington & Kuhn, 2003).

Furthermore, physician communication and diabetes self-management were strongly associated in a study of 2,000 patients receiving diabetes care across 25 Veteran Affairs facilities (Heisler, Bouknight, Hayward, Smith, & Kerr, 2002). Specifically, patients who felt their physicians' spent adequate time delivering information on their illness and treatment and including them in the decision making "had significantly better self-reported understanding of their diabetes care, and it was patient understanding that had the strongest independent on self-management" (Heisler et al., 2002, p. 250). Therefore, physician communication is a key indicator of clinical outcomes, patient experience and satisfaction.

Reward and Recognize: Studer (2013) advises healthcare organizations to not undervalue the impact of reward and recognition on a physician (Studer). It is essential to find creative ways to celebrate physicians' contributions and show appreciation for their hard work. Leaders, managers, or staff can initiate simple "thank you" notes. Celebrating Doctor's Day can also reinforce a physician's sense of purpose in the organization.

Patient "must haves". There are also must-have tactics in patient communication by clinical staff and leaders. These are activities that are critical to driving excellent patient experience. Hourly rounding, leader rounding on patients, and pre-and-post call visits are examples of such must-have tactics that impact the patient experience:

Hourly Rounding: The patient's registered nurse on duty engages in hourly patient rounds, focused on pain, positioning, and personal needs. Rounding is intended to anticipate and address patients' needs before it escalates to a complaint. Such careful attention demonstrated towards their needs will subsequently increase patient safety and satisfaction (Reimer & Herbener, 2014).

Leader Rounding on Patients: In addition to hourly staff rounding, a nurse leader engages in daily rounding on new admissions to ascertain whether any service or quality issues have arisen (Reimer & Herbener, 2014). The nurse manager is expected to round at least once on all new admission in consideration of time constraints. Printed note cards with the manager's name and direct contact phone number are given to each patient. Additionally, the patient is given the name of a unit charge nurse who could immediately intervene if any issues arise. During rounds, the nurse managers may receive compliments or complaints from patients regarding the care received, which would be passed along to the staff member (Kennedy, Wetsel, & Wright, 2013).

Pre-and Post-Visit Calls: Calls made before and after patient visits have an impact on behavior. Confirmation calls made before scheduled appointments reduced the rate of no-shows (Christensen, Lugo, & Yamashiro, 2001). Post-visit calls, or discharge phone calls, is an opportunity for the organization to follow up with the patient after a visit or hospitalization. During the discharge phone call, a nurse ensures the patient understands the discharge instructions and allows the patient to ask any questions. Additionally, the organization uses this

valuable patient time to attain feedback on the care received (Spaulding et al., 2010). Previous

research demonstrates an association between discharge phone calls and decreased

hospitalization rates and increased medication compliance (Williams, 2008; Slater, Phillips, and

Woodard, 2008). Other research demonstrated a decrease in adverse events and an increase in

quality of care due to phone calls to patients' post-discharge (Setia & Meade, 2009).

A success story related to the implementation of patient "must haves" is demonstrated at

a 28-bed surgical unit in a suburban 461-bed medical center. The unit implemented the nurse

manager rounding on patients, discharge phones calls, and classes for enhancing discharge

teaching capabilities by the nurses. The unit's HCAHPS patient satisfactions scores resulted in a

steady increasing trend over 18 months following the implementation of three patient must-have

activities (Kennedy et al., 2013).

The relationship between "must haves" and management theories. There are several

management-related concepts that validate the positive impact of the prescribed must-have

behaviors on organizational performance. Specifically, the employee, physician, and patient

must- have tactics influence employee satisfaction, which also impact the patient experience.

Motivation and feedback, social network theory, and social capital provide the theoretical

foundational and linkage to these critical must-have organizational activities.

Motivation and feedback. Through modeling and feedback activities of leaders and

managers, employees and physicians become increasingly satisfied with their workplace and feel

motivated to meet organizational goals. Rounding for outcomes by senior leaders with

employees and physicians conveys the attention to individuals' needs and the importance of

recognition. The careful selection of employees and the 30 and 90 day follow up sessions with

one's manager also underscores the manager's attention to the subordinate's needs and areas of

growth that are restricting the employee from meeting any organizational goals (Spaulding et al., 2010). The subsequent rounding with the employee serves as a follow up to the identified needs of the employee, further solidifying managerial responsiveness.

The frequent feedback within the Studer approach addresses two levels of the feedback interventions theory (Kluger & DeNisi, 1996): task learning (related to the specifics of the central task) and task motivation (related to the valuation of the central task). The feedback interventions theory states that feedback impacts these two hierarchical levels (Kluger & DeNisi, 1996). Improving performance, patient, and employees' satisfaction are the main tasks. These central focuses lead to intrinsic rewards when there is positive instant feedback from patients and staff, and recognition from leaders. (Spaulding et al., 2010). The regular touch points regarding performance and satisfaction targets of the Studer approach leads to increased learning and motivation by staff, physicians, and patients.

Social network theory. In a healthcare organization, the reliance on teams and networks of staff are vital to the execution of quality improvement initiatives. These social relationships within healthcare organizations are the focus of the social network theory. The overall integration of the organization is contingent on the "density" and "strength of connections" within a social network (Shortell & Rundall, 2003). Similarly, the communication between frontline staff and senior leaders may indicate the "overall degree of access or empowerment throughout the organization" (Spaulding et al., 2010, p. 6). These connections formed during rounding contribute to senior leaders understanding the behaviors of the employees within the units of the organization. Lines of communication are shortened among the hierarchal levels of the organization through the purposeful connections made "up and down the supervisory structure" while engaging in must-have activities employed in the Studer approach (Spaulding et

al., 2010). The focus on relationships within the social fibers of a healthcare organization increases the sense of accountability on every level.

Social capital. Social capital may be perceived to be a product of social networks (Spaulding et al., 2010). This type of capital is generated through the cultivation of diverse relationships that foster performance and action within an organization (Coleman, 1988). Social capital is further engendered when organizations nurture and promote the connections and relationships between individuals (Detmer, 2001). When partnering with the Studer Group on implementing the evidenced-based leadership framework, a healthcare organization invests in social capital as leaders begin to hardwire various prescriptive activities or must haves (e.g. key words at key times, rounding for outcomes, thank you notes) that align behaviors and connects people. These key behaviors are intended to enhance communication and trust among employees and between employee and patients. Therefore, the rise in social capital is made apparent in the increase in employee and patient satisfaction (Spaulding et al., 2010).

Performance management. The second sub-section within aligned behaviors is performance management, which involves retaining talent, and training and development to better manage high, middle, and low performers. An organization will typically have about 34% high performers, 58% middle/solid performers, and 8% low/subpar performers (Studer, 2013). Individuals in each of these performance categories differ in character and work ethic, and therefore each respond differently to change. In order to move the organization towards performance excellence, it is vital to understand each of the performance categories, how each responds to change, and the types of conversations that need to occur with a high performer, middle performer, or low performer.

High performer: High performers are the experienced and most trustworthy employees who are punctual, positive, and who solve problems. They are characterized as confident role models who have the ability to motivate and influence team members. High performers are quick to implement new tools, techniques, or behaviors, and therefore accept change willingly (Studer, 2013).

Middle/solid performer: While this type of employee has solid attendance, exhibits loyalty, and wants to perform at a high level, middle performers require additional experience and training to move into the high performer category. Middle performers can identify issues, but may not exude the confidence to formulate a solution. Therefore, mentoring this category of performers is exceedingly critical. Studer (2013) states that good middle/solid performers are vital to the organizational success and provide good balance among high performers. They need to be aware that leadership is committed to their development and retention. Middle performers will typically be influenced by high performers in change adoption. Their performance is delayed, as they need to be trained. However, they still desire to be successful (Studer, 2013).

Low/subpar performer: The low performer is quick to point out problems, but offers no solutions. These individuals will criticize or blame leadership, while displaying passive-aggressive behavior (Studer, 2013). Due to their negative mindset, they do not achieve goals and demonstrate little commitment to the mission and goals of the organization. Low performers do not welcome change or improvement. According to Studer Group research from "Straight A Leadership Assessment," 52% of low performers not meeting expectations are aware of their shortcomings, while 48% are unaware of it and do not have a corrective action plan from their supervisor (Studer, 2013).

Performance wall: As the organization begins to mobilize towards top-tier or top-decile performance standards by engaging in the activities of the EBL framework, the gap between low performers and everyone else widens (Studer, 2013). The sentiment leads to discomfort and eventually intolerance. The high performers and some of the middle performers become frustrated as they observe the low performers not engaging in change. Many of the middle performers may fall victim to the negativity of the low performers who try to disrupt the change efforts. At this point in time, the organization hits a "performance wall" (Studer, 2013, p. 219). In order to prevent regressing backward in performance, the organization needs to address the performance issues by "recruiting and retaining high performers, retaining and developing middle/solid performers, and moving low/subpar performers up or out" (Studer, 2013, p. 220). Performance management is the key to maintaining forward momentum in reaching high performance goals.

The relationship between performance management and human capital. In fostering a culture of high performance wherein consistency and reliability are the standard, Studer (2013) proclaims that human capital should be an organization's largest investment, fundamental responsibility, and biggest opportunity. Human capital development is the major emphasis of any Studer partner organization looking to reach high performance caliber. The focus on hiring and retaining the best involves providing educational and training opportunities for different levels of performers (Wang & Shieh, 2008). The Studer approach recommends quarterly training for all staff, not just for management or senior leadership (Spaulding et al., 2010).
Performance management is a key training opportunity for managers as addressing high, middle and low performers has distinguished nuances. Dealing with low performers is vital to an organization rising above the prolific "performance wall" (Studer, 2013). Since low performers'

negative attitudes may have an adverse impact on the significant human capital (e.g. high and middle performers) of an organization, solid performance management involves managing out low performers, which is essential to retaining the critical human capital of an organization.

Aligned process. The third element of the EBL Framework is creating an aligned process through "standardization" and "accelerators". In healthcare, standardization results in improved quality of care and patient safety (Bozic et al., 2010; Kirkpatrick & Burkman, 2010; Rozich et al., 2004). Technological advancements are examples of "accelerators" that can increase speed, productivity, and output of employees, which is critical in healthcare as the emphasis is to improve quality while decreasing costs.

Standardization: Process improvement begins with standardizing a process that will generate consistent and reliable results. Some organizations have used LEAN or Six Sigma strategies, which are designed to remove any waste, redundancies or inefficiencies in a system to develop a more effective process. Each process improvement strategy evaluates the current steps that could be changed or eliminated to create a more efficient workflow (Studer, 2013). There are a number of standardization methods employed to improve patient care: clinical guidelines, algorithms of care, templates for electronic medical records, and surgical checklists (Kirkpatrick & Burkman, 2010). Adherence to standardized, evidenced-based processes of care in total joint arthroplasty cases resulted in improved clinical outcomes and decreased length of hospital stay for patients undergoing the joint surgery (Bozic et al., 2010). A review in the American Journal of Obstetrics and Gynecology suggests standardization may reduce the incidence of malpractice litigation (Kirkpatrick & Burkman, 2010). Furthermore, a pilot study at a multispecialty group at Luther Midelfort Mayo Health System was initiated to reduce the variance in clinical practice patterns of clinicians. The results of the pilot initiative demonstrated

improvements in patient safety by standardizing the sliding-scale insulin protocol shared by providers within the multispecialty group (Rozich et al., 2004). Improved clinical outcomes and quality, reduced malpractice litigation, and enhanced patient safety are the products of standardization in health care.

Accelerators: The second element of aligning the process is focusing on "technology that accelerates the process" (Studer, 2013, p. 238). Technology accelerates cost savings through increased output and productivity (Studer, 2013). Cost reduction may surface as dollar savings in some scenarios, while other savings may be recognized in improved productivity and efficiencies. For example, the implementation of the electronic health record has (EHR) increased the productivity of nurses by reducing documentation time during a shift. A literature review focused on the impact of the EHR demonstrated a 24.5% decrease in the time nurses spent documenting with the use of bedside workstations and a 23.5% reduction in time with the use of central station desktops (Poissant, Pereira, Tamblyn, & Kawasumi, 2005). Essentially, the implementation of technology in organizations will likely lead to innovative business processes, new skills, and new organizational structures that would contribute to process improvement and increased productivity for employees (Brynjolfsson & Hitt, 2000).

Discussion. The Studer Group recognizes the challenges of an industry that is continuously changing. Through an evidenced-based approach focused on "hardwiring excellence," the Evidence-Based Leadership Framework is made up of key components (aligned goals, aligned behaviors, and aligned behaviors) that can be adopted by healthcare organizations and championed by healthcare leaders who desire to lead high performing organizations. The success of the EBL framework is underscored by its close alignment with several theoretical management underpinnings, including motivation and feedback (Kruger & DeNisi, 1996),

management by objectives (Drucker, 1976), social networks (Shortell & Rundall, 2003), human capital (Wang & Shieh, 2008), and social capital (Coleman, 1988; Detmer, 2001). The components of the EBL framework are collectively designed to create a "culture of high performance," however, it is only successful when executive leadership is committed, staff and physicians are engaged, and patients are completely satisfied with the care delivered during their visit.

High-Reliability Healthcare Maturity Model

The concept of high-reliability science found in the aviation and nuclear plant industry is adaptable to the healthcare sector. A framework was developed by integrating the principles of high-reliability organizations, knowledge ascertained through work completed with thousands of healthcare organizations accredited and certified by the Joint Commission, and extant studies explicating how hospitals have implemented the high-reliability principles in their respective organizations (Chassin & Loeb, 2013). The resulting framework, High-Reliability Healthcare Maturity Model, suggests that a movement towards high reliability in healthcare organizations requires three fundamental changes: (a) leadership obligation to foster a culture of zero tolerance of patient harm; (b) organization-wide assimilation of high reliability practices necessary for a safety culture; and (c) implementation and overall adoption of the most sophisticated process improvement methodologies (Chassin & Loeb, 2013). The next section will elaborate on each of the three domains and the specific components under each change domain that should be of significance to healthcare leaders aiming to develop high performing, highly reliable organizations. The model also illustrates four stages of maturity for each domain, including beginning, developing, advancing, and approaching.

Leadership. The commitment of leadership in the organization's quest for high reliability and performance is exemplified through consensus regarding a singular vision of preventing and removing any potential harm to patients. There is alignment among various leadership constituencies, including the board of directors, senior management, physicians, and nurse leadership. Each of these leaders share the goal of "zero harm" (Chassin & Loeb, 2013, p. 468), with an unrelenting passion to improve safety on an ongoing basis. The following subsections highlight the various areas of the leadership domain of change and corresponding stages of organizational maturity.

Board. The board of trustees or directors of a healthcare organization are critical stakeholders that must exemplify commitment to a high priority strategy of achieving safety and quality 100% of the time. In a study of high performing and low performing hospitals, the board processes and dynamics demonstrated a major impact on the performance of hospitals (Kane et al., 2009). The hospitals in which board members exhibited greater engagement in strategic decision making and readiness to question management actions where appropriate were seen as high performing organizations (Kane et al., 2009).

The four stages of organizational maturity will be discussed as it relates to the progress of the health organization's board in promoting a high reliability culture. In the beginning phase, the board's emphasis on quality is almost entirely centered on regulatory compliance. In the developing stage, the board becomes receptive to reports from the organization's committee on quality. In the advancing stage, the board participates in establishing quality goals and a plan of action, while also examining adverse safety events. In the approaching stage, the board pledges their commitment to meeting high reliability standards throughout the entire clinical operation (Chassin & Loeb, 2013).

CEO/management. Hospital leaders (CEO, chief medical officer, vice president of medical affairs, chief nursing office) are also significant individuals to champion the path to high reliability. Their visibility and activism for an organizational quality strategy is encouraging for the organization's healthcare workforce. Similar to the board in the beginning stage of organizational maturity, the CEO/management team is focused primarily on regulatory compliance. In the developing phase, the CEO recognizes the necessity for a quality plan, which he/she assigns to a subordinate to develop and implement. In the advancing phase, the CEO assumes the lead role in devising and deploying a quality program. In the approaching phase, management becomes active champions of zero patient harm, with clinical processes already beginning to reveal zero or near-zero rates (Chassin & Loeb, 2013).

Physicians. In order for a healthcare organization to progress towards high reliability status, physicians must play a vital role leading and participating in the quality improvement initiatives (Chassin & Loeb, 2013). At the beginning of implementing high reliability principles, physicians portray lack of eagerness to participate in the improvement activities. In the developing phase, physicians display more motivation and begin to champion select quality improvement initiatives and participate in some throughout the organization. Momentum gains in the advancing stage as physicians lead and partake in the majority of quality activities, but it is not until the approaching stage that they assume a more routine leadership and participative role in the quality improvement process.

Quality strategy. A quality program needs to be developed that addresses the unique safety issues and quality challenges of the healthcare organization and patient population. To accelerate advancement towards high reliability, the quality strategy may benefit from financial incentives and employee promotion opportunities resulting from a department meeting

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performance metrics (Chassin & Loeb, 2013). In the beginning stage of implementing high

reliability principles, quality does not appear to be a top strategic priority. In the developing

phase, quality becomes a competing strategic imperative, and eventually climbs to top three or

four of the strategic goals in the advancing stage. Finally, in the approaching stage, quality soars

to the top as a main strategic priority for the organization (Chassin & Loeb, 2013).

Quality measures. Data transparency throughout the entire organization is an accelerant

to achieving quality goals. In the beginning stages, quality measures are internally visible to

neither the healthcare workforce, nor the public. The measures are also not part of an employee

incentive or reward program. In the developing phase, a few measures begin to be reported

internally and publicly, but are not yet part of a reward program. By the advancing stage, quality

metrics and results are reported internally on a routine basis, and some measures are reported

publicly and initiated into an employee incentive program. Finally, in the approaching phase, all

key quality indicators are regularly shared internally and reported publicly, and the staff reward

program becomes a part of the daily norm by systematically reflecting achievement of quality

measures.

Information technology. Leaders in high reliable organizations rely on information

technology (IT) to support quality improvement initiatives. IT is the vehicle used to automate

efficient and effective processes to sustain high performance (Chassin & Loeb, 2013). During the

beginning stages of implementing high reliability principles in healthcare organizations, IT

demonstrates minimal to no support for quality initiatives. In the developing phase, IT

participates in selected quality improvement initiatives; the "principles of safe adoption," (p.

475) however, are not applied (Chassin & Loeb, 2013). By the advancing stage, there is greater

IT solutions support for the quality strategy, and members of the organization commit to safely

adopting the IT solutions. In the approaching stage, IT solutions are adopted and become a

critical facet to maintaining quality improvements.

Safety culture. With the intent to "continuously improve health care for the public," the

Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare

Organizations, or JCAHO), represents a symbol of quality as the not-for-profit organization that

validates nearly 21,000 health care organizations' commitment to upholding quality performance

standards (The Joint Commission, 2016, para. 1). One of the Joint Commission's requirements

for accrediting and re-accrediting health care entities is a patient safety program with designated

leadership to ensure Joint Commission Standards and National Patient Safety Goals (NPSGs) are

met consistently (The Joint Commission, 2016). The NPSG program was first established by the

Joint Commission in 2002 to help accredited healthcare entities focus on specific issues

impacting patient safety and how best to address them in an attempt foster a culture of safety

(The Joint Commission, 2016). To meet the Joint Commission Standards and NPSGs intended

to promote a safety culture, the following section will expand on the second domain of change of

the high-reliability healthcare maturity model, and its five corresponding components.

Trust. The high-reliability healthcare maturity model is derived from a model by Reason

and Hobbs (2003) that states that a culture of safety has three main characteristics: trust, report,

and improve. Employees feel a certain level of trust among peers and superiors that errors and

hazardous situations are regularly recognized and reported. The culture of trust is made possible

when the organization eliminates intimidating conduct that prevents open reporting.

Additionally, when reports are made, leadership does not disregard the problem, but rather

moves expeditiously to resolve the error or unsafe condition, and communicates back to the

employees what improvements were made. When the components of "trust, report, and improve"

are consistently occurring within an organization, "they reinforce one another and produce a stable organizational culture that sustains high reliability" (Chassin & Loeb, 2013, p. 477)

During the beginning stages of implementing high reliability principles in healthcare organizations, a mechanism for assessing trust or intimidating conduct is non-existent. In the developing phase, some clinical departments begin to establish a level of trust and collegiality. By the advancing stage, leadership models appropriate behaviors in an effort to foster a trusting atmosphere for all staff. The CEO and clinical leaders also lead effort to remove intimidating behavior from the organization. Lastly, in the approaching phase, increasing levels of trust are apparent in all clinical departments, which are measured (Chassin & Loeb, 2013).

Accountability. All employees should be committed and accountable to following and practicing the organization's established safety principles. When reviewing the stages of organizational maturity towards a high reliability culture, the beginning stage is characterized by an emphasis on assigning blame for a safety error. There is also a lack of equity or transparency in standard disciplinary methods. By the developing phase, there is consensus over the importance of fair disciplinary policies and procedures, which are implemented in some clinical areas. In the advancing phase, managers and leaders assign high priority to enforcing all aspects of a safety culture. Additionally, equitable disciplinary processes become transparent and different areas begin to adopt them. In the approaching phase, the standard disciplinary practices are fully adopted throughout the healthcare organization, and all employees exhibit personal accountability for upholding a safety culture. Ultimately, accountability is cultivated by instituting safety standards across the board, and when employees fail to maintain the prescribed safety protocols, fair and equitable disciplinary practices are used as appropriate (Chassin & Loeb, 2013).

Identifying unsafe conditions. To become a safety culture, clinical and non-clinical staff must be inclined and able to identify and report potential errors or unsafe conditions. Hospitals display reactionary tendencies as they respond to incidents in which harm has already been inflicted on patients. Leadership engages in root cause analysis to determine the origin of the issue, and then work on delivering corrective actions plan to prevent repeat harm (Chassin & Loeb, 2013). Conversely, high reliability organizations function proactively with the participation of all members of the organization recognizing potential harm before it even occurs. When assessing this particular component of a safety culture and the stages of organizational maturity, healthcare organizations conduct root cause analysis only for adverse events in the beginning stage, but potential errors, close calls, or "early warnings" are not given much attention. In the developing phase, pilot programs are initiated to report close calls in some clinical areas. In the advancing stage, employees in many other clinical areas begin reporting unsafe conditions and practices to superiors. In the approaching phase, the entire workforce engages in routine reporting of close calls, which allows for issues to be resolved before causing any harm unto patients. Furthermore, there is a communication strategy to report out resolutions and outcomes to clinical areas, therefore keeping the workforce fully informed and engaged (Chassin & Loeb, 2013).

Strengthening systems. In contrast to focusing on single incidents, hospitals are called to compile all investigative data on adverse events, errors, or close calls to determine whether there are trends with certain safety systems (e.g. infection control). The aggregated data can then be used to detect which system defenses or safety controls are in need of re-assessment, thus identifying weaknesses or gaps that can pose serious threats to patients if not remediated immediately. As an organization moves through the stages of organizational maturity in this

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particular component of a safety culture, the beginning stage is characterized by a lack of foresight into evaluating "system defenses against quality failures" (Chassin & Loeb, 2013, p. 479). In the developing phase, leadership starts to recognize a trend in system weaknesses in clinical departments, however, there is a lack of initiative to begin improving systematic problem areas. By the advancing stage, healthcare leaders track system weaknesses and create a priority list of what to improve. In the approaching stage, a more proactive attitude emerges as system defenses are evaluated, and weaknesses are improved (Chassin & Loeb, 2013).

     Assessment. In order to move the needle on creating a safety culture within a healthcare organization, trust, accountability, identifying unsafe conditions, and strengthening systems must be routinely measured to validate the organization's progress. In the beginning stage of building a high reliability organization, there are no existing metrics to evaluate the safety culture. In the developing phase, some measures of a safety culture emerge in certain clinical areas. By the advancing stage, measures of safety gain traction and are employed organization-wide. In the approaching phase, the board receives ongoing reports on safety culture measures as safety becomes a strategic priority. Additionally, projects to improve system defenses and controls are in progress with intentions of realizing the benefits of a fully operational safety culture (Chassin & Loeb, 2013).

     Robust process improvement. Process improvement methodologies are critical to addressing safety and quality challenges in healthcare organizations while working towards high reliability status. Chassin and Loeb (2013) propose the utilization of robust process improvement (RPI) tools to fix erroneous processes. There are three components of RPI: methods, training, and spread (Chassin & Loeb, 2013). RPI involves the synchronized incorporation of lean, six sigma, and change management, which are complementary tools described in more depth under

the methods component. Each of the components of RPI and organizational stages of maturity are described in the following sections.

Methods. RPI is the final domain of change that is necessary to progress into a culture of high reliability, and ultimately, high performance. Healthcare organizations in the beginning stages of organizational maturity may not possess an established a formal quality management plan. By the developing stage, healthcare organizations start to discover various process improvement tools. In the advancing phase, the organization decides to institute all three RPI tools. In the approaching phase, lean, six sigma, and change management methods are accepted across all areas of the organization (Chassin & Loeb, 2013). The following subsections will review each type of RPI tool in greater detail.

Lean. Lean production methodology (lean) is a widely used management approach to identify and remove waste from an organization (MacInnes, 2002), improve productivity (Lewis, 2000), decrease overall cost of a process (Lewis, 2000; MacInnes, 2002), enhance quality and process time (MacInnes, 2002), and ultimately boost an organization's competitive advantage (Lewis, 2000) while improving healthcare delivery and quality (Kuo, Borycki, Kushniruk, & Lee, 2011). Originally derived from Taiichi Ohno's Toyota Production System (TPS), lean principles are built on Toyota's primary objective of increasing efficiencies in production and processes primarily through the consistent elimination of waste (Sunder, 2013). The Toyota production system has been known for utilizing less human and financial capital, space, material, and time while producing larger quantities of products with fewer defects (Womack, Jones & Roos, 1990). Lean is also referred to in the literature as "lean management" or "lean thinking", which in simplest terms is "using less to do more" (Institute for Healthcare Improvement, 2005, p. 2).

In general, organizations are comprised of a number of processes, or series of actions,

intended to deliver value to consumers, and in healthcare specifically, the patients are the

primary customers (Institute for Healthcare Improvement, 2005). The central idea of lean

emphasizes the value assigned to any process by differentiating between value-added steps and

non-value-added steps, and removing any non-value added steps from the process (Institute for

Healthcare Improvement, 2005, p. 2). There are five fundamental principles of lean, which first

begins by postulating the value desired by the consumer of goods or services (i.e. a patient values

time spent in the facility or cost of services (Womack & Jones, 1996). The second principle of

lean involves highlighting each activity in the process that is value-adding and non-value adding

from the patient's perspective, which in lean language is termed "value stream" (Sunder, 2013;

Womack & Jones, 1996). The third principle of lean is making improvements to the process

flow, which entails eliminating bottlenecks (i.e. long wait times) caused by non-value added

steps, and adding more process flexibility and reliability into the mix that creates value for the

consumer (Sunder, 2013). The fourth principle of lean suggests that process flow should

thoroughly consider and fulfill a patient's demand or needs, or "pull" in lean terminology

(Sunder, 2013; Womack & Jones, 1996). Finally, the fifth principle entails identifying all waste

in the organization, and resorting to the removal of these non-value activities (Sunder, 2013).

The ultimate goal of lean is to create a flawless process that meets the customers' needs

and values. The "perfect process" is described as instituting steps that are considered valuable

from the customer standpoint, capable of producing a decent result each time, available (delivers

the desired output, in addition to quality), adequate (absent of any delays), flexible, and "linked

by continuous flow" (Institute for Healthcare Improvement, 2005, p. 6). If any of these

dimensions are not met in the process, the product is waste. The Lean methodology presents

eight forms of waste that are typical in organizations: over processing, inventory, wait time,

defects, overproduction, unnecessary transportation and motion by employees, and unused

human resources (MacInnes, 2002; Ohno, 1988; Womack & Jones, 1996). Common wastes

prevalent in healthcare include long wait time by patients, unnecessary utilization of inventory or

medical supplies, overproduction or overutilization of healthcare services, and unused human

capital to fulfill value add services.

The lean process begins with responsible and knowledgeable individuals, not necessarily

in leadership positions, coming together in a "kaizen event," which is a four-to-five-day session

meant to thoroughly evaluate current processes and decide on future improvements to implement

(Institute for Healthcare Improvement, 2005, p. 6). The participants begin by identifying the

main value streams, or processes, that occur in a healthcare organization. The main products or

services-such as a clinic visit, a visit to the emergency department, or an inpatient encounter-are

supported by key processes that must be mapped in the current state. Each process step is

evaluated from the perspective of internal (i.e. physicians) and external (i.e. patients) customers,

and waste is identified throughout the process mapping. Then a "future state value stream map"

is proposed based on a process that is in an ideal state of perfection for internal and external

customers (Institute for Healthcare Improvement, 2005, p. 8). If necessary, participants shift

staffing as appropriate to meet the needs of the new process.

As with any successful quality improvement project, continuous evaluation of process

changes is critical to the success of sustaining the desired future state. The Plan-Do-Study-Act

(PDSA) methodology is a valuable tool used to devise incremental tests of change ("plan");

employ the tests on a minor scale ("do"); assess and analyze the outcomes compared to the

current state and determine additional improvements ("study"); acquaint the workforce with the

new adjustments ("act"); and finalize whether the modified process is appropriate and sustainable. Each time a new process is changed and introduced, the "just in time" inventory, or continual measurement of processes is significant in ensuring behavioral changes are occurring (Institute for Healthcare Improvement, 2005, p. 9). A robust and transparent performance measurement system for demonstrating improvements, or diversions, from the lean process has the capacity to motivate desired performance in an organization.

Six sigma. As lean is a quality-focused approach that serves to eliminate waste in an organization, six sigma is a quality improvement (Black & Revere, 2006) and quantity-oriented methodology that uses statistical techniques to recognize, measure, and reduce variability in processes (Kuo et al., 2011). The CEO of Motorola, Bob Galvin, is noted as the pioneer for adopting and endorsing six sigma as a business initiative back in 1987 (Sunder, 2013). However, the six sigma methodology and concepts is known to have its foundational bearings in total quality management (TQM) principles, which Edward Deming introduced to the United States in the 1980s (Black & Revere, 2006). There are several TQM principles that have contributed to some of the main concepts of six sigma, including the idea that every member of an organization should be supportive of the quality initiative; that there should be an intensive training and education program regarding six sigma; and that root cause analysis should be central to a quality improvement methodology (Black & Revere, 2006).

Six sigma utilizes two main methods: Define, Measure, Analyze, Improve, Control (DMAIC) process and Define, Measure, Analyze, Design, and Verify (DMADV) process. When a healthcare leader's goal is to redesign an existing process, DMAIC is the appropriate methodology. When the intent is to develop a new product or process plan, DMADV is most fitting (Kuo et al., 2011). The first three steps in each method are the same with the first step as

defining the problem. The second step is to measure what is valued added in relation to the problem. The third step is to analyze, or determine root causes of the problem through statistical methods (Ettinger, 2001). In DMAIC, the fourth step, improve, is to "mobilize change initiatives." The fifth step is to control, or to maintain improvements within the organization (Ettinger, 2001, p. 14). In DMADV, the fourth step is to design the new product or process, and then verify that the new design meets the requirement of the customer or organization. Essentially, the six sigma methods look to reduce variability in a process, inspire "breakthrough improvement" (Sunder, 2013, p. 26), and eliminate any errors by defining a critical goal related to a process improvement, identifying what is most significant to the process, implementing new initiatives or designs, and ensuring an enduring outcome through careful monitoring and surveillance (Ettinger, 2001).

Lean and six sigma are distinct in what each method accomplishes and by what technique. There are commonalities, however, that bridge the two RPI tools and complement one another for a greater impact in an organization when used simultaneously. Both methods are structured process improvement approaches with the common objective of increasing productivity and creating a cost savings for the organization (Sunder, 2013). Moreover, lean and six sigma focus on the needs and desires of the consumers of product and services. In order for variations and wastes to be minimized and eventually eradicated, through six sigma and lean respectively, employees need to be active participants in the process improvement activities and planning. Most importantly, leadership and management need to champion the initiatives from the beginning in order to attain widespread organizational buy-in (Sunder, 2013).

Change management. Change management is the third RPI tool that works in tandem with lean and six sigma to attain organizational acceptance and seamless implementation,

maintenance, and sustainability of the new or adjusted processes introduced through the lean and six sigma approaches (Chassin & Loeb, 2013). In order to remain competitive in the business environment of any industry, organizations must undergo organizational transformations to keep up with a changing business marketplace (Kotter, 2007). John Kotter's "eight-stage process of creating major change" (Kotter, 2012, p. 23) is an example of a change management strategy that emerged as a result of a thorough review of successful organizational transformations. The eight stages expose two main patterns: change must be shepherded by motivated and qualified leaders, not just strong managers, and secondly, transformational change typically occurs in several sequential steps (Kotter, 2007; Kotter, 2012):

- Establish a sense of urgency: Leaders must focus on the current healthcare market and the competition impacting business performance. Areas of improvement or opportunity, current emergencies, or potential errors or safety concerns should be discussed in a format that incites action and attention.
- Form a powerful guiding coalition: A powerful group capable of working cohesively as a team and who exemplify high influence within the organization should lead the change effort.
- Develop a vision and strategy: The guiding coalition should provide a roadmap of the future of the organization, which serves as the vision that appeals to patients (the customer), stakeholders, and the workforce. A strategy is devised, which highlights how the vision will be realized and executed.
- Communicate the vision: Utilizing every possible communication channel and pipeline to share the particular need for change, the vision, and strategy is critical to engaging all key external and internal participants in the change effort. It is not

enough to verbalize the vision; it is imperative for the guiding coalition to display the ideal behaviors expected of the entire workforce.

- Empower broad-based action: Challenges or obstacles, including dysfunctional systems or organizational structures, that impede the vision from becoming reality should be revised or removed. The workforce should be empowered to partake in the change effort through risk taking, and thinking outside of the normal activities and current status quo.

- Generate short-term wins: To maintain the momentum and urgency for change, small changes, or short-term wins, should be actively planned and sought after, and celebrated when achieved. Managers would need to take on the responsibility of improving performance, setting goals, and rewarding individuals who helped facilitate the wins.

- Consolidate gains and produce more change: Leadership trust and credibility is manifested through short-term wins, which allows for added momentum to overcome greater challenges that do not align with the vision. Healthcare leaders would need to focus on human resource functions such as hiring, promotions, and development opportunities for those individuals who have the potential to carry out the change strategy and vision. Furthermore, the organizational transformation should consider innovative projects and ideas to bolster the change process.

- Anchoring new approaches in the culture: Ensuring the long-term consistency of newly introduced processes and behaviors requires sharing with the entire workforce the linkage between the new approaches and the progress made in organizational performance. Communicating the connections between the change

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effort and organizational success can help the changes become the social norm.

Furthermore, as the current leaders progress upward and onward to new ventures,

it is equally important to ensure there is adequate succession planning and leader

development to ensure future successors support and carry on the same

approaches.

There are six change management practices for healthcare organizations (Giniat et al.,

2012) that align with Kotter's eight-step change model (Kotter, 2012). These change

management practices engage the voices and perspectives of the workforce while working to

transform the organization through robust tools, technology, and methods of process

improvement (Giniat et al., 2012). The success of these six change management practices for

healthcare organizations is dependent on leadership sponsoring, committing, and participating in

each change related practice, which is a key component of the definition of high performing

organizations (Alliance for Health Care Research, 2005), high performing hospitals (Taylor et

al., 2015), high performing work practices (Garman et al., 2011), and high reliability

organizations (Chassin & Loeb, 2013). Each of the six change management practices identified

as key to success of change within a healthcare organization demonstrate comparable principles

found in Kotter's eight-step change model (Kotter, 2012).

- Articulating a business case and vision for change: In order to garner support for a

  change effort from vested stakeholders (clinicians, nurses, managers, other

  members of the workforce), leaders must communicate the bridge between a

  compelling reason for the change effort and the strategic direction of the

  organization. The desired future state of the organization would take into account

  any market trends or "competitive realities" (Kotter, 2012, p. 23), such as

regulatory mandates (Giniat et al., 2012). In essence, Kotter's first stage in the change process, creating a sense of urgency, (Kotter, 2012) is evident in the practice of articulating motives for transformation that should incite some earnestness in making the change effort a priority within the organization.

- Assessing organizational risk and readiness: As each organization carries its own unique internal nuances, it is critical to identify any obstacles of the change effort, and to address them to ensure the organization's readiness for change (Giniat et al., 2012). Ironing out any potential barriers, such as organizational structures or systems that challenge the vision for change (Kotter, 2012), could safeguard against any deterrents of a smooth transition. As change from the norm manifests as risk taking to many, taking the time to evaluate an organization's current state and to address any roadblocks aligns with Kotter's fifth stage, "empowering broad-based action" (Kotter, 2012, p. 23).

- Mobilizing and aligning leaders: A change effort within a healthcare organization requires the influential support and buy-in of leaders, who hold top-tier authority to attract and sustain faithful followers. The group of healthcare leaders act as the "guiding coalition" coined in Kotter's second stage of his change model (Kotter, 2012, p. 23). Each leader develops and shows dedication to an action plan, which exhibits their commitment to the change initiative. In aligning leaders to the change effort, their collective brainstorming of a vision and strategy to carry out the change effort is analogous to Kotter's third stage of creating major change (Kotter, 2012).

- Building awareness and commitment to the change effort: A sophisticated, logical, and thoughtful communication plan is necessary to develop cognizance of the new vision and strategy among all stakeholders. As Kotter (2012) states in the fourth stage of his change model, "communicating the change vision" is a key step in raising awareness of the essential actions and training activities needed to implement the plan for change (p.22).

- Aligning the organization: When the vision and strategy are delivered to the entire workforce, it is essential for leaders, or the guiding coalition, to demonstrate the behavior and actions expected of all employees (Kotter, 2012). Such an effort by healthcare leaders can help ensure employees imitate the same mindset and key behaviors that lead to a desired set of outcomes in the vision for change (Giniat et al., 2012). Furthermore, roles and responsibilities must be clearly delineated in healthcare organizations where complex governance structures can confuse accountability for decision making and action, which can jeopardize the change process (Giniat et al., 2012).

- Tracking performance improvement and benefit realization: Monitoring "quick wins" and sharing the benefits of those incremental changes with the organizational workforce can engender added motivation to overcome challenges that can surface during the change project (Giniat et al., 2012, p. 88). Kotter calls these wins "short-term wins" that are evident in the sixth stage of his change model (Kotter, 2012, p. 23). Metrics would need to be put into place to track improvements in performance at the employee levels.

Training. In order for the impact of three RPI tools, lean, six sigma, and change management, to be realized in an organization, all employees should be knowledgeable about the tools based on their job functionalities (Chassin & Loeb, 2013). As healthcare organizations begin their journey to high reliability, training may be only available for employees in the compliance or quality departments. In the developing stage, consensus develops around the significance of availing other departments to training opportunities in RPI methods. By the advancing phase, select employees receive training in RPI, with a goal to expand training to more employees. In the approaching stage, RPI is deemed mandatory for all employees, which will allow the process improvement tools to spread throughout the organization to both internal and external customers (Chassin & Loeb, 2013).

Spread. In high reliability organizations, RPI tools are used organization-wide for all improvement projects. Additionally, internal customers (staff) are required to be proficient in the RPI methodologies, which is a necessary skill to have in order to advance or be promoted within the organization. Furthermore, external customers (patients) are active participants in revamping care processes. Evidence of these three notions is indicative of the approaching stage in an organization's maturity towards exceptional reliability (Chassin & Loeb, 2013). The beginning stages resemble a lack of commitment to adopting RPI methods system wide. In the developing phase, a few departments demonstrate uptake of some RPI tools and eventually progress to reaching a positive ROI in the advancing phase wherein many more departments adopt RPI methods to improve business processes, quality, and safety concerns. Essentially, the goal is to ensure every employee has the tools and resources to solve difficult issues and be accountable to organizational quality and safety (Chassin & Loeb, 2013), which are primary responsibilities of healthcare leaders.

Discussion. The High-Reliability Healthcare Maturity Model illustrates three fundamental changes related to leadership, safety culture, and process improvement initiatives that must be executed by healthcare leaders who want to achieve high-reliability status within their respective organizations (Chassin & Loeb, 2013). First and foremost, leaders must be committed to fostering a culture of zero tolerance towards patient harm. Zero tolerance of patient harm means instilling widespread acceptance of high reliability practices, such as accountability for identifying and remediating unsafe conditions throughout the healthcare organization. Implementation of lean, six sigma, and change management practices is necessary to ensure an organization can become error-free, or highly reliable. Throughout the change process within leadership, developing a safety culture, and initiating process improvement strategies, healthcare leaders can determine whether progress is being made by observing the four stages of maturity (beginning, developing, advancing, and approaching) towards cultivating a high performing and highly reliable healthcare organization. The next step for healthcare leaders would be to measure their performance to determine whether change is occurring in the direction towards high performance.

Measuring Performance

In order to improve performance and reliability within a healthcare organization, there needs to be a transparent mechanism to track progress for meeting goals and executing strategies. Organizations, whether non-healthcare or healthcare related, have a fiduciary responsibility to uphold. With the current market trends of lowering costs within healthcare organizations, while improving quality and patient satisfaction, balance is a key in managing the needs of various customers (e.g., patients, family members, payers), as well as the resistance from clinicians to adopt necessary initiatives (Nevius, 2016) to meet the Triple Aim (McCarthy & Klein, 2010).

Strategic goals can be monitored via two particular methods within healthcare organizations: pillar framework (Studer, 2013) and balanced scorecard (Kaplan & Norton, 2007).

The pillar framework. The Studer Group enlists the pillar framework model to measure performance within a partner organization. The consulting firm adopted the measurement framework from author Clay Sherman (1993) who established the concept of four pillars in the book *Creating the New American Hospital: A Time for Greatness*. Studer Group modified the model and developed a five-pillar framework that includes quality, people, finance, service and growth (Studer, 2013). Primarily, the pillar framework is utilized to communicate the mission and vision of the organization (Robbins et al., 2012). Organizations who adopt the pillar framework invest in a quality board that is visible to the employees in which data is tracked and measured regarding their progress with goals associated with each pillar. For example, an organization may display their monthly patient satisfaction scores under the service pillar compared to their target score. By communicating and displaying results, managers are able instill motivation for providers and staff to continue behaviors that drive maintenance of positive results or to change processes to improve results of unsatisfactory patient satisfaction scores.

These pillars represent operational outcomes that guide organizational behavior and processes and instill consistency and focus to achieve the goals set within each of the pillars. Similarly, an empirical study of high-performing medical groups led to the development of a framework for assessing the performance of a medical group based on four domains (i.e. clinical quality performance, patient satisfaction, organizational learning, and financial performance Shortell et al., 2005). Each of these four domains can be linked to one of the Studer pillars. Clinical quality performance is related to quality; patient satisfaction is consistent with the service pillar. Organizational learning relates to the people and growth pillars. Financial

performance perceptibly relates to the finance pillar. Shortell et al. (2005) states that the four

domains serve as a "potential strategic roadmap" for healthcare leaders to advance the

performance and heighten the competitive position of a medical group (p. 410). Comparatively,

the emphasis on monitoring the organization's progress by tracking data related to the five pillars

can also serve as motivation for staff and providers to continuously improve or maintain their

satisfactory performance.

Utilizing the pillar framework, collecting results and scores for each of the pillars, and

reporting this data relative to organizational goals can be regarded as reinforcing evidenced-

based management (Spaulding et al., 2010). Evidence-based management employs the best

available evidence and research to make management decisions that align with an organization's

mission, vision and goals (Walshe & Rundall, 2001; Kovner & Rundall, 2006). By analyzing

data pertinent to the pillar goals of the organization, such analysis can lead to decisions that

impact goal achievement (Spaulding et al., 2010). Organizational decisions promulgate

organizational change in policies and procedures, which necessitates a system for tracking

results. The continued measurement of data pertaining to progress with each pillar goal allows

leadership to better gauge the implications of decisions made (Kovner & Rundall, 2006). The

Studer approach can be deemed an evidence-based approach considering that more than 700

organizations have partnered with The Studer Group and adopted the EBL and pillar

frameworks. Spaulding et al. (2010) argue that the Studer approaches are evidence-based if these

organizations realize improvement in scores on the five pillars, which ultimately signifies the

success of the management approach.

Balanced scorecard. The Balanced Scorecard ("BSC") is a mechanism for tracking

performance in four areas: finance, customer service, internal business processes, and learning

and growth (Kaplan & Norton, 2007). To respond to financial pressures, healthcare organizations have historically relied on performance measures such as expense ratios that are entered in to Key Performance Indicator (KPI) dashboards to track progress (Kaplan & Nevius, 2001). Unfortunately, focusing primarily on financial targets through KPIs can cause the organization to lose foresight into the wide array of management challenges faced by healthcare leaders. For example, focusing solely on the expense ratio can foster shortsighted decisions, such as increasing the patient to physician ratio, or cutting back on training and development opportunities for staff. Consequences of such decisions include low employee morale, high turnover, increased expenses in recruiting new employees, and diminished quality care (Kaplan & Nevius, 2001). Therefore, the BSC complements traditional financial measures with the addition of three measures. The three "intangible assets" necessary for creating growth and advancement opportunities in organizations include customers, internal processes, and learning and growth (Kaplan & Norton, 2007, p.2).

The four BSC measures collectively are used to develop a healthcare strategy map to articulate the roadmap to implement strategy in healthcare organizations (Kaplan & Nevius, 2001). First, financial goals are the crux of all healthcare organizations, regardless of their for-profit or not-for-profit status (Kaplan & Nevius, 2001). Financial viability is the main objective that is defined by growth and revenue margins, while balancing efficiency and cost goals. In order to meet financial measures of success, healthcare organizations must gratify the needs of its key stakeholders, or customers, which is the second BSC measure. Customers include patients, families, referring clinicians, government agencies, and insurance payers. The main customer oriented measures in healthcare include patient satisfaction surveys, physician referrals, number of positive and negative patient complaints, and inclusion in preferred provider lists. By

maintaining a positive image and reputation through successful outcomes and accessibility to care, healthcare organizations can cultivate relationships among key constituencies. Financial and customer objectives are further reinforced by delivering excellence in internal processes that include clinical and administrative processes. Key internal processes, the third BSC measure, includes admission and discharge rates, operating efficiency, planning, innovation, and relationship management. Lastly, learning and growth objectives buttress the three preceding BSC perspectives as it focuses on human capital through the recruitment and training of employees to build their skills and competencies, and ultimately improve the culture and environment.

To close the gap between the formation and implementation of strategy, the BSC provides organizations with the ability to connect its long-term strategic vision with its short-term activities (Kaplan & Nevius, 2001). By utilizing the measurement system as a leadership and management system, organizations can realize breakthrough success (Kaplan, 2002). Implementing a BSC in a healthcare organization begins with a project team comprised of senior leaders and clinicians who gather to decide on the organization's strategy through the development of a strategy map (Kaplan & Nevius, 2001). The strategy map represents a systematic approach for communicating targets and initiatives that are outlined to fulfill the organizational strategy.

In building a strategy-focused organization centered around the balanced scorecard, the next step would involve "cascading the BSC throughout the organization" (Kaplan, 2002, p. 4). It is critical for leadership to communicate a message that it is everyone's duty to be aligned with the organization's mission and vision, and that employee's participation contributes to meeting the BSC targets. The BSC's targets and initiatives trickle down to the business units and

departments who establish their own strategies to align their value with the organization's objectives. Executives who have used the BSC view the system as an exceedingly effective way to convey a motivational and meaningful message to employees regarding the organization's strategy (Kaplan, 2002). Leaders can further gain followers by incentivizing employees by associating variable pay to their performance on the BSC (Kaplan & Norton, 2007). Next, a strategy-focused organization highlights strategy as a continuous process by integrating the strategy with the planning and budgeting process. In the planning and budget process, the leadership team creates "stretch performance" targets followed by enhancing the data collection and reporting systems for measuring performance (Kaplan, 2002, p. 5). Lastly, to inspire learning and growth, the leader should review the department's performance on the BSC measures and conduct monthly management meetings to discuss action plans related to addressing any shortfalls on any of the scorecard measures (Kaplan, 2002; Kaplan & Norton, 2007).

The balanced scorecard has helped several leading healthcare organizations in the United States in improving their performance. At Duke's Children's Hospital, the CEO Jon Meliones used the BSC to convince administrators and clinicians to integrate management and leadership responsibilities of cutting expenses, while also maintaining quality care and saving lives (Kaplan, 2002). The BSC allowed management to monitor progress in specific measures, and subsequently determined quickly whether a modification or an enhancement to a strategy was necessary to course correct the organization's direction (Kaplan & Nevius, 2001).

Montefiore Medical Center, an academic medical center based in Bronx, New York, is another successful case study that utilized the BSC to turnaround a $57 million budget deficit (Ross, 2001). After trimming down expenses by $15 million, the chief operating officer Elaine Brennan decided to implement the BSC as a management framework to understand performance

in key measures, and to focus attention on systems and processes. As a result, Montefiore

Medical Center joined the Balanced Scorecard Hall of Fame in 2001 for exceedingly positive

results in cost cutting, customer satisfaction, revenue spikes, and investment in innovative

technology and new programs (Ross, 2001).

Peter Person (2001), CEO of Saint Mary's/Duluth Clinic, believed in the balanced

scorecard approach as a valuable management tool. In particular, Person (2001) believed it was

critical to have an easily accessible and understandable strategy with cascading goals to drive

and measure performance and determine priorities. Based on scores for particular measures,

Person felt that the organization could shift their actions and priorities to improve scores. As a

result of various levels of organizational stakeholders buying in on the BSC approach, Saint

Mary's/Duluth Clinic was able to create a $20 million turnaround in operating margin, decrease

expenses, improve cash flow to 150 days' cash on hand, and allocate resources to fund several

expansion projects (Person, 2001).

Theories of Leadership Evident in Healthcare

Certain skillsets and a specific styles of leading are crucial to transforming a healthcare

organization from low and mediocre performance levels to high performing status. The literature

designates certain leadership styles in healthcare, starting with lean leadership (Liker & Convis,

2011), which values employee engagement and productivity practices to reduce costs and

augment an organization's competitive advantage in its respective market (Lewis, 2000). Lean

leadership theory demonstrates visible associations with contemporary leadership theories such

as transformational leadership (Bass & Riggio, 2006), servant leadership (Greenleaf & Spears,

2002), and leadership in self-managed teams (Yukl, 1997). A major connection between each of

these leadership theories is the emphasis on cultivating a supportive culture in which there is an enriching human interaction among peers, and between subordinates and their superiors.

Lean leadership. Modeled after Toyota's leadership framework, Liker and Convis (2011) offer a contemporary leadership theory called lean leadership that encompasses four aspects. These characteristics include the following: (a) be dedicated to personal development; (b) mentor and train peers and subordinates; (c) drive continuous improvement of working practices, also known as kaizen, and (d) develop a vision with corresponding goals (Poksinska et al., 2013). Lean leadership also involves the utilization of lean managerial practices and tools (Liker & Convis, 2011).

The first characteristic of lean leadership, *be dedicated to personal development*, entails displaying a predilection for augmenting one's knowledge and skills before assuming the role of developing others (Poksinska et al., 2013). Toyota's philosophy, also known as True North, is founded on several key values in which leaders should immerse themselves (Liker & Convis, 2011). These values include "the spirit of challenge, *kaizen, genchi genbutsu*, teamwork, and respect for humanity" (Poksinska et al., 2013, p. 888). Genchi genbutsu is a Japanese term that translates to "go and see," which represents the common Japanese organizational policy of requiring leaders to learn the daily operations of the company by engaging in a specific area or business unit (Haghirian, 2010, p. 10). Toyota leaders exemplify this Japanese business practice as they are well regarded for their thorough understanding of the operations, their technical acumen, and leadership prowess in developing and leading their employees (Liker, 2004).

The second characteristic of Lean leadership, *mentoring and training peers and subordinates*, further relates to the concept of genchi genbutsu. Genchi genbutsu also refers to a one to two-year training program for young, novice employees who have joined the company

shortly after matriculating through a university (Haghirian, 2010). Such a development program would be practical for aspiring young healthcare leaders who have just completed Masters programs in Health Administration. Lean leaders, in the same accord as Toyota leaders, must share their mastery of the organization's culture with the employees, especially with young and eager aspiring leaders (Poksinska et al., 2013). The cultural norm should glorify knowledge sharing and continuous organizational learning (Mann, 2009). As employees are coached and developed, there is a level of trust that encourages risk taking and innovate experimentation without fearing consequences of failure (Mann, 2009). In fact, some research confers the efficacy of lean leadership is substantiated by leader promotion of employee participation and empowerment (Emiliani, 1998; Found & Harvey, 2007; Liker, 2004) in improving practices and problem solving through the "hands-on approach of genchi genbutsu" (Haghirian, 2010, p. 11). Lean leaders refrain from coming up with solutions themselves, but rather captures the thought process of employees through active inquiry.

Daily kaizen, or *driving continuous improvement of working practices* through active employee participation, is the third characteristic of Lean leadership (Liker & Convis, 2011). Lean leaders' priority is to make employees aware of their individual responsibility for continuous operational improvements and to provide them with the tangible and intangible resources to foster improvement within their respective areas (Found & Harvey, 2007; Spear, 2004). Facilitation of brainstorming activities for employees is a key skillset for lean leaders to demonstrate in order for innovative contributions and continuous learning to occur among eager employees (Mann, 2009). Facilitation of brainstorming activities for employees is a key skillset for lean leaders to demonstrate in order for innovative contributions and continuous learning to occur among eager employees (Mann, 2009). In reference to Toyota's philosophy and values,

teamwork is instrumental to the organization's success; therefore, lean leaders must find ways to engrain the team philosophy throughout the organization (Found & Harvey, 2007; Liker & Convis, 2011).

The fourth characteristic of lean leadership, *develop a vision with corresponding goals*, calls on lean leaders to develop their own organization's version of Toyota's True North vision (Poksinska et al., 2013). A healthcare organization's long-term objectives and strategic improvement goals to reduce cost, consistently achieve quality care, and improve patient experience would constitute a version of the True North vision in the healthcare arena. Goals set to achieve the Truth North vision involve all levels of management and leadership, thus calling on individuals to partake in specific actions and improvement initiatives to mobilize the organization toward high performance standards (Liker & Convis, 2011).

The implementation of lean management practices and tools supports the success of lean leaders (Liker & Convis, 2011). There are four fundamental elements that comprise lean management practices: daily accountability processes, leader standard work, visual controls, and discipline (Mann, 2009). Daily accountability processes pertain to a method of following up on assigned tasks that are necessary to improve areas of opportunity or critical problems. A set meeting model with a standard agenda, timeframe, and frequency fulfills some of the expectation under daily accountability processes (Poksinska et al., 2013). Leader standard work supplements these accountability processes by leaders engaging in a daily routine that includes specific activities, such as reviewing the progress made with performance measures (Liker & Convis, 2011). Visual controls such as signs, displays, and tools that provide immediate and clear information regarding a targeted situation or condition serves as another lean management system that aids leaders in managing and controlling processes (Liker & Convis, 2011; Mann,

2005). Last of all, discipline is essential to implement the initial three elements as envisioned (Mann, 2005).

Research on lean leadership theory is typically presented as a distinct theory without connections to existing leadership theory (Poksinska et al., 2013). However, Poksinska, Swartling, and Drotz (2013) perceive linkages between lean leadership and leadership theories such as transformational leadership (Bass & Riggio, 2006), servant leadership (Greenleaf & Spears, 2002), and leadership in self-managed teams (Yukl, 1997). Lean leadership and these three contemporary leadership theories all emphasize the critical nature of human capital and relationships in accomplishing organizational and process improvement.

Transformational leadership. The presence exuded by leadership within organizations impacts employee satisfaction and potential for burnout, ultimately influencing the organization's health and performance (Porter-O'Grady & Malloch, 2007). Reed (2004) posits that leadership is the sole cause of cultivating a toxic work atmosphere, while other literature states that other factors can be a root cause for unhealthy work settings (Weberg, 2010). In a leadership assessment within healthcare systems, Weberg (2010) found a significant positive relationship between transformational leadership and "increased satisfaction, increased well-being, decreased burnout, and decreased overall stress in staff nurses" (Weberg, 2010, p. 246).

Transformational leadership is considered one of the most widely researched leadership theories over the last three decades (Northouse, 2010). James MacGregor Burns (1978), a political sociologist, has been noted as one of the first to elaborate on transformational leadership (Gabel, 2013; Northouse, 2010; Poksinska et al., 2013). Burns (1978) posits that there is a connection between the roles of leaders and followers. A transformational leader focuses on the motives and needs of followers to maximize their individual potential, and heighten the amount

of motivation and level of morality in oneself, as well as in followers (Burns, 1978; Northouse, 2010).

Burns (1978) highlights a distinction between transactional leadership and transformational leadership, with transactional leadership emphasizing contingent rewards or management by exception (Bass & Riggio, 2006). Essentially, a positive exchange occurs between leaders and followers that results in a reward (Northouse, 2010), or conversely a negative exchange results in constructive criticism to correct behavior, or negative reinforcement (Northouse, 2010). Conversely, transformational leadership underscores the importance of intrinsic motivation and developing followers (Northouse, 2010), which Bass & Riggio (2006) believes contribute to the popularity of transformational leadership theory. Transformational leadership is suitable in the healthcare industry that is rapidly changing as it fits a workforce "who want[s] to be inspired and motivated to succeed in times of uncertainty" (Northouse, 2010, p.171).

Bass (1999) explains the three-pronged approach that transformational leaders should deliver in order to motivate followers to exceed performance expectations. First, leaders must elevate the conscious awareness of followers regarding the significance and value of specific organizational goals. Second, leaders must find tactics to get followers to rise above their own personal interests for the betterment of the team or organization. Third, leaders need to mobilize followers in the direction of activating their higher-level needs (Bass, 1999; Northouse, 2010).

There are four components of transformational leadership that characterize this type of leader: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Bass & Riggio, 2006). Idealized influence, also known as a charismatic presence (Northouse, 2010), is exemplified by a model leader who shares and upholds his or her vision, as

well as the organization's mission with focus and determination (Gabel, 2013). In healthcare, clinicians and other healthcare personnel greatly respect, trust, and willingly associate with leaders with idealized influence (Gabel, 2013).

Inspirational motivation is demonstrated by a leader who influences and motivates employees to commit to high expectations and the organization's mission and vision (Northouse, 2010). Through personal actions, words, and behaviors that demonstrate adherence to the organization's mission, healthcare leaders inspire and energize employees to emulate the same behavior. In an instance of a staff shortage, the healthcare leader may volunteer to cover patient care responsibilities while asking staff to provide the same extra support (Gabel, 2013).

Intellectual stimulation is exemplified through a leader's ability to instill creativity and innovation in subordinates by challenging the status quo and their own habitual beliefs (Northouse, 2010). This component of transformational leadership is also applied when brainstorming new solutions to problematic situations in the workplace. Medical leaders may challenge other clinicians to research and establish more efficient and effective methods to providing medical care that increases quality outcomes, saves time and resources, and ultimately reduces costs for the organization (Gabel, 2013).

Individualized consideration of followers is the final and fourth component of transformational leadership. Leaders create a supportive and caring environment for subordinates characterized by active listening and attention to the unique needs of employees (Northouse, 2010). As a coach and adviser to various subordinates, the leader focuses on the employee's path to self-actualization and implements tactics that apply to each unique individual's growth and development trajectory. In healthcare, the leader may recognize employees for accomplishments in fostering a safety culture that has reduced medication errors (Gabel, 2013). Transformational

leaders may delegate to capable employees to allow them to overcome personal challenges (Northouse, 2010). In other situations, where the employee has trouble with organization, transformational leaders may need to assign necessary structure with concrete directives (Northouse, 2010).

Servant leadership. A relationship exists between transformational leadership and servant leadership (Stone et al., 2004). Servant leadership is a theory that was originally developed by Robert K. Greenleaf in the 1970s that highlights the concept and motivation of a leader to be a servant to followers (Greenleaf, 1977). The correlation between transformational leadership and servant leadership is the similar style of focusing on people and human capital, in particular, the emphasis on demonstrating appreciation and individualized consideration of the entire workforce (Stone et al., 2004). Furthermore, both leadership styles stress the significance of mentoring and empowering followers to achieve their goals.

Conversely, there is one major differentiating factor between transformational leadership and servant leadership, which is the focus of the leader (Bass, 2000; Stone et al., 2004). In transformational leadership, the leader's priority is the organizational objectives (Bass, 2000; Stone et al., 2004); therefore, transformational leaders endeavor to match their own and others' needs with the organization's needs. Through the transformational leader's example and behavior, they strive to engender followers' commitment and empower them to accomplish organizational goals (Yukl, 1998). In servant leadership, the needs of the followers exceed all other priorities in an effort to mentor and develop them as individuals to meet their personal goals (Bass, 2000). Essentially, servant leaders' supreme desire to serve people surpasses any organizational initiative or goals (Stone et al., 2004).

Greenleaf (1977) invokes servant leaders to reflect on the impact of their actions and the actions of the people that they serve on the most vulnerable and underprivileged in society, which is fitting in healthcare where the sick who are cared for represent a vulnerable population. Along with a moral compass (Trastek, Hamilton, & Niles, 2014), servant leaders display the following qualities: awareness, building community, commitment to the development of people, conceptualization, empathy, foresight, healing, persuasion, and stewardship (Spears, 2004). These characteristics foster strong relationships, rich interactions, and trust between leaders and people served, and are crucial to developing a healthy patient-provider relationship (Trastek et al., 2014).

Healthcare providers display the qualities of a servant leader as they set an example for the healthcare team in building trustworthy relationships with patients through strong interpersonal interactions, also known as patient-centered communication. Patient-centered communication has been associated with better quality outcomes, improved patient experience, and patient's adherence to provider's treatment plan (Wanzer, Booth-Butterfield, & Gruber, 2004). The overutilization of healthcare services through repeat diagnostics procedures or treatments would be alleviated through the high-trust relationship created between the patient and the healthcare team led by servant leaders (Trastek et al., 2014).

Healthcare providers who demonstrate the qualities and characteristics of a servant leader have the ability to promote changes in patient behavior impacting health outcomes (Trastek et al., 2014). Self-determination theory explains how concepts such as autonomy, competence, and relatedness contribute to patients' willingness to adjust health behaviors (Ryan, Patrick, Deci, & Williams, 2008). Autonomy is defined as the intrinsic drive motivating changes in behavior. Competence relates to the self-confidence of the patient in their capacity to change. Relatedness

signifies the patient's discernment towards feeling respected, understood, and treated

satisfactorily by the healthcare team (Ryan et al., 2008). In order to contribute to a patient's

sense of autonomy, competence, and relatedness, healthcare providers working as servant

leaders, will need to impart skills, resources, and feedback required to motivate change in

patients through self-determination (Trastek et al.,2014). Servant leaders in healthcare must

orchestrate a team that is devoted to assigning priority to patient's best interest and consistently

providing them with value-added care.

Leadership in self-managed teams. There has been an emerging trend of teams being

assigned daily tasks and responsibilities instead of being delegated to specific individuals within

an organization (Yukl, 1997). Teams comprised of multi-skilled individuals are central to the

success of lean organizations (Liker, 2004), because their interdependence and coordination of

activities will lead to the achievement of shared goals within the organization (Hill, 2010). As

teamwork is a critical aspect to quality healthcare delivery (Trastek et al., 2014), the leadership

within self-managed teams is fundamental to meeting performance goals related to quality,

financial, and most significantly the patient experience. For example, a Veterans Health

Administration (VHA) study of 125 VHA hospitals examining culture and patient satisfaction

indicated a significant positive relationship between teamwork and patient satisfaction scores in

the hospital setting (Meterko, Mohr, & Young, 2004). Conversely, a bureaucratic culture was

significantly and negatively related to patient satisfaction in the inpatient setting, therefore

pointing to an important implication for healthcare leaders to create a culture built on principles

of teamwork versus silos (Meterko et al., 2004).

The effectiveness of leadership's function and processes determines the success of the

team, "both affective and behaviorally based team outcomes" (Stagl, Salas, & Burke, 2007, p.

172; Zacarro, Rittman, & Mark, 2001). In contrast, an ineffective team leader could be the ultimate cause of a team's failure (Stewart & Manz, 1995). Therefore, a team's success is contingent on the efficacy of leadership's functions, which can be designated to one single team leader and/or shared by multiple team members (Hill, 2010), also known as shared or distributed leadership (Day, Gronn, & Salas, 2004). Shared leadership takes into account the team's leadership capacity (Day et al., 2004), which entails different roles, internal dynamics, and associations between individuals on the team (Yukl, 1997).

Two types of leaders exist within self-managed teams: external leaders who support and monitor the team's effectiveness within the environment (Hill, 2010), and internal leaders who organize and direct activities of the team (Yukl, 1997), thus focusing on task and relational activities (Hill, 2010). Team leadership represents a complicated phenomenon that is broken down using Hill's Model for Team Leadership, which provides a helpful tool to support team leaders in problem solving (Hill, 2010). Leaders of teams can benefit from a "mental model" in which external or internal leaders can determine how to drive team effectiveness, identify team challenges, and take proper steps to remediate the issues (Hill, 2010, p. 243). Team effectiveness is measured by the team's performance and level of team development. Based on the stage of team development, the leader's decision-making pattern and actions will change (Stewart & Manz, 1995). Carew, Parisi-Carew, and Blanchard (1986) also posit that the varying leadership styles of coaching, delegating, directing, and supporting will alter based on the team's development stage (Kinlaw, 1998).

In Hill's Model for Team Leadership (Hill, 2010), the team leader has three types of decisions to consider regarding the team's functional state, which will determine the leader's style. During a problem situation, a leader must first decide to continue observing and

monitoring the team versus stepping in to resolve the issue or to assist the team. In order to make an informed decision, the leader must search for information to analyze the current status of the team through interviewing team members, conducting surveys, and assessing team outcomes (Fleishman et al., 1991). Shared leadership opportunities can become beneficial at this point in time as team members can contribute to the monitoring phase (Hill, 2010). The second phase would be information structuring, which is analyzing and interpreting the data retrieved in order to elect a course of action (Fleishman et al., 1991).

The second leadership decision to be made under Hill's Model for Team Leadership is whether the leader should intervene to tackle relational or task issues. Relational, or maintenance functions, include fostering a positive environment, resolving interpersonal issues, and establishing a cohesive unit. Task leadership roles include project completion, decision making, problem solving, plan development, or goal achieving (Hill, 2010). Team leadership that is considered superior tend to concentrate on both task and relational functions (Kinlaw, 1998). Furthermore, leadership behaviors that are dually focused on task and relational functions are associated with perceived team effectiveness (Burke et al., 2006).

The third leadership decision to be made under Hill's Model for Team Leadership is whether internal (task, relational) leadership actions or external (environmental) leadership actions should be taken. According to Hill (2010), "to be an effective leader, one needs to respond with the action that is required of the situation" (p. 249). Depending on the circumstances, the team leader would carry out internal (task, relational) leadership actions or external (environmental) leadership actions (See Figure 1 on next page).

Figure 1. Hill's Model for Team Leadership. *Note*. This figure demonstrates Hill's Model for Team Leadership. The overall goal of this model is to outline the types of leaderships decisions that are made by team leaders, the internal and external leadership actions that are carried out based on the situation, and how these actions impact overall team effectiveness.

Implications for Young Aspiring Leaders

While there exists an immense amount of research on the stereotyping and prejudice of older adults, the number of millennials and young adults in the workplace represent a growing majority in the current labor workforce who may experience similar discrimination. According to the United States Census Bureau (2015), those born between 1982 and 2000 represent 83.1 million of the nation's population, which exceeds the population of 75.4 million baby boomers. Millennials and young adults under the age of 40 represent the majority, yet do not share the same protection against employment discrimination compared to those 40 years of age and older under the Age Discrimination in Employment Act of 1967. As there are physical, emotional, and

mental repercussions for ageism amongst the older generations, reverse ageism among younger generations could have the same potential consequences.

Ageism is the concept from which age discrimination was derived. Butler (1969) shared the first definition of ageism as "prejudice by one age group toward other age groups." Several years later, Butler (1975) revised the definition to "a process of systematic stereotyping and discrimination against people because they are too old, just as racism and sexism accomplish this for color and gender." Even Butler's definition expresses a bias toward older adults as it does not include a qualification of discrimination due to being considered too young. Both of his definitions relate back to social dominance theory, which emphasizes both "individual and structural factors that contribute to various forms of group-based oppression" (Sidanius et al., 2004, p. 846). While ageism is a term that typically is associated with discrimination against older adults, it is a term that can also be directed towards younger adults (Iversen, Larsen & Solem, 2009). The workplace is undergoing a cultural shift in which "youthism predominates" considering that the labor workforce continues to age and baby boomers continue to retire (Thornton & Luker, 2010, p.141).

Discrimination in the workplace. Reverse age discrimination is impacting the younger generation of millennials and young adults under the age of 40 who are looking to climb the organizational ranks. A longitudinal study of 7,225 working women revealed an age trend among those who experienced perceived age discrimination (Gee, Pavalko, & Long, 2007). The study revealed perceived age discrimination is prominent in the 20s, decreases in the 30s, and peaks in the 50s (Gee et al., 2007). Other studies corroborate the under-studied phenomenon that younger employees are also discriminated against by employers and by society at large (Johnson & Neumark, 1997; Nelson, 2005). Snape and Redman (2003) found that participants under the age

95

of 30 felt that they had experienced significantly greater levels of age discrimination in comparison to those 40 and over. In the same study, the participants over the age of 50 did not report significantly higher levels of discrimination than any of the other age groups (Snape & Redman, 2003).

Potential attitudinal and psychological consequences of age discrimination include diminished organizational commitment and stress. Snape and Redman (2003) found significant relationships between perceived age discrimination and two forms of commitment: affective and continuance commitment (Snape & Redman, 2003). Affective commitment relates to a desire or commitment on the basis of emotional connections the employee cultivates with the organization. Continuance commitment is defined by commitment based on perceived costs of departing from the organization (Jaros, 2007). Johnson and Neumark (1997) report that there is a greater likelihood of older adults to separate from their employer when they experience age discrimination in the workplace. Another study sampled individuals aged 25-74 and discovered an association between perceived age discrimination and higher psychological distress (Yuan, 2007).

Garstka, T. A., Schmitt, M. T., Branscombe, N. R., and Hummert, M. L. (2004) explored the association of perceived age discrimination and psychological well-being, which were characterized by two measures of personal self-esteem and life satisfaction scores. While there was an association between perceived age discrimination and harm to psychological well-being among older adults, there was no association for young adults (Garstka et al., 2004). As over a decade has passed since the Garstka et al. (2004) study, and while the number of young adults under 40 has surpassed the population of older adults (United States Census Bureau, 2015), the

results of the proposed research study focusing on early career professional under 40 years of age may provide substantial feedback for policymakers working to improve ADEA legislation.

In terms of healthcare management occupations, the number of jobs is expected to grow 19% from 2014 to 2024, the greatest growth rate compared to any other occupation, according to the United States Department of Labor Bureau of Labor Statistics (2015). Such growth will create 2.3 million jobs due to the aging population and health reform that has provided millions with health insurance (United States Department of Labor Bureau of Labor Statistics, 2015). Therefore, the medical field will become more enticing to young adults due to the availability of jobs. Those with Bachelor's degrees will soon enter graduate programs geared toward health administration with hopes of increasing their knowledge to be given the opportunity to take on leadership positions at healthcare organizations throughout the United States. With the baby boomers retiring, young leaders will soon take on more senior roles. A projected 3.6 million baby boomers are set to retire in 2016 and more than 25% of millennial workers will step into management roles (Schawbel, 2015). Therefore, it is critical for reverse ageism to be given attention as the younger generation represents a major part of succession plans for many organizations in the United States.

Chapter 2 Summary

This comprehensive review began with a review of the healthcare landscape within the United States with an emphasis on the impact of the Affordable Care Act on organizational performance. The legislation requirements of the ACA trickle down to the organizational level wherein healthcare leaders must demonstrate the healthcare acumen and people orientation to mobilize the workforce to achieve performance goals. High performing organizations were discussed from different angles through a deep dive into varying terminologies, measures, and

practices of what is considered "high performing" in existing literature. There is major emphasis of human resource functions and leadership and management interactions that directly impacts employee engagement and organizational performance in high performing organizations.

The next section of Chapter 2 focused on the innovative strategies and practices developed and implemented by healthcare leaders that differentiates the struggling low performing organizations from the high performing organizations that will maintain stability during times of constant change (Studer, 2013). Two change management and performance-driven frameworks were discussed: High-Reliability Health Care Maturity Model (Chassin & Loeb, 2013), and Studer Group's Evidenced Based Leadership Framework (Studer, 2013). The balanced scorecard (Kaplan & Norton, 2007) and pillar framework (Studer, 2013) are two common methods for measuring performance in healthcare organizations. In a service oriented industry, certain leadership styles, behaviors, and practices are common in healthcare, including lean leadership (Liker & Convis, 2011), transformational leadership (Bass & Riggio, 2006), servant leadership (Greenleaf & Spears, 2002), and leadership in self-managed teams (Yukl, 1997). The role of healthcare leaders will continue to be impacted as current and evolving market trends affect stakeholder relationships, decision making and strategic thinking (DeVore & Champion, 2011; Iglehart, 2011; Santilli & Vogenberg, 2015).

Lastly, as the focus of this research study is leaders under the age of 40, an overview of the Age Discrimination in Employment Act (ADEA) was provided, along with the underlying connection to Social Dominance Theory (Sidanius et al., 2004). Age discrimination and intergenerational issues occur in the workplace, and unfortunately, those under the age of 40 are not protected under the ADEA. Potential attitudinal and psychological consequences of age discrimination include diminished organizational commitment and stress (Snape & Redman,

2003). This qualitative research study serves to raise awareness of the social injustice, if any, that occurs among healthcare leaders in the United States under the age of 40. Chapter 3 will provide a comprehensive examination of the research design and methodology used to elicit qualitative data regarding the challenges, best practices, and strategies of high performing, young healthcare leaders.

Chapter 3: Research Design and Methodology

Introduction

The purpose of this study was to explore best strategies and practices that healthcare leaders under the age of 40 adopt for their respective organizations amidst a rapidly changing industry. The capturing of individual experiences of healthcare leaders under the age of 40 through their personal recollections underscored the qualitative nature of this research study (Creswell, 2003). This chapter highlights the qualitative research method employed and the reasons for using a phenomenological approach to gather data to support the study. The research design is demonstrated through a description of the population, sampling method, participant selection methodology, and the process of acquiring Institutional Review Board (IRB) approval, which stresses the significance of the protection of human subjects. The data collection strategy is discussed along with an explanation of the interview protocol and questions that were tested for reliability and validity. There is an acknowledgement of the researcher's bias as a young leader in healthcare. The chapter concludes by explicating the procedures for data analysis and the process for discovering themes that contribute to the findings of this research study.

Re-Statement of Research Questions

This chapter describes the research methods that were applied to achieve the objective of this study, which was to primarily answer these four research questions:

RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?

RQ2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?

RQ3: How do healthcare leaders under the age of 40 measure the success of the strategies and practices employed to lead their respective organizations?

RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?

Nature of the Study

The descriptive nature of this study applies a qualitative approach to examine the research questions. The central research questions for the study are descriptive and explanatory (Creswell, 2014). The questions are descriptive as the responses described the occurrence of individuals under the age of 40 in leadership roles in healthcare. The research questions are explanatory as the goal is to expound patterns of behavior related to the phenomenon of having enormous leadership responsibility in a healthcare organization at a young age. The descriptive and explanatory nature of the study was achieved through open-ended interviews comprised of questions that were intended to elicit thorough responses about healthcare leaders' "experiences, perceptions, opinions, feelings, and knowledge" (Patton, 2002, p. 23).

The assumptions of a qualitative study are evident in the customary characteristics of qualitative research (Creswell, 2013; Hatch, 2002; Marshall & Rossman, 2011). First, data can be collected in the natural setting in which individuals are entrenched in the particular issue or problem under review. Second, the researcher becomes the "key instrument" in gathering data, and in this study, interviews will be the main method for collection of data (Creswell, 2014, p. 185). Third, qualitative studies utilize several sources of information versus depending on one data source. All sources of data are arranged into categories, patterns, or themes that are meant to reveal the deep-rooted perceptions of participants regarding the problem or issue. The fourth assumption of qualitative research is that it invokes an "emergent" (p. 186) process, which means

that the original research strategy may continue to develop as data collection continues (Creswell, 2014). The fifth assumption is how the researcher engages in reflexivity, or reflecting "how their role in the study and their personal background, culture, experience, and experiences hold potential for shaping their interpretations" (Creswell, 2014, p. 186). Reflexivity occurs throughout the data collection and the analysis period as the researcher assigns themes and meanings as data is gathered and processed. Finally, qualitative research produces a holistic view of varying perspectives among participants (Lakshman, Sinha, Biswas, Charles, & Arora, 2000), reveals different aspects related to an issue or problem under investigation, and ultimately portrays a grander and emerging view of a phenomenon (Creswell, 2014).

Qualitative research is a strong approach as several types of qualitative designs allow one to interpret meaning, patterns, and themes by engaging in an intense and concentrated interaction with participants to examine their experiences (Creswell, 2014). There are five types of qualitative designs that can be employed based on the subject matter. If the subject matter entails examining processes, events, and measures, case studies or grounded theory is most suitable. If one seeks to explore the culture and behaviors of a particular group of individuals, then ethnography would be the most applicable qualitative design. Finally, if the topic focuses on individuals, narratives and phenomenological studies should be employed.

Richards and Morse (2013) cite two main reason for approaching research through a qualitative lens: "the research question[s] require it, and the data demands it" (p. 25). Data in qualitative research is typically collected through observations, interviews, documents, or audio-visual materials. The open-ended nature of the four central research questions for the study requires gathering data through interviewing healthcare leaders under the age of 40 and actively listening to their responses. Qualitative interviews are advantageous as participants can highlight

significant historical information that is critical to the research, and secondly, the flow of questions can be controlled in order to elicit thoughts and perspectives of the participants (Creswell, 2014).

Although Johnson and Christensen (2004) suggest that qualitative research is a strong methodology for uncovering essential detail regarding individual's unique experiences related to phenomena, there are limitations to the qualitative data collection approach of interviewing participants. First, interviews deliver "indirect information filtered through the views of interviewees," (p.191) which may not convey the full picture and is subjective (Creswell, 2014). Second, interviews take place in a location determined by the researcher or participant, and may not be the natural field setting. Third, participants may vary in their ability to perceive and communicate responses to open-ended questions. Fourth, the researcher's mere presence during the interview could potentially create some biased answers (Creswell, 2014; Johnson & Christensen, 2004). Additional biases are created on the part of the researcher through the interpretive nature of qualitative research. Researchers must provide explicit detail on their personal "biases, values, and personal background, such as gender, history, culture, and socioeconomic status (SES) that shape their interpretations formed during the study" (Creswell, 2014, p. 187). Finally, due to potentially prolonged data collection process, transcribing, and analysis of qualitative interviews, Robert and Morse (2013) posit the shorter turnaround of a quantitative study.

Methodology

The qualitative design that was employed in this research study is phenomenology. According to Creswell, phenomenology is a design that "describes the lived experiences of individuals about a phenomenon as described by participants" (Creswell, 2014, p.14). The

purpose of this phenomenological study was to describe the experiences of young healthcare leaders under age 40 in their respective organizations. The central phenomenon of this research study is defined as young healthcare leaders who have earned director or above roles in a health care organization. According to the American College of Healthcare Executives (ACHE), "an international professional society of more than 40,000 healthcare executives who lead hospitals, healthcare systems, and other healthcare organizations," 73% of the 35,320 leaders who provided their age were over the age of 40 (American College of Healthcare Executives, 2014). Given most healthcare executives are 40 and older, and due to few studies exploring young healthcare leaders' experiences in the literature, a phenomenological study devoted to understanding young healthcare leaders' lived experiences best fits the goal of the qualitative research study.

Structured process of phenomenology. In phenomenological research, interviews are the standard technique for collecting data from individuals who share experiences related to the same phenomenon (Giorgi, 2009; Moustakas, 1994). Van Manen (1990) posits that phenomenology is a retrospective and interpretive method for comprehending and developing meaning for individuals' complicated experiences that have occurred in the past. To capture meaning through phenomenology, Frankl (1988) explains how the qualitative research design is meant to address how a person understands oneself and how one infers their purpose or existence within a situation or setting. The researcher made meaning of an individual's existence by interpreting four existentialisms that support phenomenological reflection: "*temporality* (lived time), *spatiality* (lived space), *corporeality* (lived body), and *relationality* or *communality* (lived human relation)" (Richards & Morse, 2013, p. 68; Van Manen, 1990).

A weakness of the phenomenological design is the potential for presuppositions or biases (Richards & Morse, 2013) that may impact the interpretation of collected data. Part of the

structured process of phenomenology is the goal of bracketing all previous knowledge regarding a subject matter. Before interviews were conducted, the participants' "assumptions, knowledge, and expectations" are noted about the topic in an effort to call out all preconceived notions (Richards & Morse, 2013, p. 70). Interviews were audio recorded with prior approval from the participant, which was transcribed and used as a tool to reflect and interpret the conversation between participant and researcher. The phenomenological process continued with an analysis of the interviews in which the researcher considered one's unique experiences, observations, and the involvement of other individuals, which ultimately evolved into an understanding of the significance of participants' experiences that were not previously apparent to the human psyche.

Appropriateness of phenomenology methodology. The strengths and appropriateness of the phenomenology methodology was evident in two key assumptions of the qualitative design. First, individual's descriptions of their insights and discernments enlightens the audience with "evidence of the world," as exemplified by how individuals perceive their respective situations or contexts as they live it daily (Richards & Morse, 2013, p. 68). This research study sought to understand the perceptions of young leaders in healthcare based on their lived experiences within their respective organizations. The second assumption underscored the significance behind the phenomenological expression, "existence as being in the world," reinforcing the notion that individuals' mere existence in their "worlds" is full of meaning (Richards & Morse, 2013, p. 68). Essentially, human behavior was exemplified in the framework of the four existentialisms introduced previously. This research study sought to understand leaders' "relationships to things, people, events, and situations" (Richards & Morse, 2013, p. 68) within the healthcare marketplace and within their respective worlds, or organizations.

Research Design

Developing the research design entailed visualizing the study at different levels. According to Richards and Morse (2013), the general design of the research study must be aimed at answering the research questions. In order to elicit responses to the research questions from participants who could provide applicable qualitative data, there was a thorough participation selection process starting with a discussion of the analysis unit, population, sample size, and sampling technique.

Analysis unit. The ideal participant, the analysis unit, of the study was a healthcare leader under the age of 40 who holds a director and above position within their respective organization in the United States. The roles above the director position include senior directors, executive directors, senior administrators, vice presidents, presidents, chief executive officers, chief operating officers, chief financial officers, chief medical officers, or chief information officers (ACHE, 2016). According to the American College of Healthcare Executives (2016), positions for healthcare leaders are represented in multiple settings: ambulatory care facilities, consulting firms, healthcare associations, home health agencies, hospices, hospitals and hospital systems, integrated delivery systems, long-term care facilities, managed care organizations, medical group practices, mental health organizations, public health departments, and university or research institutions The analysis unit of this research study was individuals under the age of 40 holding a position title of director and higher in organizations as stipulated by the ACHE.

Population. The population was comprised of young healthcare leaders under the age of 40 who had been recognized nationally in either *Becker's Healthcare Review* ("Becker's"), or *Modern Healthcare* over the last 5 years. According to Patton (2004), the population encompasses a group of people that the researcher is interested in studying from which the

sample for the study is derived. For the purposes of this study, the population of healthcare leaders was defined as the recipients of awards from two recognized healthcare entities: *Becker's Hospital Review*, which publicizes a yearly list of *Rising Stars: 25 Healthcare Leaders Under Age 40*, and *Modern Healthcare's* annual "Up & Comers Award", which recognizes 12 healthcare leaders who are 40 years and younger, and have demonstrated substantial work in healthcare administration, management, or policy (Modern Healthcare, 2016).

Becker's Healthcare is a renowned source for healthcare industry leaders searching for leading-edge business and legal information. One of Becker's widely read trade publications is *Becker's Hospital Review*, which publicizes a yearly list of *Rising Stars: 25 Healthcare Leaders Under Age 40*. Roney (2012) describes this elite group of talented and driven men and women who, before the age of 40, have earned executive positions within their respective health system or organization. Through peer nomination and editorial research, these respectable leaders are recognized for spearheading organizational initiatives and improving the performance and financial health of the institution. Roney (2012) states that many of these nominated leaders hold records as the youngest executives within their respective organizations. Over the last five years, 2012 to 2016, there are 125 healthcare leaders, male and female, who have been recognized as a *Rising Star* through the Becker's publication.

Modern Healthcare is another prominent source of information for healthcare leaders as it provides weekly updates on healthcare trends, policies, and research through a print magazine, a web presence, and electronic newsletters. Similar to Becker's list of *Rising Starts: 25 Healthcare Leaders Under Age 40, Modern Healthcare* has been publishing an annual "Up & Comers Award" for over a decade, which recognizes 12 healthcare leaders who are 40 years and younger. Winners of this prestigious award are chosen based on four main criteria: (a) leadership

roles and accomplishments, (b) operating and financial performance of organization under the healthcare leader's purview, (c) participation in community service, and d) additional leadership positions outside of the nominee's main organization (Modern Healthcare, 2016). Over the last five years, 2012 to 2016, there are a total of 60 healthcare leaders, male and female, who have been recognized as one of the "Up & Comers" through *Modern Healthcare's* award.

Sample size. From the distinct population of young healthcare leaders recognized in *Becker's Hospital Review* and *Modern Healthcare* over a five-year timeframe, a sample of participants were invited to participate in interviews. Creswell (2013) posits that sample size should be determined based on the qualitative design chosen for the study. For a phenomenological research study, there should be three to ten participants (Creswell, 2014). In an earlier study by Creswell (1998), he postulated that five to 25 would be suitable. Morse (1994) states that at least six should be used in a phenomenological research design. Another approach to determine an adequate sample size is employing the notion of saturation, which is derived from grounded theory (Creswell, 2014). After interviewing a certain number of participants, the participants begin to share similar or identical perspectives. At this point, saturation is met as the new data no longer presents novel information or themes, and collection of data can therefore stop (Charmaz, 2006). For the purposes of this qualitative, phenomenological research study, the sample consisted of 15 research participants, which is within the criteria outlined by Creswell (1998, 2014) and Morse (1994).

Purposive sampling. Purposive sampling, also known as purposeful sampling, is a non-random sampling technique used to gain perceptions of individuals to enhance the knowledge base for a phenomenon (Onwuegbuzie & Leech, 2007). Purposive sampling represents the most common form of sampling in qualitative research (Onwuegbuzie & Leech, 2007), in which

participants are chosen based on their characteristics, knowledge, time availability, inclination to participate, and involvement in the "phenomena of interest" (Richards & Morse, 2013, p. 221). In qualitative research, participants should be selected based on their ability to articulate their knowledge and experience surrounding the research questions. Purposefully selecting "good informants" ensures a sample that is willing to provide critical feedback to fulfill the purpose of the study (Creswell, 2014, p. 221).

In the purposeful sampling methodology, Koerber and McMichael (2008) support a sample size as small as two to three participants as long as a diverse sample that achieves the purpose of the study through a series of interactions can be gathered. Since this research study involves single interviews with research participants, two or three participants under the postulation of Koerber and McMichael (2008) will not suffice with purposive sampling. As such, 15 research participants serve to provide diversity and adequate interactions to produce rich data. To recruit the research participants purposefully, a sampling frame, or master list was defined, which applied criteria for inclusion, exclusion, and maximum variation.

Participation selection. A three-step process was employed in order to develop a final list of participants. First, the sampling frame, or master list, was identified. Second, the sampling frame will be reviewed and criteria for inclusion and exclusion was instituted according to the list of eligible participants. Third, criteria for maximum variation was established. The dissertation committee reviewed and approved the process for deriving the master list.

Sampling frame. The participation selection process involved developing a sampling frame, or master list of possible participants. There are two main public domain website sources that were utilized to generate the master list of participants. The available lists on Becker's list of *Rising Starts: 25 Healthcare Leaders Under Age 40* and *Modern Healthcare's* annual "Up &

Comers Award" from 2012 to 2016 served as the sources to develop the sampling frame. In total, there are 211 distinguished healthcare leaders who have appeared as awardees in *Becker's Hospital Review* and *Modern Healthcare* between 2012 and 2016. The names, year of selection for recognition, titles, organizations, and ages of the 211 healthcare leaders awarded on *Becker's Hospital Review* and *Modern Healthcare's* websites between 2012 and 2016 were gathered into an Excel document. Each of the leaders within the master list were found on LinkedIn to determine whether they fit within the criteria for inclusion as discussed in the subsequent section. Any instance in which the healthcare leaders appears in multiple years, or in both publications, the list was filtered to only maintain one single occurrence of the healthcare leader being recognized. Since the list of awardees was available in a public domain, site permission was not necessary to access the list. Contact information was not available on the websites. LinkedIn will be utilized to contact the participants through the personal contact feature, InMail. The researcher connected with the healthcare leader by attempting to add the individual as a contact, and by sending a personal message introducing the research study using the recruitment script (see Appendix C).

     Criteria for inclusion. The criteria for inclusion in the research study included the following:

- can be found on LinkedIn, which is the source for contact information,
- has at least a Master's degree or medical degree,
- is currently under the age of 40,
- lives within the United States of America,
- agrees to be audio recorded, and
- responds and expresses interest to be involved in the study.

Criteria for exclusion. The criteria for exclusion included:

- any factors that do not meet the aforementioned criteria for inclusion,

- if the characteristics, education level, and age are unable to be determined on the

  Becker's and *Modern Healthcare* sites or LinkedIn, then the individual will be excluded

  from study.

- participants must be in geographical proximity to the researcher who resides in Dallas,

  Texas

- As age is the main criteria for inclusion, an exclusion algorithm was applied (Table 1.0).

  Depending on the age of the leader during the year of recognition, specific age ranges

  were excluded from the master list to ensure the participant would be under the age of 40

  in 2017.

Table 1.0

Algorithm for Age Exclusion Criteria

Recognition Year	# of leaders with age available	Exclusion Algorithm	# of potential participants remaining
2012	33	Filter out 36 and over	13
2013	32	Filter out 37 and over	16
2014	30	Filter out 38 and over	16
2015	31	Filter out 39 and over	25
2016	17	Filter out 40 and over	15

Note. The number of remaining potential participants is highlighted in the last column of Table 1.0 totaling 85 healthcare leaders who would be found on LinkedIn to confirm educational backgrounds. Of the 85 potential participants, six did not have LinkedIn, 24 were duplicates, and five did not list educational background, or did not fit the inclusion criteria of a medical or master's degree.

Purposive sampling maximum variation. After applying criteria for inclusion and exclusion criteria, the sample size was at 50 potential participants. The master list was narrowed down to a total of 26 potential participants who were directly messaged through the personal feature on LinkedIn. One of the most popular strategies for purposive sampling is maximum variation sampling (Sandelowski, 1995). In this technique, an extensive variety of participants, groups, or settings was purposely chosen for the study in order to provide a heterogeneous sample of varying experiences (Onwuegbuzie & Leech, 2007). Divergent perspectives could be captured that demonstrates the intricacies of the world (Creswell, 2002). In this particular study, the criteria for maximum variation was reviewed in this order: (a) healthcare leaders of varying ages under 40, (b) representing a mix of male and female healthcare leaders, (c) representing various healthcare organizations, (d) holding different positions titles, (e) varying educational backgrounds, and (f) from several states. The goal of such a selection method is to examine the differences among healthcare leaders as well as the "common core" (p. 141) of being a healthcare leader (Polkinghorn, 2005). The master list was narrowed to a final list of 15 by utilizing a criterion for maximum variation, and agreement that the healthcare leader would participate in the research study.

Protection of Human Subjects

As human subjects were involved in this research study, the Pepperdine University Institutional Review Board (IRB) guidelines were adhered to through several considerations. It was essential to consider protection of human subjects to ensure the rights, welfare, and safety of research participants throughout the research process. Furthermore, a human subjects protection program validates whether desirable values are maintained in the research protocol. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research ("the

Commission") was created in 1974 as a result of the enactment of the National Research Act

(U.S. Department of Health & Human Services, 2016). The Commission was tasked with

assessing and determining the following (U.S. Department of Health & Human Services, 2016):

> (i) the boundaries between biomedical and behavioral research and the accepted and
>
> routine practice of medicine, (ii) the role of assessment of risk-benefit criteria in the
>
> determination of the appropriateness of research involving human subjects, (iii)
>
> appropriate guidelines for the selection of human subjects for participation in such
>
> research and (iv) the nature and definition of informed consent in various research
>
> settings.

Furthermore, the Commission was delegated the responsibility of assigning the basic ethical

principles that should be considered in human subject's research (U.S. Department of Health &

Human Services, 2016). There are three central principles that are pertinent to the ethical

concerns involving human subjects. The first basic principle is respect for individuals, which

entails a person's ability to consent to participate in research without duress. The second

principle is beneficence, which is abstaining from inflicting any harm, and justifying maximum

benefits of the research while minimizing any potential dangers or threat to safety. The third

principle is justice, which distributes burden and benefits equally among all people.

As the research study presented minimal risks to the participants, an exempt application

was submitted to the IRB for review and approval before beginning recruitment of participants.

Before data collection commenced, an exempt IRB application was submitted to the Pepperdine

Graduate and Professional School Institutional Review Board, which included the informed

consent form (see Appendix B) and recruitment script (see Appendix C). Creswell (2014) states

that the researcher's responsibility is to determine the potential "physical, psychological, social,

economic or legal harm" (Creswell, 2014, p. 95). Some ethical standards to consider and avoid include "exploitation of participants" and "collection of harmful information" (Creswell, 2014, p. 98).

Consent information was provided in writing and a waiver of research participants' authorization from Institutional Review Board (IRB) or Privacy Board was requested. The approval of the waiver was contingent on the presence of minimal risk to the privacy of the participant. A suitable proposal to protect participant information from "improper use and disclosure" by destroying participant identifiers as early as three years (Pepperdine University Graduate & Professional Schools Institutional Review Board, 2015, p. 13-14) was provided. To protect the identity of the participants' responses, the recordings were saved under a pseudonym and transferred to a USB flash drive, which will be kept in a safe, locked drawer and will be eventually destroyed. The researcher transcribed and coded the interviews herself to prevent a third party from improper use. The documents containing the transcribed interviews and coding analysis were also transferred to the same USB flash drive and maintained in the same locked drawer at the researcher's residence, and will be destroyed after three years. The participant's name, affiliated organization, or any personal identifiable information were not reported. Instead a pseudonym with a generic organization name were used to protect confidentiality. The informed consent form disclosed the purpose of the study, gave the participant the choice to participate free of coercion, and ensured confidentiality of the data of the participant. Additionally, the participant could withdraw at any time without negative consequences. Participants were permitted to skip any questions during the interview. The informed consent form also asked for permission to record the interview to be later transcribed. Essentially, these disclosures will helped minimize risks to the participants.

Risks and benefits of participation were communicated during the informed consent process. Physically, the participant may have developed some fatigue as the interviews could have lasted more than 60 minutes. Psychologically, the participants may have not realized they had experienced age discrimination and by participating in the interview they may recognize that they may have personally experienced age discrimination recently or in the past. Bringing up such a sensitive topic could potentially have troubled participants with lower self-esteem or life satisfaction. Socially, the participant's realization of the discrimination may have resulted in a reconsideration of one's commitment to their employer. However, it is the hope that the findings produced some social benefits including raising awareness of discrimination of young adults and creating a social movement to revising the American Discrimination in Employment Act (1967) that only protects those 40 and older.

Other human subjects' considerations included confidentiality and potential deception of participants. Confidentiality and privacy of participants were fully protected through the reporting of data in aggregate form. Additionally, participant's names, affiliated organization or any personal identifiable information were not reported. Instead a pseudonym from a "generic organization" was used to confidentiality was protected. If personal and destructive information was shared during the interview, steps were taken to protect the participant's privacy. All interviews were recorded on a smart phone device and on recording feature on a laptop with the participant's agreement. The recordings were saved under the participant's pseudonym and transferred to a USB flash drive, which will be kept in a safe, locked drawer within the researcher's residence for three years. The documents containing the transcribed interviews and coding analysis were also transferred to the same USB flash drive and maintained in the same locked drawer at the researcher's residence for three years. With regard to deception, there was

no intent to deceive any of the participants. When the research is published, the participant is able to receive a copy of the paper to support "reciprocity" with the participant (Creswell, 2014). Lastly, there was no remunerations for partaking in the interview, and no conflicts of interest.

Data Collection

After the research study was approved by the IRB and the final list of 15 participants was finalized, data collection commenced. Data collection strategy involved setting up interviews either via phone or email depending on the contact information available on the master list collected via LinkedIn. A formal email or phone recruitment script was utilized to contact participants (See Appendix C). The purpose of the recruitment script was to utilize a standard communication tool to reach out to potential participants, express the purpose of the research study, and assess participants' level of interest in joining the research study. Most phone calls involved initially communicating with an assistant, or gatekeeper, who served as a liaison between the researcher and healthcare leader. The phone call with the assistant provided an introduction regarding the purpose for requesting a 60-minute meeting with the healthcare leader, and availability of the participant if the assistant agreed to schedule an interview immediately on behalf of the participant. If additional communication was needed directly with the healthcare leader, a direct email address for the participant was obtained and the assistant's email address to be email carbon copied in the message containing the recruitment script.

After an interview date was finalized, a formal email was sent to the participant and assistant (if applicable) with confirmation of the date and time emphasizing a 60-minute timeframe, the purpose of the study, and the interview questions. In addition, the informed consent form was emailed to the participant highlighting the following (see Appendix B): (a) participation in the study is voluntary, (b) the participant is able to withdraw at any time without

any negative repercussions,(c) a pseudonym from a "generic organization" will be utilized throughout the study, (d) the interview will be recorded with the participant's permission and can be stopped or paused at any point in the conversation, and (e) upon request, any published papers can be sent to the participant.

Participants were requested to confirm their agreement to participate in the research study, along with the date, time, and the desired location for the interview. Furthermore, it was requested that the informed consent be reviewed and emailed back in PDF form prior to the scheduled interview. Blank copies of the informed consent form were brought to each interview in the event that the informed consent was not signed before the interview date. If a healthcare leader decided to respectfully decline participation in the research study, or in the event that a participant choose to withdraw from the study for personal or logistical reasons, a backup list of 10 potential participants that were ranked based on inclusion, exclusion and maximum variation criteria was utilized. The recruitment process was repeated until the desired sample size of 15 participants was met.

Interview Techniques

Effective qualitative interviewing techniques center on the researcher's ability to engage in conversation (Kvale, 1996) by asking appropriate questions and actively listening to the participants (Rubin & Rubin, 1995). After the appointment time was set at a location that is convenient for the participant (Gubrium & Holstein, 2011) and void of distractions and interruptions (Richards & Morse, 2013), the process of deriving meaning from the social interaction between researcher and participant commenced. Even though the participant signed the informed consent form stating he or she was willing to be audio recorded, it was critical for permission to be obtained in person once again. Gubrium and Holstein (2011) cite the potential

impact that knowledge of the conversation being recorded can have on the information shared during the interview.

There are three types of interview techniques: structured, unstructured, and semi-structured. Structured interviews represent a regimented interview process that utilizes a set of questions that are planned prior to the interview. During a structured interview, follow up questions are not asked. Unstructured, or interactive interviews, do not require as much preparation as there are no predetermined questions (Richards & Morse, 2013). Instead, the participant has the freedom to openly share his or her story and knowledge. Compared to the structured interview process, follow up with participants occurs with unanticipated probes to confirm understanding of responses, which is done in a fashion that minimizes interrupting the participant's thought process. Unstructured interviews are typically used in ethnographic studies, grounded theory, narrative inquiry, discourse analysis, and case studies (Richards & Morse, 2013).

Semi-structured interviews include the use of open-ended questions that are designed in advance, with probes that are either planned or unplanned. While Richards and Morse (2012) stated that semi-structured is commonly used in ethnographic studies or grounded theory, it was seen as the best fit for this phenomenological research study. Semi-structured interviews were conducted with the 15 participants of the study. The researcher was sufficiently knowledgeable about the central phenomena of being a healthcare leader under the age of 40 from her personal lived experience, which allowed the design of questions and the chronology of the questions in advance in order to the frame the discussion. While the same questions were asked of all participants, it may not have been in the same order for every participant as probes were inserted throughout the interview (Richards & Morse, 2013).

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An ice breaker was used at the beginning of the interview to develop rapport with the participant, followed by 10 to 12 open-ended questions that were prepared in advance and derived from the review of literature (Gubrium & Holstein, 2011). Active listening was practiced by avoiding interruptions to ensure the participant's narrative was not skewed. Planned or spontaneous probes are acceptable during qualitative interviews to clarify the participant's responses (Rubin & Rubin, 1995), however, such input should be carefully inserted during the interview so as to not interrupt the participants' thought process (Gubrium & Holstein, 2011; Richards & Morse, 2013). Rubin and Rubin (1995) postulate the probable emotional stress placed on participants due to the open-ended, probing, and exploratory nature of qualitative interviewing. Subsequently, the interviewer was ready to deal with emotional outbursts. The goal was to create a comfortable ambiance for the participant, which was further characterized by presenting oneself in an unbiased manner and refraining from displaying emotion, disapproval, and any expressions of astonishment.

Interview Protocol

The purpose of qualitative interviews is to capture personal perspectives and opinions from the participants of the study (Creswell, 2014). Rubin and Rubin (1995) states that qualitative interviews employ three types of questions: primary questions that guide the interview from the beginning of the conversation; probes to further explain responses or to prompt examples; and follow up questions that produce meaning for the central questions. Interviews were primarily face-to-face, or over Skype, which were recorded with permission from the participant.

Relationship between research and interview questions. Expertise and knowledge was gained through the literature review process (Gubrium & Holstein, 2011), which led to designing

interview questions that addressed each of the research questions. Gubrium and Holstein (2011) recommend the development of 10 to 12 specific questions. The purpose of each of the interview questions was to elicit open-ended responses that create meaning for each of the research questions as the participant is engaged to share their personal stories of their lived experiences (Kvale, 1996). As such, this study consisted of four research questions, in which two to three interview questions were designed to address each of the research questions (See Table 2.0).

Table 2.0

Research Questions and Corresponding Interview Questions

Research Questions	Corresponding Interview Questions
RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?	IQ 1: What strategies and practices do you employ in leading your organization? IQ 2: What challenges do you face in implementing strategies and practices? IQ 3: How do you overcome resistance or opposition to strategies and practices?
RQ 2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?	IQ 4: What healthcare market trends impact your current day to day operations? IQ 5: As a young healthcare leader under the age of 40, what have been some challenges you have encountered in leading your organization?
RQ3: How do healthcare leaders under the age of 40 measure the success of the strategies and practices employed to lead their respective organizations?	IQ 6: How do you define and measure your success as a leader? IQ 7: What is your definition of a high performing healthcare organization? IQ 8: What methods do you employ to measure and track the organization's performance and success?

(continued)

Research Questions	Corresponding Interview Questions
RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?	IQ 9: What leadership style/traits has helped you promote into your leadership role? IQ 10: What advice would you give to aspiring young leaders entering into leadership positions?

Note. The table identifies four research questions and corresponding interview questions. Interview questions were reviewed by a panel of two peer-reviewer and expert reviewers.

Validity of the study. Creswell and Miller (2000) define validity in terms of justifying whether data and findings are accurate, trustworthy, and credible from the perspective of the researcher, the subject matter experts, and the readers. Richards and Morse (2013) share a general practice for designing validity in research designs, which entails demonstrating thoughtfulness in verifying the suitability of the questions, data collected, and methodology. When this rule is applied in establishing validity, there is better confirmation that data collected addresses the premise in each research question. Creswell (2014) states that qualitative validity is characterized by the confirmation of "accuracy of the findings by employing certain procedures" (p. 201). As such, a three-step process was employed to establish validity for the interview protocol: (a) prima-facie-validity and content validity, (b) peer-review validity, and (c) expert review.

Prima-facie and content validity. The initial step in confirming validity of the ten interview questions was to employ the technique of prima-facie validity, or face validity. Face validity implies that the interview protocol is measuring what it is intended to measure by demonstrating readability and clarity for the recipient (Polit & Beck, 2004). To confirm prima facie validity, a table was constructed that conveys the relationship between each research question and the corresponding interview questions, as displayed in Table 2.0. On the left hand

side of the table are the four research questions, and the right side displays the corresponding questions.

Content validity states that the interview protocol sufficiently "represents the entire content of the theme being measured," or in this qualitative design, the central research questions being studied (Youngson, Considine, & Currey, 2015, p. 6). Development of each interview question was informed by the extensive literature review regarding strategies and practices employed by healthcare leaders and organizations, their challenges in the healthcare marketplace, and the strategies for measuring success. Proper content validity was ensured as by being guided by existing literature (Youngson et al., 2015). The interview protocol was further subjected to content validity through peer review and an expert review process.

Peer-review validity. The second step in establishing validity for the interview protocol involved the process of engaging peers to test for validity. The two peer-reviewers were doctoral students partaking in qualitative dissertation research for the organizational leadership program at the Graduate School of Education and Psychology at Pepperdine University. Peer reviewers received emailed directions to conduct the peer review and a copy of table one containing the research questions and corresponding interview questions (see Appendix D). Upon reviewing each research question and corresponding interview questions, the peer reviewer was asked to ponder whether each interview question clearly demonstrated relevance to the research question in the following manner:

1. If the interview question was directly relevant to the research question, the peer reviewer was asked to mark "Keep as stated."

2. If the interview question was irrelevant to the research question, the peer reviewer was instructed to indicate "Delete it."

3.   If the interview question was in need of modification to best address the research question, the peer reviewer was asked to suggest modifications in the space provided.

4.   If the reviewer felt additional interview questions were necessary, the peer reviewer was able to recommend questions in the lines provided.

5.   Once the analysis was completed, the peer reviewer was instructed to return the completed form via email.

6.   When consensus was not met for particular interview questions, an expert panel was engaged to provide advisement on the impasse.

The results of the peer review process were as follows:

- Original IQ1, IQ2, IQ3, IQ6, IQ8, IQ10 passed the test for peer-review validity and were recommended to "keep as stated" by both peer reviewers.

- Original IQ 4 was marked with a suggested modification by one peer reviewer, while the other reviewer decided to "keep as stated". After additional discussion, IQ4 was modified to: "What environmental challenges, internally and externally, impact your day-to-day operations?"

- Original IQ7 was marked with suggested modifications by both peer reviewers to consider different phrasing of the question. After further discussion, the question was modified to "What constitutes a high performing, or successful healthcare organization?"

- Original IQ5 ("As a young healthcare leader under the age of 40, what have been some challenges you have encountered in leading your organization?") and Original IQ9 ("What leadership style/traits has helped you promote into your

leadership role?") required expert review as the peer-reviewers and researcher were unable to reach consensus.

- An additional question related to RQ4 was recommended to add to the interview protocol, which subsequently became IQ11: "If you could start over, what would you do differently?"

Expert review validity. To establish further validity of the interview protocol, individuals with content expertise in phenomenological research were asked to review the protocol. The dissertation chair and two committee members served as expert reviewers of validity of the qualitative instrument. When there was disagreement among the peer reviewers and researcher regarding specific interview questions, the dissertation chair stepped in to advise accordingly. In particular, there was a lack of consensus on the phrasing of IQ 5 and IQ 9. The dissertation chair provided feedback on whether the questions responded to the central research questions, and recommended modifications. A new table was constructed that demonstrated the changes that were made following peer and expert review (see Table 3.0).

Table 3.0.

Research Questions and Corresponding Interview Questions (Revised)

Research Questions	Corresponding Interview Questions
RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?	IQ 1: What strategies and practices do you employ in leading your organization? IQ 2: How do you overcome resistance or opposition to strategies and practices? IQ 3: What leadership characteristics have helped you promote into your leadership role?

<div align="right">(continued)</div>

Research Questions	Corresponding Interview Questions
RQ 2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?	IQ 4: What challenges do you face in implementing strategies and practices? IQ 5: What are the external environmental challenges that impact your day-to-day operations? IQ 6: What are the internal environmental challenges that impact your day-to-day operations? IQ 7: What are the obstacles of being a young leader in healthcare?
RQ3: How do healthcare leaders under the age of 40 measure the success of the strategies and practices employed to lead their respective organizations?	IQ 8: How do you define and measure your success as a leader? IQ 9: What constitutes a high performing, or successful healthcare organization? IQ 10: What methods do you employ to measure and track the organization's performance and success?
RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?	IQ 11: What advice would you give to aspiring young leaders entering into leadership positions? IQ 12: If you could start over, what would you do differently?

Note. The table identifies four research questions and corresponding interview questions with revisions based on feedback from peer-reviewers and an expert reviewer. Subsequent changes were made to the order and phrasing of questions within the interview protocol.

Reliability of the study. Qualitative reliability assumes that the qualitative research approach can be replicated consistently among different researchers (Gibbs, 2007). To confirm reliability of the interview protocol, the interview will be piloted with at least one participant who meets inclusion criteria for participation. The objective of the pilot session is to test for clarity of, wording, and understandability of the interview questions, which further strengthens content validity as well (Youngson et al., 2015). Moreover, pilot sessions help to determine

whether there are an adequate number of quality questions that can be asked within a time frame of 60 minutes. Timing was recorded to ensure the interview does not surpass 60 minutes. Answers were reviewed thoroughly to determine whether the questions and answers make sense and actually reflect responses to the central research questions. Changes to the interview protocol were made appropriately based on feedback from the participant.

Statement of Personal Bias

Creswell (2014) recommends that a statement of personal biases related to the research study be incorporated as a validity strategy. Illuminating one's biases serves as one approach for improving the capacity to evaluate the accuracy of discoveries and to provide substantiation to readers who can relate to the openness and honesty of the researcher during her self-reflection. In accordance with Creswell's (2014) postulation regarding bias, the following statement highlights personal bias: This research study was pursued as a result of personal experiences of being under 40 and holding leadership roles in different healthcare organizations for over five years. The researcher holds a Bachelors in Health Promotion and Disease Prevention and Master's degrees in Health Administration and Gerontology, which impacts her perspectives in how healthcare organizations should be operated. Witnessing colleagues within the same age category and in comparable or superior positions inspired the researcher to seek the opportunity to examine these individuals' journeys through their successes and best practices in their respective organizations. The personal challenges of younger leaders in the healthcare industry was of particular interest, including discrimination based on age.

Bracketing and Epoche. The risk of personal bias interfering with the research study can be mitigated through bracketing or Epoche. Biases in the form of previous knowledge, personal theories, or experiences needs to be set aside, or bracketed, throughout the entire research

process from research design, to data collection, and coding and analysis (Richards & Morse, 2013). Giorgi (1997) describes how bracketing provides the opportunity to explore the phenomenon with clarity and a fresh perspective with the intention of understanding and explaining it in the most accurate way possible. Bracketing is achieved through writing down any presuppositions in diary or memo format (Richards & Morse, 2013).

By the same token, Epoche represents an identical process for "stay[ing] away from" or "abstain[ing]" from any "prejudgments, biases, and preconceived ideas about things" (Moustakas, 2011, p. 2). To engage in Epoche requires the researcher to spend some uninterrupted time in a quiet location reflecting on current perceptions and feelings toward a certain experience, person, or issue connected to the phenomena under examination. From these moments of self-reflection that were written in a journal, the researcher can open herself to new perspectives and meet each encounter with authenticity, and no preconceptions (Moustakas, 2011). Moerer-Urdahl & Creswell (2004) express the potential difficulty for a researcher to achieve absolute bracketing and Epoche in order to draw his or her attention solely to the participants' experiences. According to Moustakas (2011), "the challenge of the Epoche is to be transparent to ourselves" (p.3). In practicing bracketing or Epoche, researchers are open about how they perceive things through documenting in diary or memo format their personal biases, and in the process have the ability to gain personal transparency.

Data Analysis

The selected analysis was an inductive, context-sensitive process, also known as "a posteriori" (Strauss & Corbin, 1998). The analysis process entailed working with transcribed interviews to generate codes and categories of themes for each of the questions asked of the young healthcare leaders. Creswell (2014) discusses two levels of qualitative data analysis: (a) a

general process to analyze data, and (b) analysis procedures rooted within the qualitative design. Research embedded within the phenomenological qualitative design employs the analysis of substantial statements shared by participants, the engendering of meaning, and the establishment of essence descriptions (Moustakas, 1994). Furthermore, in the phenomenological research design, the analysis process leads up to a composite textural description, which "captures the core, most-often-cited events and the ideas that have contributed to the participants' emergent path" (Conklin, 2007, p. 279). Essentially, the goal of data analysis in this research study was to capture the essence of young healthcare leaders' strategies, best practices, and challenges in leading high performing organizations.

Richards and Morse (2013) provide three techniques related to the coding paradigm of interpreting categories that are derived from the qualitative interviews. The three coding techniques include open coding, axial coding, and selective coding. Axial coding prompts the researcher to center their analysis focus on a specific idea (Kuckartz, 2012). Selective coding calls for concentrated analysis that emphasizes one category at a time. Open coding represents a less structured methodology that "open[s] up the data, identifying concepts that seem to fit the data" (Richards & Morse, 2013, p. 159). Open coding is the best methodology to utilize as it allows for multiple conceptual codes, and in-vivo codes, or phrases used directly by the participants, to be applied as codes. (Kuckartz, 2012). Creswell (2014) highlights several steps for analyzing data through the coding process.

1. **Preparing and organizing**: Following each interview, the researcher listened to the audio recording, manually transcribed each of the interviews, and became immersed in the data.

2. **Reading, memoing**. The qualitative data in the form of verbatim transcripts from the interviews was reviewed multiple times to fully grasp the overall meaning (Creswell, 2014). Reflections and memos in the margins of each transcript were captured, which became part of the database for analysis (Creswell, 2014). Memos were essential to keep track of new categories, recoding and relabeling of codes, (Richards & Morse, 2013), and serve as reminders of evolving theories throughout the analysis process (Burnard, 1991).

3. **Coding**. The researcher started the process of organizing, or "bracketing chunks" of the qualitative text (Creswell, 2014, p. 197), and noting words or phrases signifying a category in the margins (Rossman & Rallis, 2012). The process involved dividing sentences, or paragraphs into categories that were labeled with specific terminology that were either predetermined based on the literature review, or emerging based on the data collected from participants (Creswell, 2014). Often times, the term was in vivo, or actual verbiage spoken by the participant. The predetermined codes were saved in a list format in an electronic qualitative codebook.

4. **Describing**. The coding process was used to develop five to seven themes, as recommended in Creswell (2014). In phenomenology, the themes are shaped into descriptions that highlight "a detailed rendering of information about people, places, or events in a setting" (p.199). These themes become the basis of the major research findings, which will be featured in the findings section of the dissertation.

5. **Representing, visualizing**. The researcher brainstormed how the descriptions and themes would be represented and visualized in a qualitative narrative. Subthemes,

varying perspectives of participants, and specific quotations comprised the detailed

discussion of themes. The interconnection of themes was also represented.

6.   **Interpreting**. The last step in data analysis constitutes arriving at an

interpretation of the findings, and highlighting lessons learned (Lincoln & Guba,

1985). Lessons learned were derived from reflecting on how the researcher's

background, experiences, and role in the study contributes to personal interpretations.

Furthermore, the essence of interpretations was further derived from the literature and

theories captured in Chapter 2. A review of the way the data collected compared or

contrasted to the extant literature was conducted. Interpretation also entailed bringing

up new questions informed by the qualitative data

Interrater reliability and validity. In the analysis process, ensuring that the coding

process can pass external validity and inter-rater reliability tests was a critical step. External

validity is the ability for the research findings of this study to be applied to other research studies

(Merriam, 1998). Creswell (2014) cautions against external validity threats that occurs when

researchers "draw incorrect inferences from the sample data to other persons, other settings, and

past or future situations" (p. 176). To prevent threats to external validity, a four-step process was

employed to establish inter-rater reliability. First, the first three interviews were transcribed and

coded. Second, a peer review committee comprised of three doctoral level students with training

in qualitative research and coding reviewed the coding results of the first three interviews. Any

suggestions or disagreements regarding the coding was discussed. Third, a consensus was

reached on the coding approach. Fourth, the agreed upon coding scheme was utilized to code the

remaining 12 interview transcripts. The peer reviewers were available to review and share

feedback as appropriate. When there were instances in which an agreement could not be met, the dissertation committee stepped in to determine the direction of the coding.

Chapter 3 Summary

Chapter three highlighted a comprehensive description of the qualitative research design and methodology used to achieve the purpose of the study. To recap the purpose of the study, a re-statement of the research questions was provided followed by a discussion regarding qualitative research and the suitability of the phenomenological methodology for this study. A detailed description was provided of how participants were selected for the study, including describing the analysis unit, population, and sample size. A purposive sampling strategy was employed, which outlines how the master list was compiled, and how criteria for inclusion, exclusion and maximum variation was utilized to derive a list of 15 participants who were contacted and interviewed. There was discussion of how human subjects were protected through approval by the IRB, and a description of the informed consent form, which was reviewed and signed by the participant prior to the interview. Next, the process for collecting data and interviewing participants in a semi-structured manner was highlighted. The process of developing the interview protocol was described along with the 3-step process (Prima Facie, peer review, and expert review) for establishing validity. To ensure reliability of the interview protocol, a pilot interview with a participant who meets the criteria for inclusion was employed. A statement highlighting personal bias was presented along with the methodology of Epoche and bracketing, or setting aside one's preconceived notions about the central phenomenon. Finally, the process for conducting data analysis and coding was methodically described, also touching upon external validity and inter-rater reliability. The objective of chapter three was met through a

comprehensive and extensive examination of the research design, methodology, and techniques

for conducting valid and reliable qualitative research.

Chapter 4: Findings

As the number of millennials and young adults under the age of 40 become the growing majority employed in entry level positions, and promoted to either supervisory, management, or leadership roles, it is critical to understand their leadership profile, the workplace challenges they face, and their strategies for overcoming obstacles as young leaders. Specifically, in healthcare, the rapidly changing industry presents internal and external environmental challenges that must be handled in the most professional and proficient manner to be an effective leader. As such, the purpose of this study is to gather best strategies and practices that healthcare leaders under the age of 40 can adopt for their respective organizations. For this study, there were four research questions that were addressed. They are as follows:

RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?

RQ2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?

RQ3: How do healthcare leaders under the age of 40 measure their success and the performance of their respective organizations?

RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?

In order to respond to these four research questions, 12 interview questions were developed and subsequently shared with a panel of two interraters and three experts to confirm reliability and validity of the questions. Once finalized, these questions were used to interview the 15 healthcare leaders who participated in the study. The interview questions are as follows:

1. What strategies and practices do you employ in leading your organization?

2. How do you overcome resistance or opposition to strategies and practices?

3. What leadership characteristics have helped you promote into your leadership role?

4. What challenges do you face in implementing strategies and practices?

5. What are the external environmental challenges that impact your day-to-day operations?

6. What are the internal environmental challenges that impact your day-to-day operations?

7. What are the obstacles of being a young leader in healthcare?

8. How do you define and measure your success as a leader?

9. What constitutes a high-performing, or successful healthcare organization?

10. What methods do you employ to measure and track the organization's performance and success?

11. What advice would you give to aspiring young leaders entering into leadership positions?

12. If you could start over, what would you do differently?

The leaders who participated in this study were enthusiastic, open-minded, and candid in their responses regarding their personal careers and experiences in healthcare. Information gathered from these interviews will serve as a valuable resource for aspiring young leaders. This chapter reports on the findings of the study, as well as an overview of the participant profiles and data collection process. Furthermore, the data analysis process and themes that emerged from the 15 semi-structured interviews are presented.

Participants

Purposive sampling was the methodology used to narrow down potential participants. Through the purposive sampling technique, potential participants were engaged based on their characteristics, knowledge, time availability, inclination to participate, and involvement in healthcare leadership. As such, the Becker's list of *Rising Starts: 25 Healthcare Leaders Under*

Age 40 and *Modern Healthcare's* annual "Up & Comers Award" from 2012 to 2016 served as the sources to develop the master list, and subsequently, the sampling frame. Based on the inclusion and exclusion criteria outlined in Chapter 3, the master list of 211 individuals was narrowed down to 26 individuals who were initially contacted via LinkedIn. Due to inadequate response rate, an additional 14 individuals from the sampling frame were contacted with an invitation to participate in the study.

Fifteen total participants were interviewed for this study. Of these 15 participants, four identified as female (27%) and 11 identified as male (73% Figure 2). The 15 healthcare leaders hold varying positions within their respective organizations, which include the following titles (see Figure 3): chief executive officer (33%); chief operating officer (20%); chief administrative officer (13.3%); chief strategy officer (6.7%); chief medical officer (6.7%); senior vice president (6.7%); and vice president (6.7%). The 15 participants represent various types of healthcare organizations, including small healthcare systems (20%), large healthcare systems (33%), academic institutions (20%), and rural organizations (27% Figure 4). The organizations varied in their tax classification statuses with 10 classified as nonprofit (67%); three classified as not-for-profit (20%); two identifying as for profit (13% Figure 5). Confidentiality was promised to all participants during recruitment, and again verbally before the interviews started.
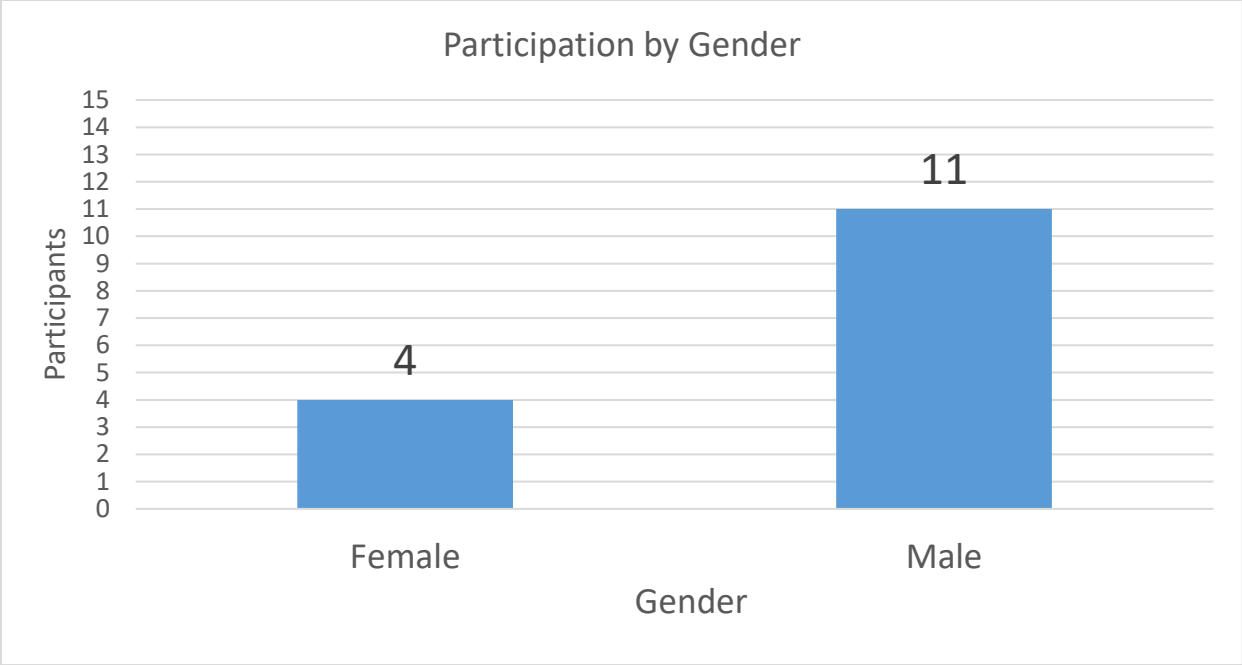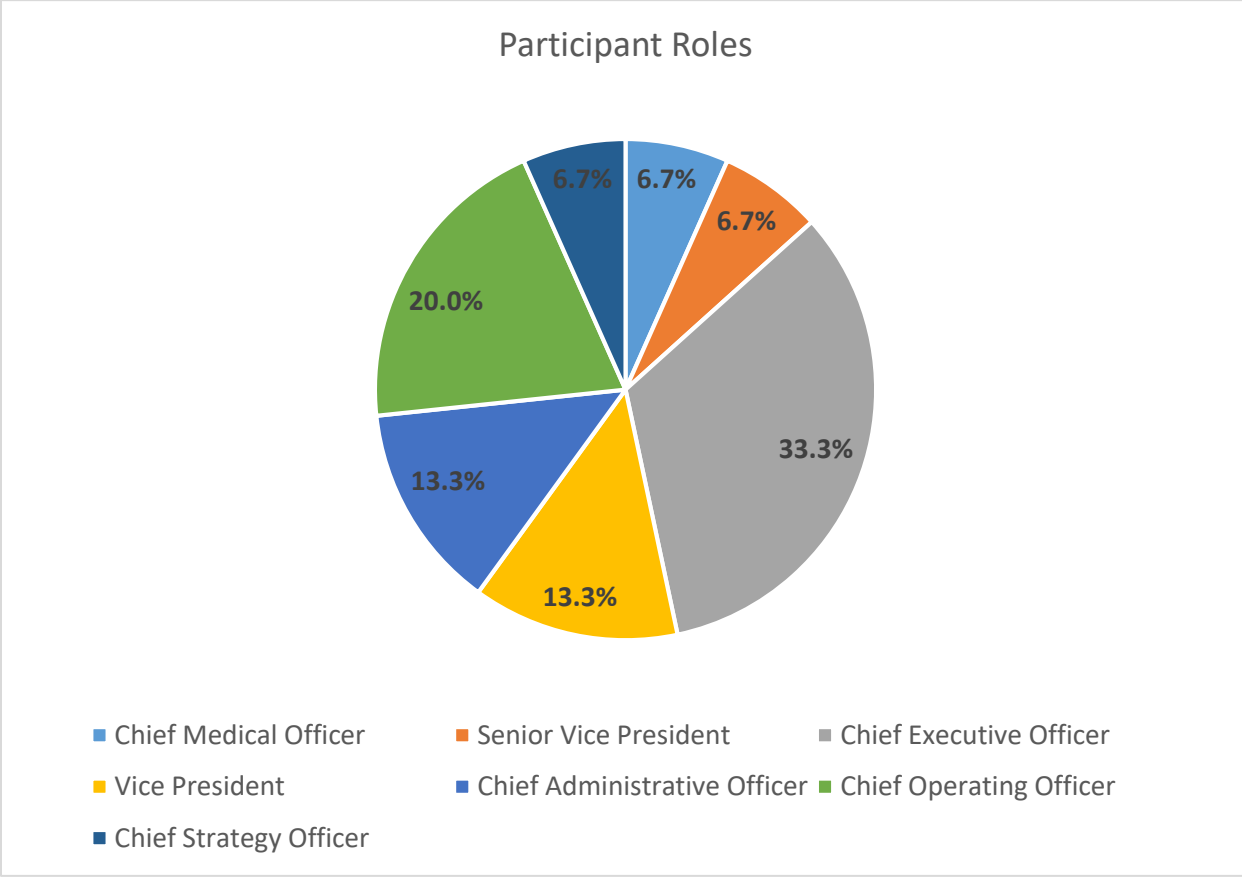
Figure 2. Participation by gender

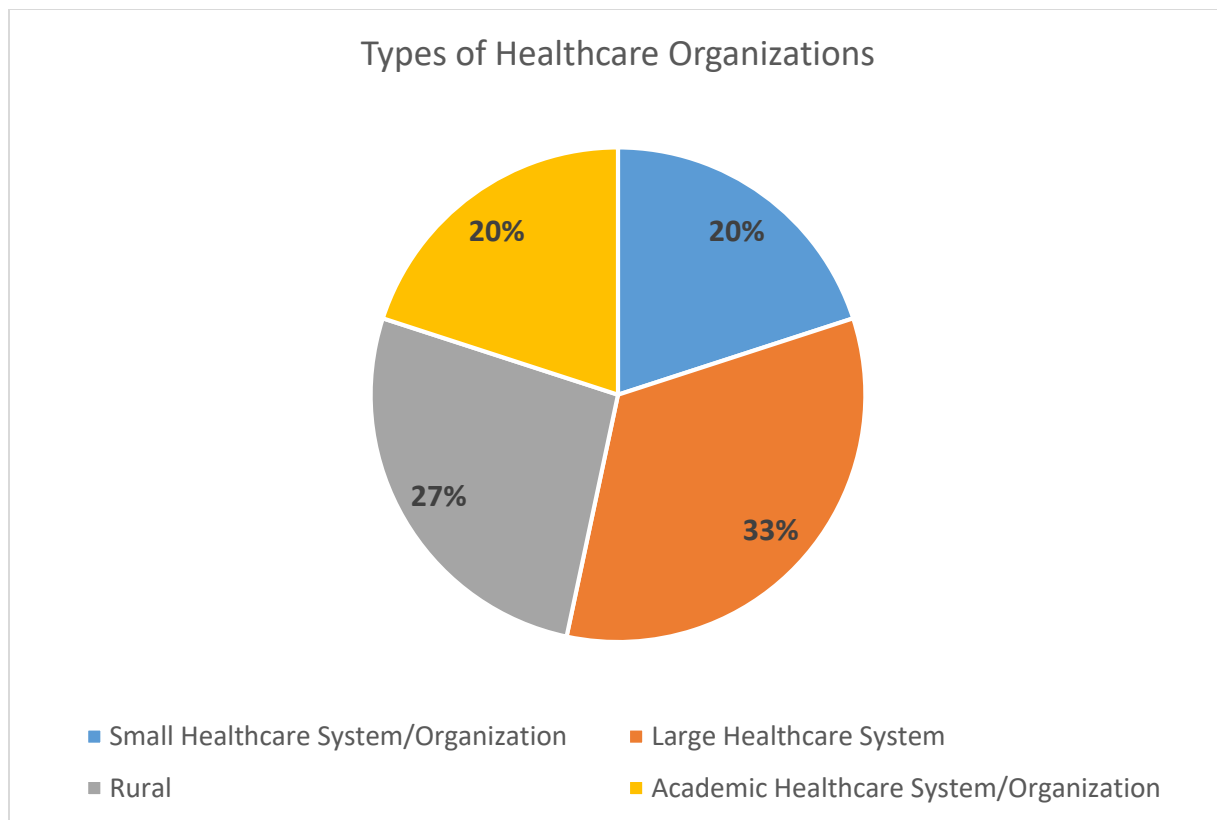*Figure 3.* Participant roles in their respective organizations
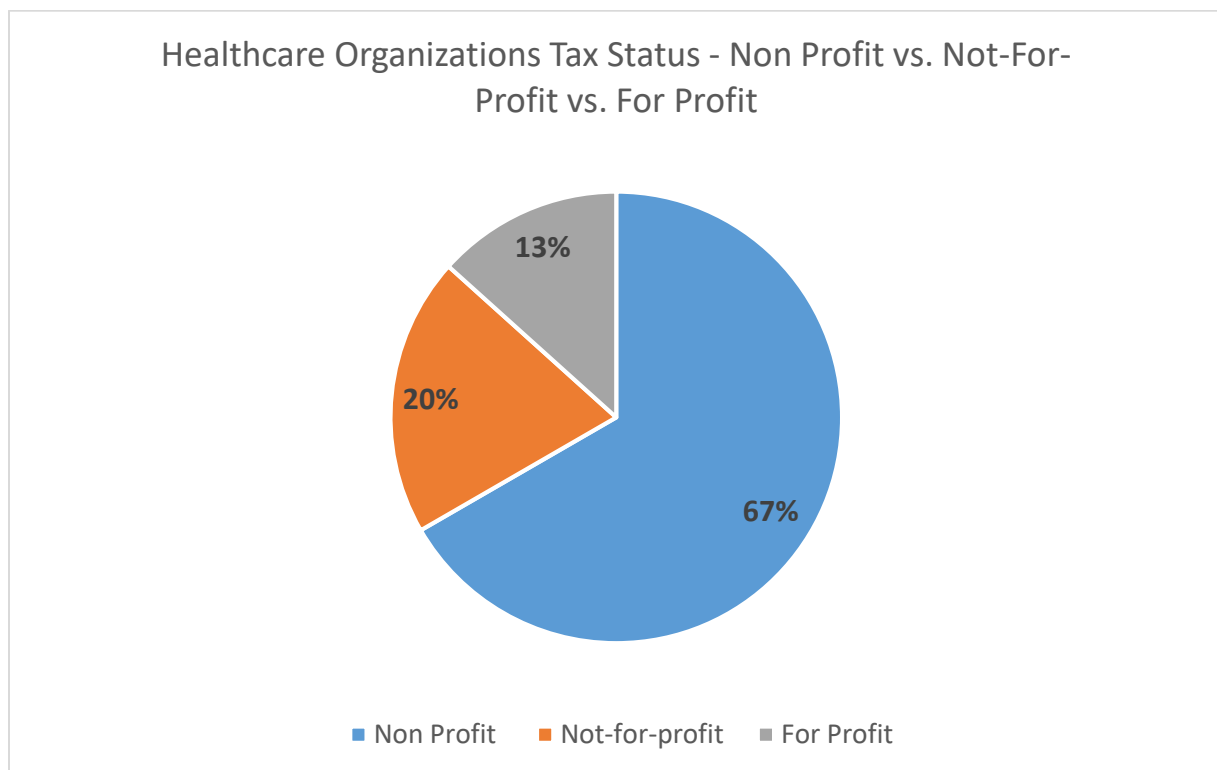
Figure 4. Types of healthcare organizations

Figure 5. Healthcare organizations tax status - nonprofit vs. not-for-profit vs. for profit

Data Collection

Data was collected from 15 healthcare leaders under the age of 40. IRB approval from Pepperdine University was granted in late December 2016. Due to the holidays, the researcher decided to wait until the beginning of January to begin recruiting participants. Data collection commenced on January 4, 2017, and concluded on March 3, 2017. This data collection period represents the first date of recruitment, in which the narrowed down list of 26 potential participants were contacted via LinkedIn, through the last interview conducted on March 3, 2017. The data collection time period was originally anticipated to span the month of January and February, but carried forward into March due to the insufficient number of recruited participants in January, scheduling conflicts, and one participant withdrawing from the study due to family obligations. Fourteen additional individuals from the original master list, who fit the inclusion eligibility criteria were contacted via LinkedIn through the Connect feature, and were also sent and InMail message inviting the healthcare leader to participate in the study, along with a brief description of the format and purpose of the study. Additionally, each potential participant was told how they were recruited based on their appearance in either Becker's Hospital Review "Rising Stars Under 40" and Modern Healthcare's "Up and Comers" publication. If e-mail addresses were available in the healthcare leader's LinkedIn profile, or on their respective healthcare organization's websites, then they were also sent electronic mail inviting them to participate along with a brief description of the format and basis of the study.

Once each participant accepted, either via LinkedIn or email, a formal email or message was crafted thanking them for their interest, and inquiring whether the participant agreed to be audio recorded, or to utilize Skype if the participant was not local to the researcher. The

informed consent document and interview questions were also attached to provide additional

background to the research study. If the participant had not responded back with their

availability, contact information, or assistant's contact information, this information was also

requested to coordinate the time, date, and location of the study. On the day of the interview, the

researcher reviewed the informed consent and received a second consent verbally to audio record

the interview. It was stressed that confidentiality would be protected via the use of pseudonyms

for both the participant's name and organization. All informed consents were received and

counter signed by the researcher, and copies were either emailed or provided to participants in

person following the interview. The Voice Memos application on the Apple iPhone, and as a

back-up, the Voice Recorder feature on a personal laptop was used to record the responses.

All interviews were conducted between the business hours of 8:00 a.m. and 5:00 p.m.

Two interviews had to be rescheduled to different dates and times due to the participants'

scheduling conflicts. Two other interview times needed to be rescheduled – one due to the

participant's schedule, and one due to the researcher's schedule. Table 4 demonstrates the

interview dates by participant, interview method used (i.e. In person, Skype, phone, or other

video conference methodology), and length of recorded interview. Recording time began when

the participant verbally consented to be recorded, and ended after the response for interview

question 12 was provided. An ice breaker question was asked prior to interview question 1. The

ice breaker question consisted of requesting the participant to walk the researcher through their

career journey from their first management role to their current executive position. The shortest

interview took 27 minutes and the longest interview took 51 minutes. The researcher took notes

during the interview to record any themes heard initially. Following the interviews, the

researcher transcribed each audio recording spending on average one and a half hours to two and

a half hours transcribing each interview to ensure there was accuracy in the transcriptions. The next step was to code and analyze the transcribed interviews.

Table 4

Participant Interview Dates, Interview Method, Length of Recorded Interview

Participant	Interview Date	Interview Method	Length of Recorded Interview (minutes:seconds)
P1	January 23, 2017	In Person	39:55
P2	January 30, 2017	In Person	51:13
P3	February 1, 2017	Skype	49:28
P4	February 1, 2017	Skype	27:17
P5	February 10, 2017	Skype	38:32
P6	February 10, 2017	Phone	49:46
P7	February 13, 2017	In Person	45:43
P8	February 13, 2017	Phone	42:53
P9	February 14, 2017	Phone	42:51
P10	February 16, 2017	Skype	34:19
P11	February 17, 2017	In Person	46:45
P12	February 21, 2017	Phone	40:42
P13	February 22, 2017	Video Conference	38:31
P14	March 2 , 2017	Phone	46:00
P15	March 3, 2017	Phone	47:20

There were minimal surprises during the interview process. There were two main deviations from the originally defined plan. The first deviation was the use of Skype and phone as the primary modes for interviewing participants. Initially, more in person interviews were expected to occur. Due to the unpredictable weather conditions where the researcher and some participants were located, it was not feasible or effective to travel to the various healthcare organizations in different states. Furthermore, one participant commented on the fact that his schedule could have unpredictable conflicts at any moment's notice. Therefore, he preferred I did not spend time and financial resources to travel to his hospital. Additionally, some participants did not have access to Skype, or preferred not to be on camera. Accordingly, phone

was the primary method for communication with the participant. Finally, P13 preferred we use the participant's organization's video conferencing tool as Skype was unavailable. The video conferencing software was downloaded and tested it with information technology (IT) prior to the interview date.

The second deviation from the originally defined plan as outlined in Chapter 3 was for the informed consent to be reviewed and emailed back in PDF form prior to the scheduled interview. Four out of the fifteen participants (27%) returned the informed consent prior to the interview. The eleven participants who did not sign off on the informed consent prior to the scheduled interview provided verbal consent and returned the signed consent form after the interview.

Data Analysis

The goal of data analysis in this research study was to capture the essence of young healthcare leaders' strategies, best practices, and challenges in leading high performing organizations. In the phenomenological research design, it is customary to capture the participant's journey through the significant events experienced, lessons learned, and knowledge gained in their emerging path. The analysis process first began with listening to the audio recording, manually transcribing each interview, and becoming fully immersed in the data obtained during data collection. To organize the generated codes or categories of themes for each of the interview questions, a coding spreadsheet was developed with twelve separate tabs for each interview question. Participants responses to each question were subsequently coded in the appropriate tab. Real-time written notes while the participants responded to interview questions, and the initial codes captured in the written notes were entered in the coding matrix. Open coding was the methodology utilized, which involved multiple conceptual codes, and in-vivo

codes, or quotations used directly by the participants to respond to each interview question, to be applied as codes (Kuckartz, 2012). Next, the researcher read the transcripts three times, highlighted quotes and apparent themes in each transcript, and engaged in bracketing large amounts of qualitative text by making thematic notes in the margins. Then, the researcher clarified and edited any of the codes captured from the written notes, or added additional codes that may have been missed initially for each interview question.

While Creswell (2014) suggested developing five to seven themes, there were instances in which fewer themes emerged for each interview question, or in some cases more than seven themes emerged. To arrive at themes, common ideas, phrases, or terms were grouped together by a color scheme on the Microsoft Excel table. The grouped ideas were then classified in a bucket, also known as thematic umbrellas to encapsulate the essence of the grouped codes. Specific phrases or terms spoken by the participants became thematic umbrellas in some cases. Individual codes were placed under each thematic umbrella based on the interconnection as a subtheme of the main umbrella term, or bucket. Themes were deemed substantial and significant if at least three or more interview participants relayed the theme in their responses.

To prevent threats to external validity, a four-step process was employed to establish interrater reliability. After the researcher transcribed and coded the first three interviews, two doctoral level students trained in qualitative research and coding reviewed the coding results of the first three interviews. Any suggestions on naming conventions for each of the themes or placement of subthemes or coded elements under the respective themes were discussed. For many of items that could not be placed under a thematic umbrella term, the inter-raters provided suggestions as to where the items should be placed. Third, a consensus was reached on the coding approach. Fourth, the agreed-upon coding scheme was utilized to code the remaining 12

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interview transcripts. The peer reviewers were available to review and share feedback as appropriate. When there were instances in which an agreement could not be met, the dissertation committee was available to determine the direction of the coding.
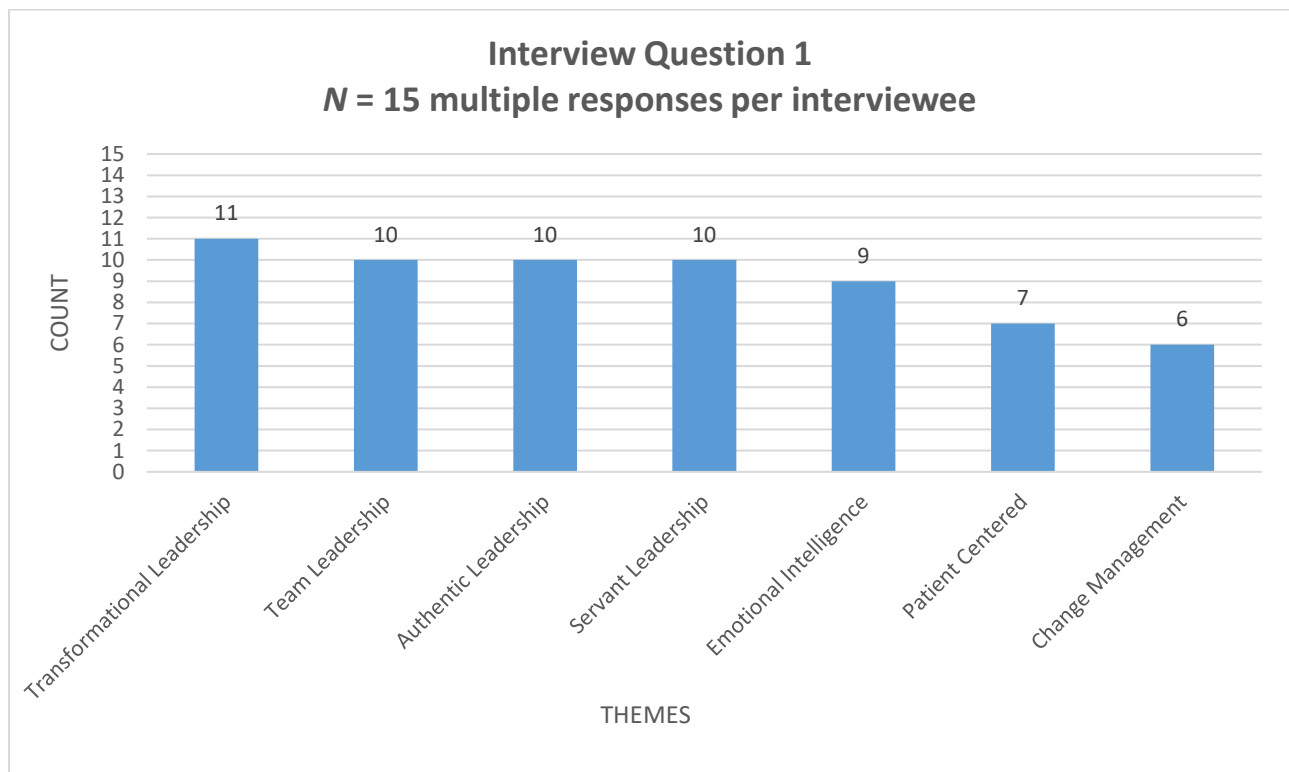
Data Display

The structure of the four research questions and the corresponding interview questions helped to organize the data and findings that are displayed in the subsequent sections. The various themes that emerged for each interview questions were listed and substantiated through verbatim statements, phrases, or excerpts from the transcribed data. To ensure confidentiality of each participant's identity, the data is displayed utilizing a pseudonym represented by the letter "P" and the corresponding participant number (e.g. Participant 1 [P1], Participant 2 [P2], etc.). A bar graph accompanies each interview question demonstrating the number of participants who responded to a question with the specific themes. Themes were considered substantial if at least three or more participants communicated the theme in their responses. Although the interview questions evoked commonalities among the various themes, the data collected for one question does not overlap with any other interview question responses. A summation of the themes for the interview questions and research questions is discussed.

Research question 1. Research question 1 asked, "What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?" This question was addressed through the collective and thoughtful participant responses to the following three interview questions:

- IQ 1: What strategies and practices do you employ in leading your organization?

- IQ 2: How do you overcome resistance or opposition to strategies and practices?

- IQ 3: What leadership characteristics have helped you promote into your leadership role?

Interview question 1. What strategies and practices do you employ in leading your organization? Based on the responses of the participants, "strategies and practices" was interpreted as necessary leadership behaviors for leading a healthcare organization. Common themes that were identified by the participants include: transformational leadership, team leadership, authentic leadership, servant leadership, emotional intelligence, patient centered, and change management (See Figure 5).

Interview Question 1
***N* = 15 multiple responses per interviewee**

COUNT

Theme	Count
Transformational Leadership	11
Team Leadership	10
Authentic Leadership	10
Servant Leadership	10
Emotional Intelligence	9
Patient Centered	7
Change Management	6

THEMES

Figure 6. IQ 1: Strategies and practices in leading organization

Transformational leadership. 11 out of 15 participants (73.3%) articulated leadership behaviors that are evident in one or more of the four components of transformational leadership. Idealized leadership was exemplified in P1's statement: "Continuing to talk about a vision, continuing to espouse greatness in the organization through a relentless focus on quality, patient safety, but also kind of living that through modeling behavior" (P1, personal communication, January 23, 2017).

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Inspirational motivation is characterized by communicating clear expectations and building enthusiasm for the goals and shared vision of the organization. P2, P3, P9, P11, and P14 spoke explicitly about the importance of communicating at all levels and setting clear goals. P2 asserted the value in, "articulating that clear vision and why it's needed not for me or the CEO, but for their patients and families and keeping that as a true north" (P2, personal communication, January 30, 2017).

The third component of transformational leadership, intellectual stimulation, is demonstrated by several participant responses. P13 speaks about giving people the autonomy to make decisions about how to accomplish goals. P10 leads through facilitation exercises to assist teams in solving problems. P10 reported, "I am hands off in terms of how decisions are made because I want the team to be ultimately accountable for their decisions" (P10, personal communication, February 16, 2017).

Lastly, individuated consideration, the fourth component of transformational leadership, was represented in participant responses that spoke about coaching and mentoring. P15 stated, "My role is coaching leaders to set goals and working with staff to achieve goals" (P15, personal communication, March 3, 2017). P11 believes that "the role of any leader in any organization, not just the healthcare organization, is to enable those you work with to succeed. When you start from that foundation, you are looking to give assistance and resources to people within reasonable limits" (P11, personal communication, February 17, 2017).

Team leadership. 10 out of 15 participants (66.7%) believed in the concept of emphasizing teamwork. P8 described "leading through collaboration" (P8, personal communication, February 13, 2017). P6 further expands by asserting, "I think that you can have the best strategy but if you don't have a good culture of a team that has bought in to the whole

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strategy and mission of the hospital, then you won't succeed as an organization" (P6, personal communication, February 10, 2017). The culture begins with "promoting a team that cares about each other and there is a lot of trust, openness, and honesty" (P14, personal communication, March 2, 2017).

Authentic. Knowing one's purpose, practicing one's core values, and exhibiting self-discipline are the cornerstones of an authentic leader. Ten out of 15 participants (66.7%) shared these leadership practices that embody authenticity. An emphasis on leading an organization based on core values was shared by P7, P8, and P13. Specific values such as integrity (P1, P11, P13), honesty, trust, transparency, work ethic, and consistency emerged as significant tenets by which one should lead an organization. P1 noted:

> I find that a lot of what I have to do has to do with relationship building and so understanding that just the very basics of good solid communication skills, building relationships, staying true to your word, demonstrating integrity, and following up on people's concerns. (P1, personal communication, January 23, 2017)

Servant leadership. Ten out of 15 participants (66.7%) expressed servant leadership tendencies as their strategies and practices for leading their respective organizations. Four participants (P3, P4, P6, P13) explicitly used the term *servant leadership* to describe their practices. Four participants (P2, P3, P6, and P10) also emphasized a focus on the frontline, whether it be listening to them or being visible to them. P3 and P13 both conveyed a willingness to "roll up sleeves" (P13, personal communication, February 22, 2017) and "do the work that they do" (P3, personal communication, February 1, 2017). Three participants (P3, P6, and P13) articulated the common practice of leading by example. Essentially, there is a genuine regard for

employees and disposition towards serving them in the organization. P14 summed up servant leadership in the following excerpt:

> I never would say you work for me… We work together and I tell everyone I work for them. It is genuine. They are the content experts in their areas. That's why they are in their roles. They need to figure out how to use me in my executive role to get done the things that they need to get to done or to benefit our patients. It's really getting rid of organizational chart in your mind and turn upside down and say you need to figure out how I can help you. And that's really my job of supporting those folks. When you do that, it promotes a team that cares about each other, there's a lot of trust there, openness, honesty, it all really fits nicely together and creates a nice environment for folks. (P14, personal communication, March 2, 2017)

Emotional intelligence. Emotional intelligence characteristics were highlighted by nine out of 15 participants (60%). A strategy used by P10 is related to inquiry and probing for understanding the root causes behind a team's problems. Similarly, P11 spoke about finding out the reasons why someone was not happy in the organization. P9 stated, "We went through a process the first 90 days and completed a cultural assessment. We wanted to know what they were most proud of" (P9, personal communication, February 14, 2017). These three examples stress self-awareness of the emotions and drives of others and empathy. In reference to self-regulation, P1 spoke about knowing how to manage one's authority, model behavior, and resolve conflicts, while P5 mentioned the art of negotiation. P1, P2, P3, P4, P9, and P11 all reported in the significance of relationship building and caring for people's concerns, which all supports the notions of empathy and social skills.

Patient centered. According to 46.7% of the participants (7 of 15 participants), patient wellbeing should drive the strategy and practices of any healthcare organization. At P8's organization, the strategy is "around measuring outcomes that matter to patients, not necessarily the outcomes that matter to us, we do that for safety and quality reasons…We really see a moral, ethical responsibility to care for people and caring for them well" (P8, personal communication, February 13, 2017). Similarly, P13 believes in "patients first – everything that we do is putting the patients at the center" (P13, personal communication, February 22, 2017). Overall, almost half of the participants shared how their strategic focus is centered on patient safety, quality and satisfaction.

Change management. Six out of 15 participants (40.0%) articulated the use of change management frameworks and steps as strategies and practices for leading their respective organizations. At P12's organization, there is a lean management system focused on healthcare in which "any of [their] new leaders have to go through a lean management certification process. Lean is applied in all areas across the board in the facility" (P12, personal communication, February 21, 2017). In P8's organization, their strategy centers around "improving and fostering a culture of leadership and excellence" which entails leading through process improvement (P8, personal communication, February 13, 2017).

In Kotter's steps for managing change, establishing a sense of urgency is the first step. P10 describes a practice of "of probing for understanding and getting to the root cause of an organization's, department, or team's problem" (P10, personal communication, February 16, 2017). The next key step to fostering a successful change effort is forming a guiding coalition. As such, P5 acknowledges creating a steering committee of leaders to map out current state and future state workflows, while P7 reported the significance of "getting the right people engaged"

in the change effort (P7, personal communication, February 13, 2017). Once the change is implemented, short term wins need to be acknowledged, therefore metrics for monitoring success need to be set up and followed up on per P5.

Interview question 1 summary. Four different, yet interconnected leadership styles are shown in response to the question, "What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?" These leadership styles include transformational leadership, team leadership, authentic leadership, and servant leadership. The four leadership styles were almost evenly spread in terms of the frequency in which the leaders mentioned different attributes of each style. Team leadership, authentic leadership, and servant leadership were each mentioned by 66.7% of the participants, while transformational leadership was mentioned by the majority, at 73.3%. Emotional intelligence was the fifth theme that emerged. The behaviors within the four leadership styles include one or more aspects of emotional intelligence, whether it be self-awareness, self-regulation, motivation, empathy, or social skills. Other themes included implementing patient centered strategies, and utilizing change management processes within the healthcare organizations.

Interview question 2. How do you overcome resistance or opposition to strategies and practices? As leaders try to implement their strategies or new practices within their respective organizations, they most often are confronted by workforce resistance. As such, leaders must be ready to respond to employee and physician concerns. The themes that were identified by the participants include: educate people on reason for change, engage people in the process, listen and empathize, build a guiding coalition (See Figure 6).
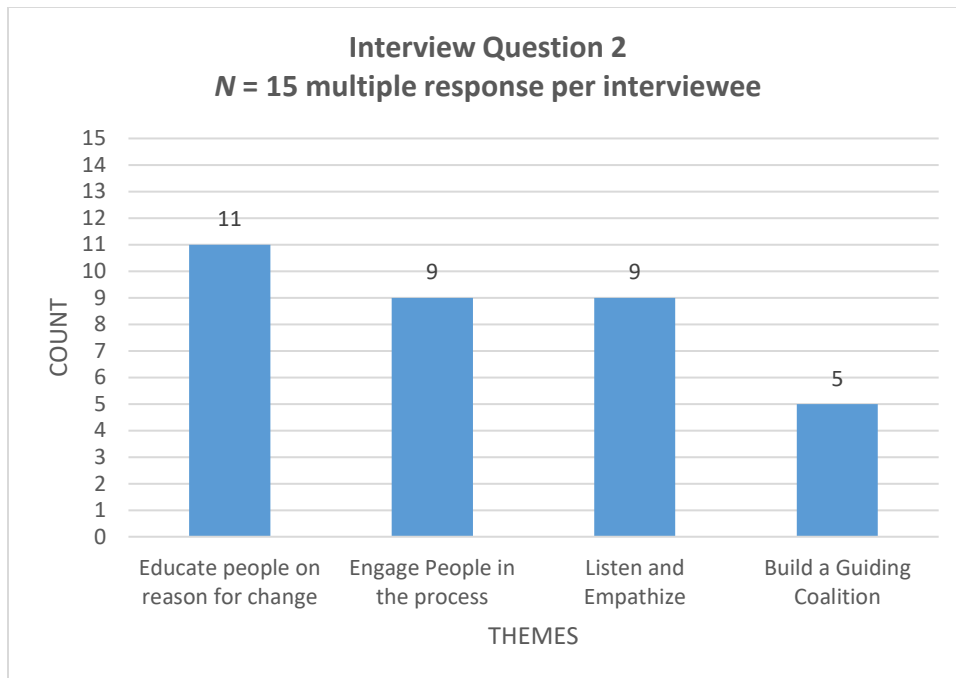
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Figure 7. IQ 2: Overcoming resistance or opposition

Educate people on reason for change. When individuals resist the idea of change, it is critical to provide them with the data to support the new strategy or practice. Seventy-three percent of the participants believed in explaining the reason for the change in order to help people overcome resistance and opposition to the change. P4 and P10 shared the importance of bringing clarity and transparency behind the reasons for the change. From P3's experience, data speaks to physicians. According to P2, it is beneficial to share evidence-based practices. As healthcare is a service oriented industry serving a vulnerable population, it is helpful to illustrate the strategy in question as a tactic for improving patient care (P1, P8, P14). P8 reminds the workforce, "that anytime a person was harmed due to processes that were poor and needed to be improved, or even good processes that could be better, we've committed a moral failure because somebody is on the other end of that broken system" (P8, personal communication, February 13, 2017).

Engage people in the process. Nine of the 15 participants (60.0%) shared the philosophy that it is better to include people in the process of change early on. P14 reflected, "engaging them at the beginning of the conversation and talking about 'here's what we are thinking about' and at least getting an initial temperature check— that alone is worth its weight in gold" (P14, personal communication, March 2, 2017). Through pre-meeting conversations and stakeholder analysis sessions, P5 and P14 commented on ensuring the stakeholders' perspectives are accounted for. P6 remarked on the importance of engaging the frontline team in determining how to make the strategy better defined and applicable to them. Ultimately, the key is to "make employees part of change and the solution" (P2, personal communication, January 30, 2017) and to give them an opportunity to provide feedback and input.

Listen and empathize. Going through the motions of engaging people in the process is one key aspect to overcoming resistance, but taking the time to listen and understand people's viewpoints requires empathy. Nine of the 15 participants (60.0%) emphasized the importance of active listening and increasing awareness and understanding of people's concerns. P4, P6, P13, and P15 stressed the value of leading by listening. P10 suggests that one "re-categorize what are the missing pieces that are either causing people to feel they need to actively resist" (P10, personal communication, February 16, 2017). P1 recommends "inhabit[ing] the shoes of those that may be opposed" and "embracing their viewpoints" (P1, personal communication, January 23, 2017). In order to empathize, one must "step back and think through concerns" of the employees (P3, personal communication, February 1, 2017).

Build a guiding coalition. Per Kotter's steps in managing change, forming a powerful guiding coalition can help mobilize people through the difficult change. Thirty-three percent of participants believed in the importance of building key relationships to help promote the change.

P5 and P14 referenced having physicians as members of the guiding coalition. P5 stated that there should be an advisory group comprised of physicians who can have peer-to-peer conversations with those who resist. In the same light, physicians could serve as partners or champions in helping to implement the new strategy (P14, personal communication, March 2, 2017). P5 also mentioned engaging higher leaders of authority such as the CEO or COO to encourage the change effort. According to P13, building a guiding coalition starts at the point of hire. P13 asserts:

> When I am hiring new leaders, or coaching new leaders, it's making sure that I have people that are aligned with the core values. Not just our core values, but where we want to go. So, starting with a base of feeling like you have the right people on the bus is not to be underestimated. Doing the leg work upfront and really understanding how a decision we make or a strategy we are going to employ, that we understand how that is going to affect individuals. (P13, personal communication, February 22, 2017)

Interview question 2 summary. The healthcare leaders shared their tactics for overcoming resistance and opposition to change strategies. People want to know the "why" behind a change effort and how it will impact them, their patients, or the organization as a whole. Therefore, informing and educating people with data and evidence regarding the strategy can help employees feel more comfortable with the idea of change. Before the change effort commences, it is essential to include people in the process, which leads into the third theme of listening to and empathizing with the individuals who have apprehensions about the change. While mentioned by only 33% of participants, building a guiding coalition of individuals who see value in the change effort, and can motivate others to buy in, can help transform the resistance into acceptance and willingness to adopt.

Interview question 3. What leadership characteristics have helped you promote into your leadership role? As the participants have rapidly progressed in their careers into executive roles, it is noteworthy to report another common thread among the 15 healthcare leaders. Five common characteristics were identified by the participants as pertinent leadership characteristics: servant leadership, tenacious work ethic, authentic, ego-less, and democratic (See Figure 7)

Interview Question 3
N = 15 multiple responses per interviewee
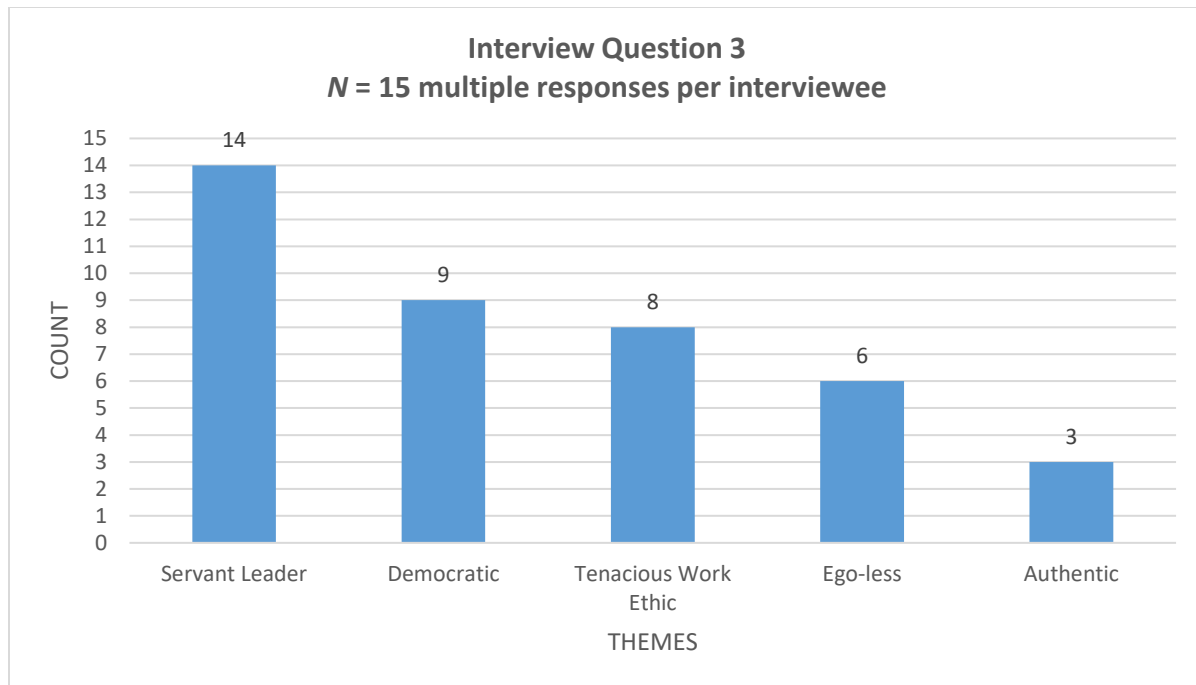
Figure 8. IQ 3: Leadership characteristics

Servant leadership. The majority of the participants (93.3%) conveyed characteristics that spoke to the profile of a servant leader. Six of the 12 participants explicitly stated that the servant leadership style helped them promote into their leadership position (P3, P5, P6, P9, P12, P13). P9 and P12 emphasized leading by example, which speaks to a commitment to the development and growth of people, which is another hallmark of servant leadership. P10 responded, "I'm willing to roll up my sleeves. I'm not afraid to do the work. I'm not afraid to shadow or talk to the frontline to understand what their perspective is" (P10, personal communication, February 10, 2017). Servant leaders go beyond their self-interest and allow the needs of the followers to

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supersede all other priorities. P5 and P12 joined P10 in expressing their willingness to "roll up sleeves" to be present among staff. P5 stated the desire to "protect people from burnout" as a reason for stepping in to help (P5, personal communication, February 10, 2017). Other characteristics under servant leadership that emerged include empathy (P1, P8), compassion (P2, P8), encouragement (P9), supportive (P15), and an open door policy (P14). These all spoke to the rich interaction and trust between the people and their servant leader.

Democratic. Nine out of 15 participants (60.0%) conveyed characteristics that represent the democratic leadership style, which includes hallmark traits such as collaboration, team leadership, and communication. The democratic leader stimulates consensus through inclusion. P1 summed up the democratic leadership style impeccably:

> I think being a good communicator helps. Speaking in clear, concise sentences, having your ideas pre-formed, and speaking to a vision. I think all of that really helps, but perhaps more important to that as I inhabited this role for a few years now is the ability to put a pause on my communication and just listen. So the art of shutting up is really key and I think once you do that you can synthesize their arguments, their concerns, and you apply empathy to that and you come to a collaborative stance, which is more powerful than the didactic stance of this is what we are doing and this is the why, and not willing to be flexible in those stances. (P1, personal communication, January 23, 2017)

P7, P13, P14, and P15 also spoke to the gift of communicating with any audience. Several leaders referenced team leadership characteristics of reinforcing team accountability (P5), and working well with others (P4). P9 asserted, "we can build a relationship around us as a team to care about the work that we do... I try to be encouraging, team first — it's always *we* never me" (P9, personal communication, February 14, 2017).

Tenacious work ethic. More than half of the participants (53.3%) articulated characteristics that demonstrate persistence, tenacity, and profound passion for the organization and its mission. In its simplest terms, *tenacious work ethic* speaks to working hard and maintaining focus, which are two coded elements shared by P7. Furthermore, it illustrates "not giving up when faced with opposition" (P6, personal communication, February 10, 2017). P2 shared a profound passion for work: "I care deeply about the work we do and the people that are providing that care, being heroes every day taking care of our patients and I want to make it better. I want to make it better for our patients and easier for our caregivers" (P2, personal communication, January 30, 2017).

Two participants acknowledged their strength is competition, which manifests as a deep-rooted desire for the organization to be excellent. P9 and P11 shared the following statements:

- I try to be competitive — Can't settle for mediocrity. Can't settle for just being as good as the next organization. It's really what we have the ability to do together that can allow us to come as a category of one (P9, personal communication, February 14, 2017).

- My top strength is competition… I've been successful because I reframed what the competition was. I have reframed that to a competition of, I want my organization to be the best (P11, personal communication, February 17, 2017).

P8 sums up exhibiting tenacious work ethic in the following description of a leadership characteristic that helped the individual promote into the executive role that they currently hold: "strong work ethic driven by mission of mercy to relieve the suffering of others" (personal communication, February 13, 2017). In healthcare, compassion for others ultimately fuels the desire to work tenaciously, persistently, competitively, and arduously.

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Ego-less. Six out of 15 participants (40.0%) represented qualities of a leader void of any ego. There is overlap with servant leader qualities, such as humility and willingness to step in to help the frontline staff. P5 and P12 state that there is no job or task that is "too small" to take on, even at the executive level. P10 acknowledges that humility is key and that "you don't know everything, that you are willing to ask for help. You are not afraid to admit when you are wrong" (P10, personal communication, February 16, 2017). P5 substantiates further by asserting, "be transparent; you don't always know the answer" (P5, personal communication, February 10, 2017). If you don't have all the answers, follow P11's advice and have smarter people who are good at your weaknesses surround you. An ego-less leader openly admits their weaknesses and vulnerabilities despite potential loss of status that may ensue. P8 advises to be teachable. P9 sums up the crux of an ego-less leader in this statement: "I try to incorporate into my leadership style being an ego-less leader. I have seen many instances in which leaders become anchored and deeply committed to their own agenda that it becomes more about them than it does the outcome" (P9, personal communication, February 14, 2017).

Authentic. Three out of 15 participants (20.0%) responded to interview question 3 with qualities of an authentic leader, one who is aware of who they are and what their values are (Robbins & Judge, 2015). P13 noted, "I really believe in being an authentic leader and not being anyone I am not meant to be. There are clearly a lot of books out there on how to be a great leader and I think you have to understand who you are at your core" (P13, personal communication, February 22, 2017). As an authentic leader practices solid values, P2 shared integrity, honesty, respect, and compassion as the core values to live by (P2, personal communication, January 30, 2017).

Interview question 3 summary. Based on the aggregated responses provided by 15 young successful healthcare leaders, five common themes emerged as key leadership characteristics of those who have promoted into executive roles early in their careers. The characteristics of a servant leader represented all but one of the 15 participants. Authentic and ego-less were two additional characteristics that had interconnections with a servant leader. Promoting into senior level roles in one's twenties or thirties requires hard work and focus, which calls for a tenacious work ethic, a value held by more than half of the participants. Finally, 60% of the participants embodied characteristics of a democratic leader who is collaborative, team oriented, and a good communicator.

Research question 1 summary. In research question 1, the participants articulated leadership strategies, practices, and characteristics that are common among healthcare leaders under the age of 40. Four different leadership frameworks emerged including transformational, team, authentic, and servant leadership. Servant leadership and authentic leadership also were common themes in interview question 3, which asked the participants which leadership characteristics helped them promote into their executive roles. In fact, 93.3% of participants stated that characteristics of a servant leader were vital to their career growth. As a servant leader's supreme desire is for people's needs to be met, there is a connection with another theme under IQ1 that states strategies within a healthcare organization should be patient centered. Emotional intelligence also surfaced as a theme in interview question 1, which overlaps with themes such as listen and empathize, servant leadership, and tenacious work ethic.

Change management emerged as a strategy employed by the participants. There is a direct connection with the themes from IQ2, which speaks to managing resistance and opposition to change. One of the steps of Kotter's steps in managing change, *to build a guiding coalition*,

surfaced as one of the themes in overcoming resistance and change. Furthermore, educating

people on the reason for change and engaging them in the process are two practices that reflects

a democratic leadership style characterized by virtue of collaboration, communication, and

consensus from employees. All other themes from research question 1 are highlighted in table 5.

Table 5

Summary of Themes for Research Question 1

IQ1. Strategies and Practices	IQ2. Overcoming Resistance and Opposition	IQ3. Leadership Characteristics
Transformational Leadership	Educate people on reason for change	Servant Leadership
Team Leadership		Democratic
	Engage people in the process	
Authentic Leadership		Tenacious Work Ethic
	Listen and Empathize	
Servant Leadership		Ego-less
	Build a guiding coalition	
Emotional Intelligence		Authentic
Patient Centered		
Change Management		

Research question 2. Research question 2 asked, "What challenges are faced by

healthcare leaders under the age of 40 in leading their respective organizations?" Four questions

were asked of participants to realize the impediments and obstacles young leaders face in their

organizations. Two of the four questions distinguish between external and internal environmental

challenges that affect day-to-day operations.

- IQ 4: What challenges do you face in implementing strategies and practices?

- IQ 5: What are the external environmental challenges that impact your day-to-day

  operations?

- IQ 6: What are the internal environmental challenges that impact your day-to-day

  operations?

- IQ 7: What are the obstacles of being a young leader in healthcare?

Interview question 4. What challenges do you face in implementing strategies and practices? Executing strategies and practices in healthcare organizations comprised of a diverse workforce creates various challenges that must be handled by leadership. Common themes identified by the participants include: competing priorities, resistance, time, regulatory changes, fear of change, and limited resources and capital (See Figure 8).
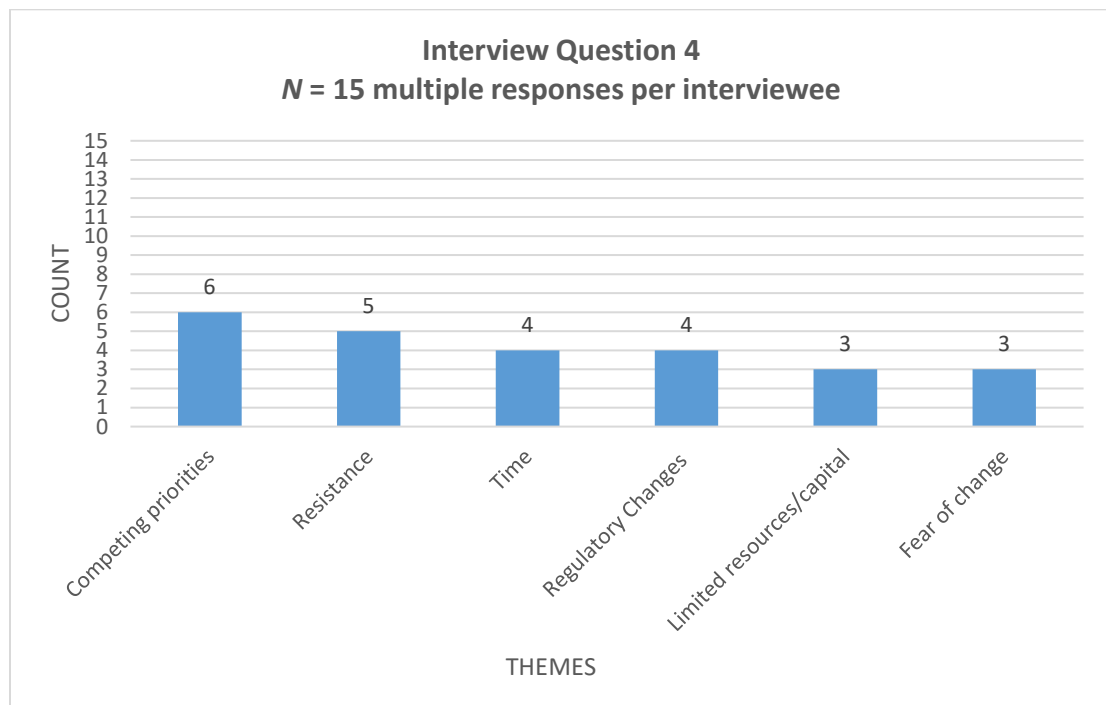

Figure 9. IQ 4: Challenges in Implementing Strategies and Practices

Competing priorities. Six of the 15 participants (40.0%) responded to interview question 4 by speaking to the competing priorities that impede the fluid implementation of strategies and practices. P5 alluded to the "firehose of projects" that floods the participant's health system, especially with mergers "caus[ing] priorities to be realigned" (P5, personal communication,

February 10, 2017). P9 and P11 reference the opposing directions received from different stakeholders who are representing their individual goals and priorities. A call to action came from P12 and P14 to focus on prioritization of goals in order to execute on strategies.

Resistance. Another impediment to implementing strategies and practices in healthcare organizations is resistance to change. Five of the 15 participants (33.3%) cited the difficulty in getting the physicians and staff to buy into the proposed strategy. In particular, one of the leaders was met with resistance from employees based on the "the concept of change from the way things were done in the past" (P3, personal communication, February 1, 2017). P2 was faced with opposition from staff due to the strategy or change not being developed at their hospital or clinic, and labeled as resistance due to "not [being] invented here… therefore I do not want to do it" (P2, personal communication, January 30, 2017). Physician resistance was shared by three of the participants (P3, P6, and P12). P6 shared from experience how physicians resist when they hear the word "*no*". P6 mentions further, "Often times it's not just us wanting to implement strategies. But it's keeping strategy in line, so that we are not spending all this money on something that cannot be part of a strategy" (P6, personal communication, February 10, 2017).

Time. With the competing priorities, time becomes a challenge for the entire organization. Four of the 15 participants (26.6%) provided responses indicating how time was a sought after commodity within their organizations. There is not adequate time to achieve everything that is desired to be accomplished within a certain time frame, therefore "You have to selectively choose. Focus is a huge thing — there's a lot of saying 'no' in this role" (P5, personal communication, February 10, 2017). P14 and P15 also describe how the administrative leadership team and physicians are inherently busier, therefore making the execution process slower.

Regulatory changes. Four of the 15 participants (26.6%) explain how governmental

regulatory changes present obstacles in implementing strategies and practices. P12, P13, and P14

all cite how healthcare is changing so rapidly. To further illustrate this concept, P12 describes

how "Every month we are going a different direction whether the government is causing us to go

one way, or local state regulations, or Joint Commission" (P12, personal communication,

February 21, 2017). There is constant movement and instability, which makes it difficult to

implement a strategy or practice before a new change becomes the new focus.

Limited resources and capital. Three of 15 participants (20.0%) expressed the obstacle of

limited resources and capital that hinder the implementation of strategies and practices. In order

to work through competing priorities, there needs to be adequate human capital to carry out

projects and priorities. Yet the diminishing reimbursements caused by regulatory changes

impacts the financial capital needed to recruit good talent, according to P4. Another participant

explained how "You really have to know how much bandwidth you have to do things and to be

as creative to do as much with as little resources that you have" (P5, personal communication,

February 10, 2017). The emphasis on managing expenses due to decreasing reimbursements

creates an internal struggle when staffing is minimized despite the host of priorities that need

attention.

Fear of change. Three of 15 participants (20.0%) cited an overarching fear of change as a

challenge when trying to implement new strategies and practices. P2 commented on "a fear of

the unknown," which translates to the attitude that "I've done this for 20 plus years and you are

asking me to do this and I'm not sure that new way is better" (P2, personal communication,

January 30, 2017). P2 further noted the subsequent result of fearing change, which is becoming a

risk-averse culture that misses out on opportunities. Another participant shared the same

experience when trying to introduce a new change. Instead of embracing the strategy as an opportunity, "the way things were done in the past 20 years" gets brought up (P3, personal communication, February 1, 2017). Such pushback goes back to the underlying fear of change that is present in organizations.

Interview question 4 summary. Various challenges of implementing strategies and practices were shared by healthcare leaders. Common themes identified by the participants include: competing priorities, resistance, time, regulatory changes, fear of change, and limited resources and capital. Many of these themes go hand-in-hand. For example, competing priorities in the workplace is in part due to the regulatory changes from the federal level that are brought upon healthcare organizations on a frequent basis. Such rapid change creates a multitude of projects and priorities for different areas of the healthcare continuum, which breeds a notion of insufficient time to complete all responsibilities. Furthermore, there is an incessant need for additional resources to complete projects and tasks related to regulatory changes. However, the regulatory changes also cause diminishing reimbursements and limited capital, which ultimately restricts organizations from bringing on additional resources. Regulatory changes are further described in the next section as it emerged as an external environmental challenge that impacts day-to-day operations.

Interview question 5. What are the external environmental challenges that impact your day-to-day operations? Outside of the healthcare organization's control are external challenges that may impede operational success on a daily basis. The four challenges that emerged from participant responses include the following: regulatory changes, healthcare reform, patient expectations and behaviors, and competition (See Figure 9).
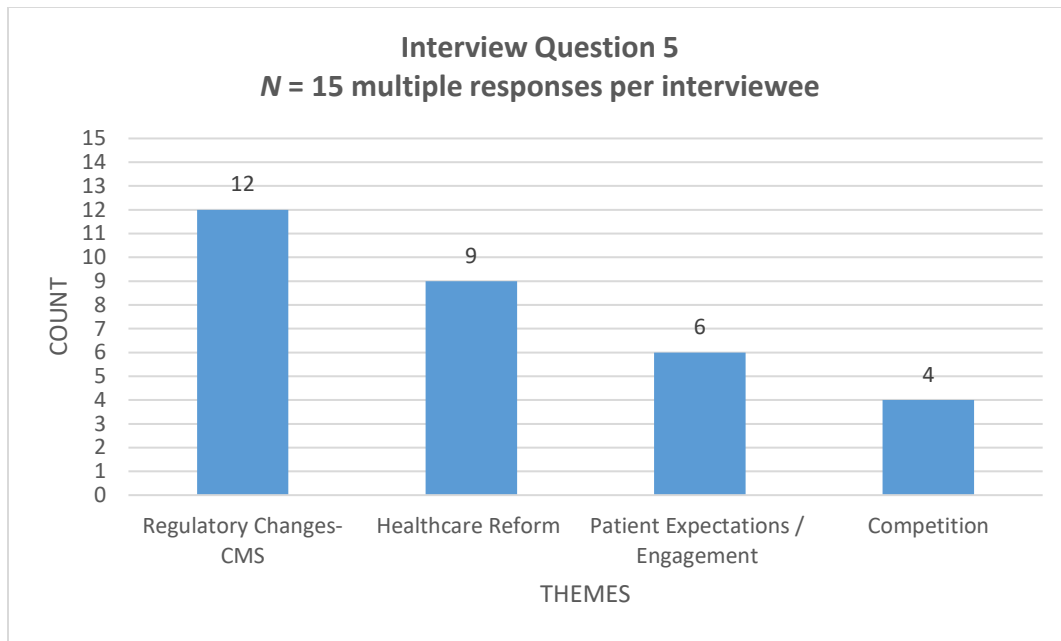
Figure 10. IQ 5: External Environmental Challenges

Regulatory changes. A large majority of participants (12 out of 15, or 80%) considered regulatory changes as the underlying external environmental challenge impacting their day-to-day operations. According to P4, changing regulations has created "more specificity around how things need to be done clinically in the hospital. Pay-for-performance impacts healthcare leaders and hospitals across the country. Obviously reimbursements go to those who perform at the top level" (P4, personal communication, February 1, 2017). Four participants (P2, P6, P9, P14) clarify the specific regulatory changes trickling down from the Center for Medicare and Medicaid Services (CMS) that impact reimbursements. Santilli and Vogenberg (2015) substantiate how hospitals and healthcare providers are financially enticed to meet pay-for-performance (P4P) measures geared at improving quality of care provided to patients, also known as value-based reimbursement, a term used by P1, P12, and P15 when responding to this interview question.

Healthcare reform. Under the new direction of President Donald Trump, the impending changes to healthcare legislation related to the Affordable Care Act (ACA) was cited by nine out the 15 participants (60%). P10 conveyed that the "competing pressures of the national healthcare reform stage" related to the forthcoming results of the Obamacare replacement bill will eventually have a downstream effect both at the federal and state levels (P10, February 16, 2017). P13 shared a sentiment of uncertainty with the following statement: "We are still holding tight on an exactly what that will mean for us and everyone is sort of preparing one way or another on what will happen with the ACA" (P13, personal communication, February 22, 2017). Amid all the other regulatory changes impacting the day-to-day operations in healthcare organizations, leadership and physicians apprehensively await the changes to the ACA and the impact it will have on patients and healthcare entities.

Patient expectations and engagement. Patients have more information at their fingertips with the ability to search anything on the Internet. Six out of 15 participants (40%) determined that patient's expectations have increased over time. Much of patient's expectations is fueled by the "more astute level of consumerism in which patients have more access to information that allows them to be more educated and selective on how they choose their healthcare partners" (P9, personal communication, February 14, 2017). P2 shared, "What patients expect from us today is very different from what they expected 20 years ago and if we can't deliver then we will be extinct" (P2, personal communication, January 30, 2017). To remain a relevant healthcare entity to patients and their family members, it is essential that quality and patient experience be regarded as top notch in order to maintain patient trust in the organization.

Competition. With patient expectations influencing their choices for where they receive

their healthcare services, four of the 15 participants (26.6%) defined external competition as a challenge. P7 and P10 both remarked on the highly competitive market within the healthcare industry. Specific examples were offered by one of the participants. P5 mentioned how urgent cares must now compete with a CVS minute clinic. Moreover, telehealth solutions have become more sophisticated for lower acuity visit in which the physician can issue prescriptions virtually (P5, personal communication, February 10, 2017). P10 further added, "Our challenge is now that we have to outpace our competition in terms of growth, which is pretty aggressive. We have to build new markets and put up new hospitals and new ambulatory surgery centers, all concurrently" (P10, personal communication, February 16, 2017)

Interview question 5 summary. Four main themes surfaced to respond to the question, "What are the external environmental challenges that impact your day-to-day operations?" The first theme centered on the regulatory requirements imposed by CMS that impact reimbursements and how care is delivered. These regulatory changes challenge healthcare organizations to be cost conscious and quality focused. The second theme focuses on healthcare reform and the unpredictability of how the ACA replacement bill will impact healthcare in the future. The third theme speaks to the empowerment of patients as more information regarding their health and their care provider is readily available, thus giving them the knowledge to set higher expectations for their care. The last theme speaks to the rising competition as retail businesses like CVS and telehealth solutions begin to emerge in the healthcare marketplace.

Interview question 6. What are the internal environmental challenges that impact your day-to-day operations? Participants reflected on the challenges that occur within the walls of their organizations. Four major themes were identified by the participants: managing human capital, managing change, managing financial capital, competing priorities (See Figure 10).

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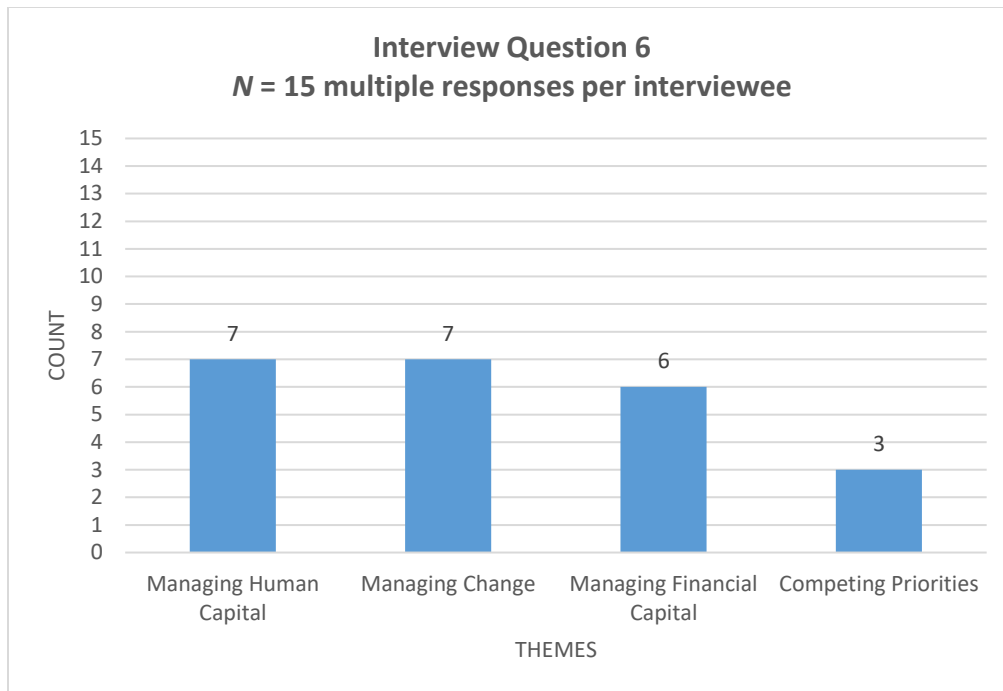
Figure 11. IQ 6: Internal Environmental Challenges

Managing human capital. As current healthcare trends require organizations to do more

with fewer resources in healthcare, managing human capital was one of the top themes that seven

out of 15 participants (46.7%) mentioned. P1, P4, and P13 specifically referenced managing

resources, and monitoring staff utilization and staffing ratios. Likewise, P14 cited the challenge

of the growing "expectation to deliver the same care with lesser personnel" (P14, personal

communication, March 2, 2017). P15 added, "people have lots of hats to wear" (P15, personal

communication, March 3, 2017). P7 and P10 also expressed the challenge of the shortage of

health service providers, in general. Lastly, P1 and P10 cited staff turnover as a challenge related

to managing human capital.

Managing change. Seven out of the 15 participants (46.7%) expressed the different

emotions and challenges related to the concept of changing from the comfortable norm. P3 and

P12 referred to the general statement, "It's always been done that way," which is articulated by

employees who are uncomfortable with change. P12 further explained that there are physicians

and staff who will inevitably display resistance to change, and be disruptive to the day-to-day operations. P8 suggests that the fear of change also impacts day-to-day operations, while P10 underscores how rapid change in the healthcare world sparks anxiety as the organization must also move at the same velocity.

Managing financial capital. Six out of the 15 participants (37.5%) expressed concern over managing their organization's financial resources. P1 suggested budget constraints impacts day-to-day operations. P4 identified a similar internal environmental challenge in the following statement:

> Managing the books — making sure there are efficiencies — that we are not overstaffed, understaffed, that we are not over-utilizing controllable expenses like drug and pharmaceutical costs, salary and wage costs, supply cost, equipment, so managing the domain to run a business, but do it efficiently while getting the quality outcomes we want. (P4, personal communication, February 1, 2017)

P14 commented on the current economic trend impacting internal operations:

> The pressure of it used to be we have to watch every dollar. Now we have to watch every penny. We have to be serious about having money and income at the end of the year to reinvest into organization to have facilities that have the best equipment and technology for our community to enjoy, and that is becoming more of a challenge. (P14, personal communication, March 2, 2017)

P8 and P9 also shared the same viewpoint as P14 with regards to having adequate capital to reinvest in their respective organizations with the intention of expanding locations and promoting facility growth.

Competing priorities. The responses from interview question 4 prompted the same theme to emerge in interview question 6. Interview question 4 asked, "What challenges do you face in implementing strategies and practices?" P5, P7, P12, P14 conveyed competing priorities to be a challenge in implementing strategies. In interview question 6, 20% of participants, including P1, P2, and P5 referenced the same concern regarding competing priorities. P1 cited the "uncertainty of competing equally noble initiatives" (P1, personal communication, January 23, 2017). P2 provided an applicable representation of competing priorities with imagery:

> Death by a thousand papercuts. We throw so much at people and we expect these things and they don't necessarily tie in together. Basically, I have 10 gallons of water that I am trying to put in a five-gallon tub and I don't have the tools and resources I need to do my work. There's just too much of it. (P2, personal communication, January 30, 2017)

Interview question 6 summary. Within their respective healthcare organizations, participants contemplated some of the internal environmental challenges that affect their operational flow. There were four major themes that were shared by the participants: managing human capital, managing change, managing financial capital, and competing priorities. Managing human capital, as defined by the participants, entails dealing with the pressure of maintaining efficient staffing ratios and coping with a workforce shortage. Closely related to managing human capital is the challenge of managing financial resources. The current economic trends call on healthcare organizations and physicians to care for patients in a more cost-efficient manner. As efficiencies are put in place to curtail spending, they generate changes to the normal operations that employees are accustomed. Therefore, another theme that surfaced was the challenge of managing change. Change management comes with a variety of emotions including fear, anxiety, resistance, and discomfort. Lastly, the workforce and leadership are further

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challenged by a multitude of competing projects and priorities, which creates further uneasiness for everyone.

Interview question 7. What are the obstacles of being a young leader in healthcare? Interview question 7 gave participants the opportunity to share challenges they have experienced in their career as young leaders in the healthcare industry. Four main themes were identified by the participants: proving credibility, level of experience or knowledge, perceptions of youth, next career move (see Figure 11).
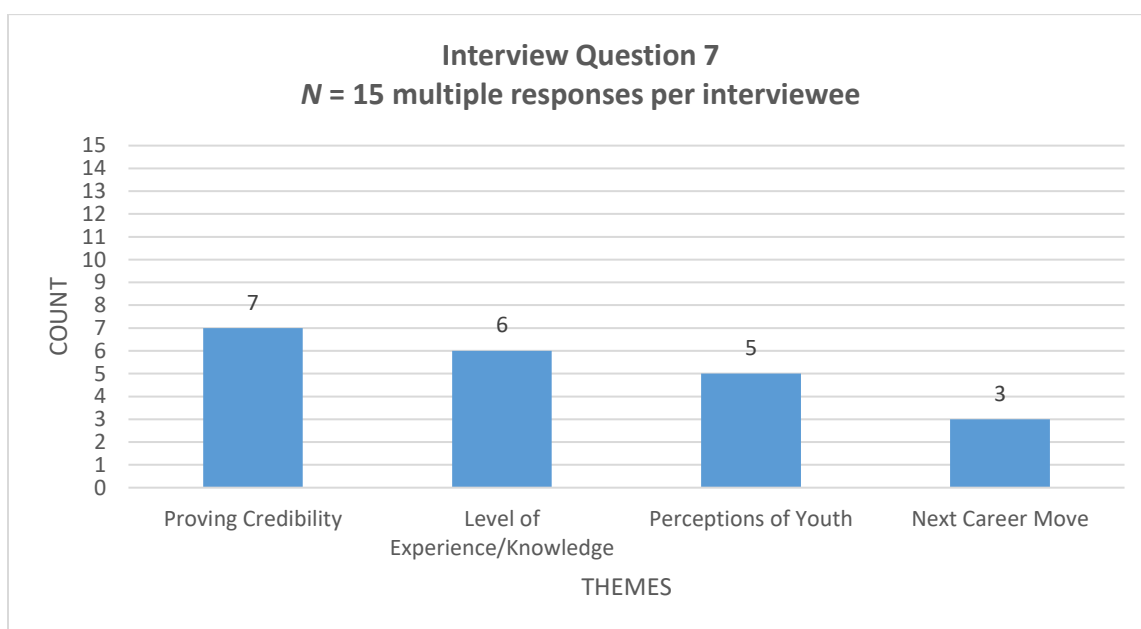

Interview Question 7
N = 15 multiple responses per interviewee

Figure 12. IQ 7: Obstacles of being a young leader

Proving credibility. Seven out of the 15 participants (46.7%) spoke about the challenge of earning the respect and trust of colleagues who were 10, 20, 30 years their senior. The first theme that almost half of the participants shared was establishing and proving credibility as a new, young leader. There was a consensus that building credibility took time, effort, and hard work especially early on, according to P14 and P15. In the following statement, P8 candidly shared a personal obstacle when given the CEO opportunity at a young age. "Establishing credibility in an aging community that wasn't sure that someone a third or fourth of their age should be in a role

like that. I was under-supported by the hospital board at that time" (P8, personal communication, February 13, 2017). P8 countered this obstacle by cold calling more seasoned CEOs for mentorship and wisdom. P9 recalled the following memory:

> I ran into labeling from those who were more senior that I didn't have what it took. You could create distance in relationships when you start to form those agenda and build walls, so I had to deal with that and overcome that every turn or right off the bat. Instead of meeting force with force, it was about meeting force with grace. As I met force with grace, some of those walls came down, and people got to understand my true intent, and perspective, and what I was about. (P9, personal communication, February 14, 2017)

Level of experience or knowledge. With minimal experience under their belt just barely transitioning out of graduate school, six out of the 15 participants (37.5%) commented on their lack of experience and knowledge in running healthcare organizations as one obstacle. P2 explained, "Clearly you don't have the level of knowledge and expertise as someone who has been in the role for 30, 40, 50 years to have been able to see the trends and different things" (P2, personal communication, January 30, 2017). Subsequently, P2 recalls the mistakes made in the participant's first managerial role, which could have been circumvented with more knowledge and experience. Although P2 made mistakes early on, the participant learned from those missteps and is now a successful healthcare leader with more than a decade of experience. Unlike the 15 participants of the study, "some people don't learn from experience, and they have been around a long time, but do not get better" (P7, personal communication, February 13, 2017). Lastly, P10 shared how with 10 years of leadership experience, five years ago the perspective from others was "What the heck does he know? He's only been a healthcare leader for five years" (P10, personal communication, February 16, 2017). To overcome such perception of inexperience, P10

advises abstaining from being overly confident, but rather countering the negative attitudes with pure humility.

Perceptions of youth. Five of the fifteen participants (33.3%) recollected the mere perception of being young for their role was an obstacle to overcome. P1 spoke about the impetuousness and recklessness attached to the impression of youth in general (P1, personal communication, January 23, 2017). Other participants provided examples of the doubt in people's minds with the following recollections that were shared:

- "First and foremost, you have to overcome what goes through a doctor's mind or someone who you are talking to about a difficult issue. 'What does this young kid know? I've been practicing medicine longer than he's been alive?'" (P12, personal communication, February 21, 2017).

- I'm sure there are people here saying "Why is this kid running the clinical enterprise?" (P11, personal communication, February 17, 2017)

- "People think that I am an intern or secretary. It's been a challenge to be taken seriously by my colleagues" (P15, personal communication, March 3, 2017).

The minimizing of the healthcare leader to a "kid" or "intern" exemplifies the very nature of youth as an obstacle.

Next career move. When an individual promotes quickly into their executive role at a young age, the next step in their career becomes an obstacle as mentioned by three of 15 participants (20.0%). P10 posed the scenario that "if you ascend too quickly, then what are you going to do, what's next?" (P10, personal communication, February 16, 2017). P3 shared the uncertainly of not knowing what to do long term, and that prior to holding a title of CEO, the

path was always known. P15 shared the same sentiment of not knowing what direction to go next career wise.

Interview question 7 summary. While the participants shared success in holding positions as young healthcare executives under the age 40, they also shared obstacles of being a young leader in healthcare. In asking the young participants about the obstacles they currently face, or have endured previously, four main themes emerged from the responses: improving credibility, level of experience or knowledge, perceptions of youth, next career move (see Figure 11). As the participants have been recognized in publications such as *Becker's Hospital Review* or *Modern Healthcare*, it is evident that they have risen above obstacles of low credibility, inexperience, and perceptions of youth. The most surprising, but sensible theme that arose was the idea of what the next career move would be for individuals who have earned the most senior level positions in healthcare so early in their careers. As such, P15 expressed the desire to slow down her career trajectory.

Research question 2 summary. In research question 2, the participants explained the different challenges they face in implementing strategies and practices in their respective healthcare organizations. Table 6 demonstrates a summary of themes from research question 2. Interview questions 4, 5, and 6 initiated overlapping responses and interconnections. Competing priorities was a theme that came up in IQ4 and IQ6. The number of initiatives presents a challenge for leaders in managing the important projects that arise from two external environmental challenges, healthcare reform changes and regulatory changes at the federal level, as indicated by responses from IQ4 and IQ5. Such competing priorities, among others, connect back to another obstacle experienced by healthcare leaders. Due to competing initiatives, there is insufficient time to handle all responsibilities, tasks, and projects. Furthermore, human and

financial capital is necessary to address the competing priorities. An additional challenge that

emerged in IQ6 relates to an umbrella theme of managing change. Subthemes of managing

change arose in IQ4, which include overcoming resistance and the fear of change felt by

employees and physicians. Strategies for overcoming resistance and opposition to change were

addressed in research question 1, interview question 2.

In IQ7, participants candidly spoke about the specific obstacles of being a young leader.

Several themes emerged including the need to prove credibility in the organization, due to lack

of experience in leadership, or inadequate knowledge of healthcare administration. One

surprising theme that emerged was some leaders' uncertainty of what to do next in their careers

as they rose quickly up the ranks.

Table 6

Summary of Themes for Research Question 2

| IQ 4: Challenges in Implementing Strategies	IQ 5: External Environmental Challenges	IQ 6: Internal Environmental Challenges Characteristics	IQ 7: Obstacles of a young leader
Competing priorities	Regulatory Changes	Managing Human Capital	Proving Credibility
Resistance	Healthcare Reform		
		Managing Change	Level of Experience/ Knowledge
Time	Patient Expectations / Engagement	Managing Financial Capital	
Regulatory Changes			
			Perceptions of Youth
Limited resources/capital	Competition	Competing Priorities	
			Next Career Move
Fear of change			

Research question 3. Research question 3 asked, "How do healthcare leaders under the

age of 40 measure their success and the performance of their respective organizations?" The

following three questions were asked of participants to elicit responses that could ultimately

respond to research question 3:

- IQ 8: How do you define and measure your success as a leader?

- IQ 9: What constitutes a high performing, or successful healthcare organization?

- IQ 10: What methods do you employ to measure and track the organization's

  performance and success?

Interview question 8. How do you define and measure your success as a leader?

Participants shared four common themes that defined and measured their success as leaders. The

themes are as follows in descending order of number of participants who articulated the

particular theme: team development and success, organizational success, personal achievement,

reduced staff turnover (See Figure 12).
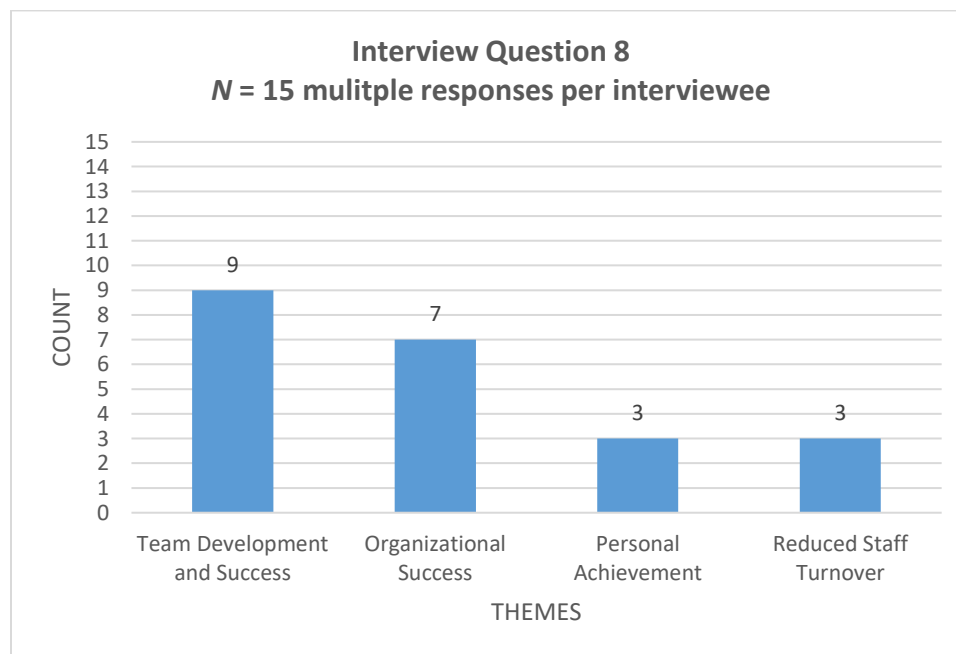
Figure 13. IQ 8: Definition and measurement of success as a leader

Team development and success. Nine of 15 participants (60.0%) expressed that their

success as a leader was primarily contingent on their team members' professional growth and

success. The servant leadership style shined through in this particular theme. For example, P1 defines and measures personal success as the following: "by the number of high functioning leaders that I've identified and cultivated" (P1, personal communication, January 23, 2017). Leadership success is further defined by answering "yes" to the following questions posed by two participants:

1) Have I made a difference to those I lead? (P2, personal communication, January 30, 2017).

2) Are people better because I was here? (P13, personal communication, February 22, 2017).

Furthermore, P14 adds that leadership success is defined and measured by individuals growing professionally under the participant's mentorship and direction, and that they are able to move up in their careers even if it means leaving the organization.

Organizational success. Seven out of the 15 participants (46.7%) stated that their leadership success was dependent on the organization's performance. P4, P6, P7 referenced organizational metrics such as patient satisfaction scores, growth, and financial metric to determine if goals were met. P15 further quantified leadership success through the achievement of 75% or more of the organization's strategic objectives that year (P15, personal communication, March 3, 3017). P3 provided a qualitative measurement of personal leadership success with the following quotation: *"I would say the ability to build a stable culture in an organization that has success long after you're gone"* (P3, personal communication, February1, 2017). P13 asks the simple question: "Is the place better because I was here?" (P13, personal communication, February 22, 2017).

Personal achievement. Leadership success of the participants was defined through different measures of personal achievement by three of 15 participants (20.0%). P4 expresses the following statement: "I would quantify those things that I achieve in my career and in my role" (P4, personal communication, February 1, 2017). P10 provided a qualitative spin to his response stating, "I listen and look for complements of how people are speaking of me… To me those comments correct me in my course to say, am I delivering the right message? Am I delivering too heavy of a message? Is it taking impact? On the qualitative side that's how I measure my effectiveness" (P10, personal communication, February 16, 2017). Finally, P11 asserted that personal leadership success is dependent on whether the goals identified by superiors have been achieved.

Reduced staff turnover. Three of 15 participants (20.0%) stated that their leadership success could be measured through turnover rates. P5, P10, and P12 believe that reduced or low turnover among employees is an indicator of their personal success as leaders. This goes hand-in- hand with keeping the workforce engaged in the organizational mission, which relates to better retention of staff within the organization.

Interview question 8 summary. Participants shared how they define and measure their personal success as healthcare leaders. Four themes were captured among participants: team development and success, organizational success, personal achievement, reduced staff turnover. First, team development and success denotes the impact the leader has on the professional growth of his or her direct reports and staff. Second, organizational success reinforces how well the organization performs in certain benchmarked categories. Third, leaders define and measure their success through the achievement of goals set by the leader's superiors, or achievement qualified by the number of complements received about work accomplished, or leadership style.

Lastly, reduced staff turnover is a quantifiable measure of leadership success when employees are being retained in the organization.

Interview question 9. What constitutes a high performing, or successful healthcare organization? Through thoughtful data analysis of participant responses, six themes were identified: focus on quality; culture that engages the workforce; focus on patient experience; cost conscious; financial growth and stability; and community outreach. Each theme will be defined in detail using participant verbatim quotations or summaries of their responses (See Figure 13).
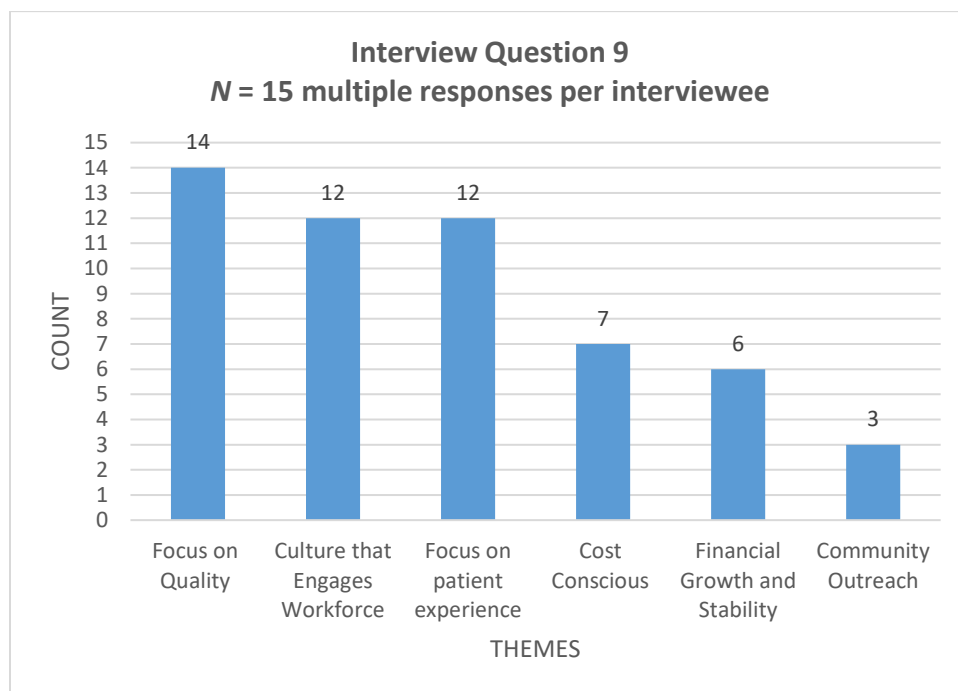

Figure 14. IQ 9: High Performing, Successful Healthcare Organizations

Focus on quality. Almost all participants (93.3%) mentioned something under the quality umbrella, including positive clinical outcomes, safety, and reliability. For P1, the notion of high reliability came to mind, as well as the need to be "driven by an exorable drive towards quality and patient safety" (P1, personal communication, January 23, 2017). Participant 10 remarked how low safety incidence and high quality constituted a high performing healthcare organization, which essentially contributes to a positive patient experience, another pillar of a successful

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healthcare organization. Two participants (P14 and P15) referred back to the concept of Triple

Aim, which focuses on three main goals for improving the overall status of the American

Healthcare system, include improving quality outcomes for patients, enhancing patient

satisfaction, and decreasing costs for the population served (Berwick et al., 2008). Patient

satisfaction and decreased healthcare costs all begin with delivering excellent outcomes and high

quality care.

  Culture that engages the workforce. A large majority of the participants (80%) expressed

the need for an engaged and motivated team in healthcare. Participant 11 described what

engagement should look like: "Everyone is rowing in the same direction. Everyone knows what

the mission is. They are on board with the mission. They support the mission. Everyone is

empowered to do the job at the highest possible level" (P11, personal communication, February

17, 2017). P1 and P14 spoke about retaining the workforce, which is a direct result of creating a

culture of teamwork, engagement, and empathy. P6 commented on the impact of poor workforce

engagement, which is poor job accountability, low motivation, and lack of buy-in. P6 adds,

"High performing organizations do a good job of creating internal motivation, or intrinsic

motivation" (P6, personal communication, February 10, 2017).

  Focus on patient experience. Twelve out of 15 participants (80%) shared a "patient first"

attitude (P2, personal communication, January 30, 2017), which places the patient at the center

of the organizational mission. Participant 9 describes this theme as consumer excellence, which

speaks to whether patients see value and benefit from the healthcare services rendered.

Ultimately, the goal is have engaged and satisfied patients who at the end of their experience

"are willing to come back and tell their story and let people feel or experience what you did to

contribute to their life, or returning them to a way that they used to function because of whatever

happened to them is the ultimate measure of a high performing organization" (P10, personal communication, February 16, 2017).

Cost conscious. Seven of the fifteen respondents (46.7%) asserted that a high performing organization is one that produces good health outcomes, while measuring and keeping costs lows. P8 explicitly defines a high performing organization with the following statement: "If our health outcomes and our patient experience are good, above average, and costs are low, then we have a high performing organization. If health outcomes are not good, or our patient experience is not good, and our costs are rising, then we are not a successful organization" (P8, personal communication, February 13, 2017). In more technical terms, P9 describes being cost conscious as "stewardship excellence," which in the participant's organization refers to utilizing resources efficiently, eliminating waste, and producing savings. P9 further stipulates that the concept of cost consciousness is the "intersection between clinical and economic values" (P9, personal communication, February 14, 2017).

Financial growth and stability. Six out of the 15 participants (37.5%) provided insight into high performing organizations exhibiting financial sustainability. Due to the current healthcare market trends of reducing healthcare costs to remain financially viable (P4, personal communication, February 1, 2017), it is critical to be cost conscious as indicated in the previous theme, so that there can be "earnings and growth" for the organization (P3, personal communication, February 1, 2017). Furthermore, P14 explains how the healthcare systems of tomorrow will need to operate: "They are going to want to be high performing in all of their metrics including financially, because you need to have a margin in order to be able to reinvest in the future" (P14, personal communication, March 2, 2017). Investing into the organization will

continue to benefit clinical quality programs, patient initiatives, and workforce engagement initiatives that all contribute to the further advancement of the organization.

Community outreach. While not mentioned by the majority of the participants, community outreach and excellence is another theme that emerged from the responses of interview questions nine. Three of 15 participants (20.0%) spoke about high performing organizations having the ability to make a difference in the community. For example, P5 shared how they "have huge community benefit and outreach. We serve a lot of underserved populations. We take on a lot of work that won't improve our revenue, but it is why we exist" (P5, personal communication, February 10, 2017). P9 added another dimension to excellence among organizations, which was coined "community excellence," or being a good corporate citizen in the community where one resides (P9, personal communication, February 14, 2017). Lastly, P10's organization tracks their reputation in the community. It is important to serve the community at large, and maintain a positive reputation through quality care and service.

Interview question 9 summary. Participants in the study shared their individual views on what constitutes a high performing, successful healthcare organization. Six themes were identified. A large majority agreed on three main concepts, including producing good quality outcomes (93%), engaging the workforce (80%), and focusing on patient experience (80%). Financial sustainability was highlighted through two themes, which consisted of organizations being cost conscious and exhibiting financial growth and stability. Lastly, serving the community through outreach programs was another hallmark of high performing healthcare organizations.

Interview question 10. What methods do you employ to measure and track the organization's performance and success? Four themes emerged from the responses of the

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participants: key performance indicators; transparency of data; dashboards/reports; and a balanced scorecard (See Figure 14).
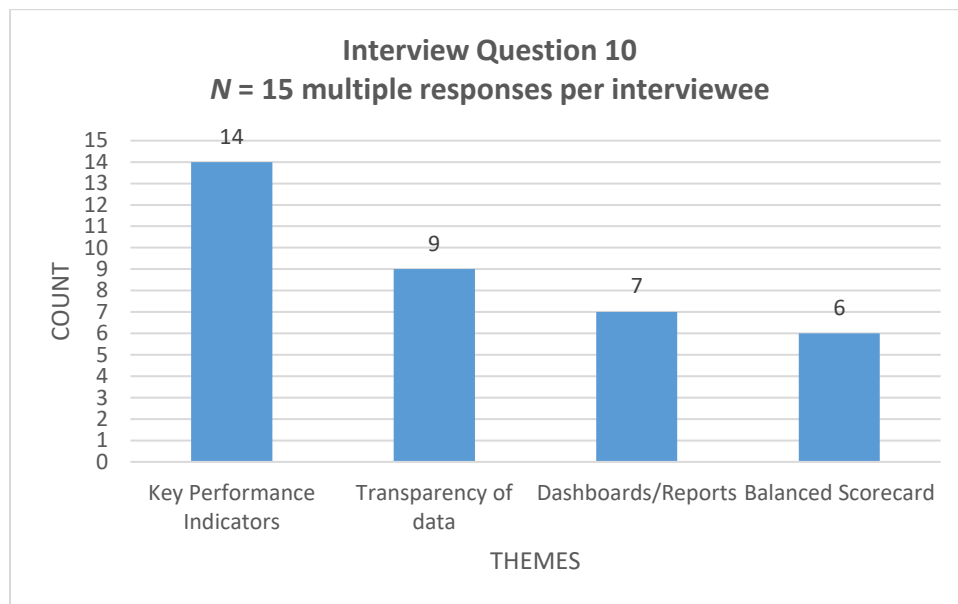

Figure 15. IQ 10: Methods for tracking organizational performance

Key performance indicators. Fourteen out of 15 participants (93.3%) responded to interview questions 10 by mentioning several of their organization's key performance indicators (KPIs), which are measurable metrics that indicate whether an organization is meeting their goals. The participants aligned on several metrics related to financial and growth targets, patient satisfaction, employee and physician engagement, quality and safety measures. P13 provides similar examples of the KPIs in the participant's organization. P13 shared, "We have KPIs for just about everything from volume metrics on the clinic and hospital side, as well as the financial metrics both on the revenue side, growth side, and expense side. Equally as important, if not more so, we focus on patient satisfaction, which we deem here as the patient experience" (P13, personal communication, February 22, 2017). Participant 2 informed the researcher of their reliance on the annual strategic plan that generates annual goals. P2 added:

Those annual goals are KPIs, or key performance indicators, are standardized across the

system so we have the system level KPIs, zone level KPIs, entity hospital level KPIs,

physician group clinical group, down to department level, so we cascade our goals from

the top to the bottom and each one them has a metric. (P2, personal communication,

January 30, 2017)

Transparency of data. Nine out the 15 participants (60%) expressed the importance of not

only tracking key performance indicators, but also sharing the information with the entire

workforce. Participant 14 shares how accountability for achieving organizational goals can be

shared from the top down to the frontline in the following statement:

One thing that is important that is managed up and down the org chart, the same reports

that the board of directors gets go all the way down to the frontline staff in a department.

I think that is really important because it aligns with the things we are tracking and

measuring our success on. It sets you up to celebrate and to be able to pause and say we

have an issue. Everyone has skin in the game here. (P14, personal communication, March

2, 2017)

P6, P8, P15 agree on engaging the workforce through the sharing of data, receiving input from

all employees, and requesting action to be taken towards improving areas in which the staff and

physicians can impact. As P14 mentioned and further substantiated by P4, celebrating successes

and discussing opportunities with the entire workforce can be made possible when the audience

is informed and fully engaged in metrics and results.

Dashboards and reports. Seven of the 15 respondents (46.7%) spoke about utilizing

dashboards as a method for tracking KPIs and sharing the visual data with organizational

stakeholders. P6 remarks, "Dashboards can give you quick snapshots of where your organization

is performing" (P6, personal communication, February 10, 2017). P10 and P15 specify the use of a stoplight methodology on dashboards to indicate whether the metric is on track (green), on track but on the verge of becoming off track (yellow), and not on track (red). This "visual management" of data as indicated by P5 (personal communication, February 10, 2017) creates a method "to take all that data and synthesize it and make it meaningful" (P3, personal communication, February 1, 2017).

Balanced scorecard. Six out of the 15 participants (37.5%) indicated that their organization uses a balance scorecard to measure and track the organization's performance and success. Kaplan and Norton (2007) define the balanced scorecard as a mechanism for tracking performance in four areas: finance, customer service, internal business processes, and learning and growth. P2 stated, "Patient experience, financial, clinical quality, employee and physician satisfaction — all of that together makes up the balanced scorecard, which is our key performance indicators" (P2, personal communication, January 30, 2017). While P2 referenced a direct connection between balanced scorecard and KPIs, it was important to define balanced scorecard as a separate theme as the literature defines it separate from KPIs. Additionally, the balanced scorecard also is used to develop a healthcare strategy map to articulate the roadmap to implement strategy in healthcare organizations (Kaplan & Nevius, 2001). As such, participant 8 articulated the following: "A balanced scorecard has been what we have been using to report on four goals in the vision statement, 'Culture of leadership in excellence, lead through collaboration, lead through process improvement, and become fiscally sustainable'" (P8, personal communication, February 13, 2017).

Interview question 10 summary. Participants presented several ways of measuring and tracking the organization's performance and success. The commonality found in the four themes

is having a mechanism for reporting and monitoring meaningful data at different levels of the organization to encourage accountability and system wide ownership of organizational success. Each organization represented by the participants employed one or more of these methods (e.g. the balanced scorecard, the multitude of KPIs, dashboards, and transparency of data) to remain vigilant of their organization's performance.

Research question 3 summary. Research question three asked, "How do healthcare leaders under the age of 40 measure their success and the performance of their respective organizations? Participants were asked three interview question to provide an understanding of how young leaders define their personal success, as well as that of the organization that they lead. Additionally, a question was asked to determine what measurement and tracking tools are used to realize an organization's successes and opportunities.

A total of 14 themes emerged from the responses to the three interview questions. Table 7 provides a summary of the themes from research question 3. Participants defined and measured their personal success as healthcare leaders based on their employee's development and success, as well as the organization's success. Moreover, two additional hallmarks of a successful leader emerged in response to interview question 8, which highlights a leader's personal achievement of goals within their organization and reduced staff turnover. Interview question 9 explored the determining factors of a high-performing and successful healthcare organization according to the young healthcare leaders' perspective. Six themes emerged including, good quality outcomes, an engaged workforce, patient experience, cost consciousness, financial growth and stability, and visibility of community outreach. Lastly, to measure organizational performance, healthcare leaders utilize the balanced scorecard, a multitude of KPIs, and dashboards to keep apprised of the organization's status. Interview question 10 also revealed how leaders prefer to be

transparent with data in their willingness to share information down to the frontline, thus calling

for action in areas of improvement and celebrations for areas of success.

Table 7

Summary of Themes for Research Question 3

IQ 8: Definition and Measurement of Success	IQ 9: High Performing, Successful Healthcare Organizations	IQ10: Methods for tracking organizational performance
Team Development and Success	Engaged Workforce	Key Performance Indicators
	Focus on Quality	
Organizational Success		Transparency of data
	Focus on patient experience	
Personal Achievement		Dashboards/Reports
Reduced Staff Turnover	Cost Conscious	Balanced Scorecard
	Financial Growth and Stability	
	Community Outreach	

Research question 4. Research question 3 asked, "What recommendations would

healthcare leaders under the age of 40 provide aspiring young leaders?" In order to respond to

this research question, two interview questions were posed to participants:

- IQ 11: What advice would you give to aspiring young leaders entering into leadership

  positions?

- IQ 12: If you could start over, what would you do differently?

  Interview question 11. What advice would you give to aspiring young leaders entering

into leadership positions? Through data analysis of participant responses to this interview

question, the following ten themes were identified by the participants: emotional intelligence,

be a lifelong learner, be an authentic leader, make an impact, find a mentor, work hard,

develop a professional and support network, follow your passion, take your time and be patient, and possess good decision-making skills (see Figure 15).
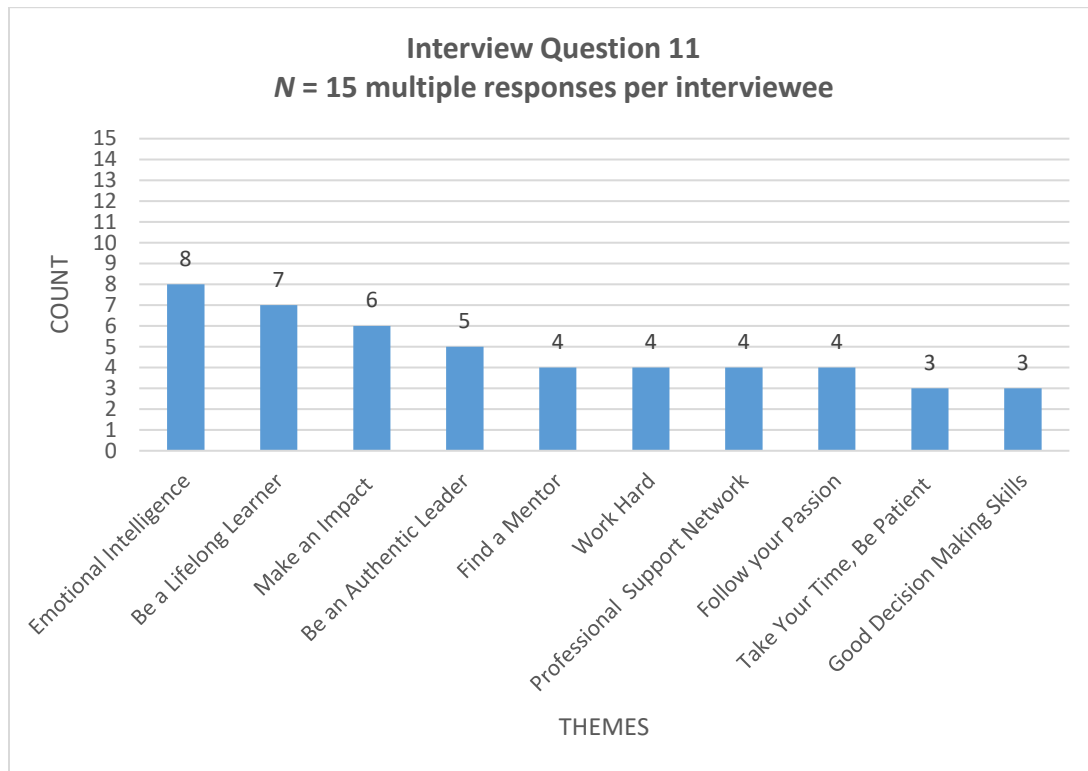

Interview Question 11
N = 15 multiple responses per interviewee

Figure 16. IQ 11: Recommendations for aspiring leaders.

Demonstrate emotional intelligence. This category emerged as the top recommendation with eight instances (53%) being mentioned by the participants either directly or indirectly. The nine instances referred to one or more of the emotional intelligence components (i.e. self-awareness, self-regulation, motivation, empathy, and social skills) as defined by Goleman (2000). As Goleman (2000) states that motivation to work should not be based on money or status, P2 advises to "look for opportunities that broaden your horizons and experience, not just your pocket book. People who chase the next job because it makes $2 an hour more or has the bigger title aren't necessarily the ones in the long term who get ahead. Know what capabilities you are trying to build and look for opportunities that build those capabilities that make a well-rounded leader" (P2, personal communication, January 30, 2017). With regard to social skills, P4

and P12 emphasized the importance of building relationships with the people in the organization because ultimately the work is accomplished as a collective effort. P4 states, "as a leader, you can't do it all" (P4, personal communication, February 1, 2017). Demonstrating empathy was advised by P8 who recommends that aspiring leaders be compassionate. Furthermore, P15 exemplified self-awareness and social skills by sharing how "people in healthcare really try and serve people, so aligning how you think and how you message to staff — it is important to engage" (P15, personal communication, March 3, 2017).

Be a lifelong learner. Seven of the fifteen respondents (46.7%) asserted the importance of taking the opportunity to learn from every experience. P5 cautions against turning opportunities down and stresses the importance of flexibility among new leaders to "just say yes and learn from the experience even if it's not what you want to do" (P5, personal communication, February 10, 2017). P13 corroborates this same message by emphasizing the value in finding the learning in everything one does. P10 advises aspiring young leaders to "subscribe to the lifelong learning methodologies that some successful people do," which entails reflecting on what knowledge and competencies are needed to become the leader one envisions they want to be in the future (P10, personal communication, February 16, 2017). To be a lifelong learner, as indicated by P15, means that one should be open to learning from individuals who they would not generally expect to learn from, whether that person be internal or external to the organization.

Make an impact. To make an impact within one's organization, as P9 directly remarked, represents the third top theme expressed by the participants. Six out of the 15 participants (37.5%) provided advice that spoke to bringing value to the other leaders and to the organization by coming up with solutions (P3, personal communication, February 1, 2017) for how the

organization can improve and ultimately generate results (P7, personal communication, February 13, 2017). Participant 14 challenges aspiring leaders to "raise [their] hand" to an opportunity to partake in, or lead a committee or workgroup (P14, personal communication, March 2, 2017).

Be an authentic leader. Five of the fifteen participants (33.3%) saw value in the characteristics of an authentic leader. Authentic leaders align their leadership style with their own personality, character, and values; therefore, remaining true to oneself, as shared by P9 and P11, is a hallmark characteristic of authentic leaders who understand their purpose. P11 goes on to further advise to "never compromise your integrity or your core values because you are the only person that lives your life. You are the only person that has to look in the mirror and see yourself" (P11, personal communication, February 17, 2017). Subsequently, when seeking an organization, find one whose mission aligns with your personal mission (P8, personal communication, February 13, 2017).

Find a mentor. Almost all of the leaders referenced an individual who was instrumental in their career progression throughout the interviews. When asked about recommendations for aspiring leaders, four out of the 15 participants (26.6%) reinforced the importance of aspiring leaders finding a mentor. P5 states that the mentor should be someone who holds the position that one desires to one day become, while P8 advises to be ready with specific questions for the mentor to answer, versus having the mentor serve as a therapist listening to one's problems. Be mindful and respect the leader's time (P8, personal communication, February 13, 2017).

Work hard. To achieve promotions into their executive roles before the age of 40, the participants of the study had to demonstrate strong work ethics in order to have been considered for their leadership positions. Four of the 15 participants (26.6%) reiterated the importance of going above and beyond to demonstrate competence and value in the organization. P3, P6, P8,

and P13, in particular, reinforced the message of how working hard will get one noticed for promotions and opportunities.

Develop a professional support network. Four of the 15 participants (26.6%) related back to their own personal experiences when they advised to establish a network of professional individuals who could support aspiring leaders in their journey. P12 and P14 recommended joining the American College of Healthcare Executives (ACHE). Seven of the 15 participants (46.6%) are Fellows of the American College of Healthcare Executives (FACHE), which is a prestigious healthcare credential to achieve by having at least five years of management experience, and by passing the FACHE qualification test. P1 adds, "I'd also advise folks to be active regionally and nationally in forums. Develop a support network of other [executives], stay in touch with folks, use networking at conferences to share war stories, figure out different approaches, and what worked and didn't work" (P1, personal communication, January 23, 2017).

Follow your passion. Four of the 15 participants (26.6%) mentioned this theme either directly or indirectly. Participant 11 offers the following wisdom: "Follow your passion as far as career wise. Don't be afraid to do what other people would not expect. If you follow what feels right and your passion and what you like, it will work out pretty well" (P11, personal communication, February 17, 2017). P7 also advises on the same notion of being passionate about a desired career path and taking action to show one's capabilities in leadership. This concept aligns with the previous theme of *working hard*.

Take your time and be patient. While the previous theme of following one's passion translates to achieving one's desired career path with vigor and eagerness, three of 15 participants (20.0%) share their advice to be patient (P10, personal communication, February 16, 2017) and to not "go up the ladder too fast" (P6, personal communication, February 10, 2017).

P10 cautions against creating too lofty of goals, such as becoming a CEO within 5 years of graduate school. Instead one should take the time to reflect and "set realistic goals that are more geared towards your development, less about what position should one be in" (P10, personal communication, February 16, 2017). One participant serves as the preceptor leader in her organization's administrative fellowship program, which she had firsthand experience matriculating through. P13 shares with administrative fellows that "the path is not always straight," and that she accepted several lateral positions within her organization that contributed to her growth by giving the participant the opportunity to reinvent herself and conquer new challenges (P13, personal communication, February 22, 2017).

Possess good decision-making skills. To become a solid leader requires the ability to make good decisions. Three of 15 participants (20.0%) believed in the significance of this skill as one moves onto the next level in their career. P7 advises to "be thoughtful or good in making decisions" (P7, personal communication, February 13, 2017). P9 adds, "let your natural gifts and talents flourish. I have seen cases when folks have been able to do that, which takes great balance, discernment, and discipline" (P9, personal communication, February 14, 2017).

Interview question 11 summary. Question 11 provides several recommendations for aspiring young leaders to consider in their career journey. As the participants were once aspiring young leaders who are successful in their paths, their advice should bring value and inspiration to many young graduates as they reflect on their next move. A total of 10 substantial recommendations emerged from these particular questions: emotional intelligence, be a lifelong learner, be an authentic leader, make an impact, find a mentor, work hard, develop a professional and support network, follow your passion, take your time and be patient, and possess good decision making skills.

Interview question 12. If you could start over, what would you do differently? Through data analysis of responses to this interview question, four themes emerged. The following themes are presented here in descending order beginning with the theme that was shared amongst the highest number of participants: I would not change anything; each experience fostered learning; work life balance; and more confidence (See Figure 16).
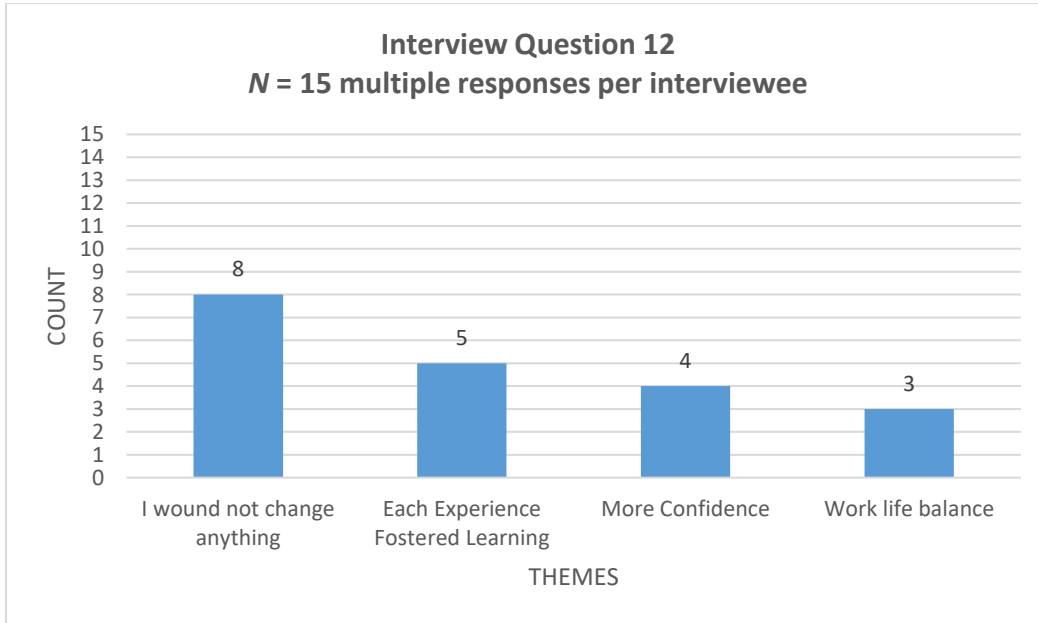

Interview Question 12
***N* = 15 multiple responses per interviewee**

Figure 17. IQ 12: Would you do anything differently?

I would not change anything. The majority of the participants expressed that they would choose to not change anything in their career. Eight out of the 15 participants (53%) shared the same viewpoint of being fully satisfied with their career journey. In fact, three out of the 15 participants (20%), expressed that they had no regrets. P3 clarifies that not wanting to change anything is far from the notion of egoism, but rather the participant admits imperfection and missteps, which unites the next emerging theme, each experience fostered learning.

Each experience fostered learning. Five of the fifteen participants (33.3%) reported that they would not do much differently in their careers as they felt that each challenge, misstep, or opportunity fostered learning and personal growth. This was evident in P9's remark: "Everything

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that I've done and everything I've gone through has helped shape my leadership and everything experientially that has informed who I am today and view the world today" (P9, personal communication, February 14, 2017). P3 strengthens the value of this theme by the following candid remark: "I've enjoyed everything every step of the way. I've fallen plenty of times but have landed on my feet, so no complaints" (P14, personal communication, March 2, 2017).

More confidence. Four of 15 participants (26.7%) shared that they would be more confident, and less insecure. P13 stated:

> I wish that I would've had more confidence. I knew at times it was the right thing to do, but maybe because of my age or lack of experience, I didn't push hard enough for some of the things. It might have been an employee that wasn't working out, but I didn't want to make that final decision. In hindsight, I could see the impact it could have had on the whole department with having the bad apple. (P13, personal communication, February 22, 2017)

Similarly, P15 talked about the desire to have learned how to have difficult conversations earlier on. Not dealing with conflict could be due to fear, and therefore, P15 reflects, "Certain problems I could have been addressed more quickly, and I could have been a more effective leader if I had really intentionally learned to have difficult conversations" (P15, personal communication, March 3, 2017). Finally, P2 recalled the following, "I just missed stuff and me personally, because of fear, insecurity and inexperience, I wasn't at my best. When you come from a place of fear and insecurity, that's when you regret a lot of your actions (P2, personal communication, January 30, 2017).

Work-life balance. As all 15 participants had to work hard to get to their current executive positions, they had to sacrifice things along the way. Accordingly, three of the 15

participants (20.0%) answered interview question 12 with statements that indicated they would have wanted better work-life balance. P8 noted:

> I would adjust my sleep habits and work life balance early on. Work long is not the same as work hard. You have to work smart. I worked long hours —16 hours day. I could have done it in 65% as many hours by being judicious and taking care of my personal health. I could have just done it as effectively. (P8, personal communication, February 13, 2017).

Interview question 12 summary. The majority of the respondents found that each experience, whether positive or negative, was an opportunity to learn key lessons that fostered personal growth. Hence, 53% of the participants mentioned in some form that they did not have any regrets and would not change anything. Conversely, 20% felt that their success caused personal sacrifices along the way, therefore suggesting that practices that supported better work-life balance would have been something that they would have done differently. Finally, a small percentage of participants (26.7%) would have demonstrated more confidence, and less insecurity or fear. Once leader alluded to the notion that increasing one's confidence comes with experience and maturity.

Research question 4 summary. Research question four asked, "What recommendations would healthcare leaders under the age of 40 provide to aspiring leaders?" To elicit feedback in response this research questions, two interview questions were posed:

- IQ 11: What advice would you give to aspiring young leaders entering into leadership positions?

- IQ 12: If you could start over, what would you do differently?

A total of 14 themes emerged from the responses to the two interview questions. The themes have one common thread, which collectively speaks to what it takes to be a successful healthcare

leader coming from a background of minimal work or management experience. If one were to inhabit the shoes of one of these effective young leaders, they would see the importance of the following recommendations and advice (See Table 8). The multitude of recommendations that emerged from a total of 92 coded elements under research question four, corroborates the notion that there is not one path for every single aspiring leader, but rather multiple key facets to becoming a great leader.

Table 8

Summary of Themes for Research Question 4

IQ 11: Advice for aspiring leaders	IQ 12: What would you do differently?
Demonstrate emotional intelligence	I would not change anything
Be a lifelong learner	
Be an authentic leader	Each experience fostered learning
Make an impact	
Find a mentor	Work life balance
Work hard	More confidence
Develop a professional/support network	
Follow your passion	
Take your time and be patient	
Possess good decision-making skills	

Chapter 4 Summary

The purpose of this phenomenological qualitative study was to determine the best practices and strategies utilized by young healthcare leaders under the age 40 in leading their respective healthcare organizations. Fifty-seven unique themes emerged from the responses of 15 participants representing various healthcare organizations. They were asked 12 semi-structured interview questions focused on four research questions that served to elicit valuable feedback on strategies, practices, and challenges of young healthcare leaders. Research question three sought to determine methods for defining and measuring success in healthcare organizations. Finally, research question four prompted recommendations for aspiring young leaders.

The top three themes overall included servant leadership, emotional intelligence, and authentic leadership. Servant leadership was the top theme that emerged in two separate interview questions (IQ1 and IQ3), and was mentioned directly or indirectly by participants 24 times. Authentic leadership was mentioned 18 times, either directly or indirectly by participants, and emerged in three separate interview questions (IQ1, IQ3, and IQ11). Emotional intelligence was the third top theme that was mentioned as a key leadership behavior in leading healthcare organizations. Through coding and data analysis of transcribed interviews, servant leadership, emotional intelligence, and authentic leadership represent the overarching leadership strategies and practices of young healthcare leaders, and top recommendations for aspiring leaders. The number one challenge faced by healthcare leaders is the constant change that occurs with federal regulations. Utilizing key performance indicators was the top theme mentioned by 93.3% of participants as the method for measuring and tracking the organization's performance and success. The themes are highlighted again for review in Table 9 and will be discussed in Chapter 5 in greater detail, along with implications, recommendations, and conclusions of the study.

Table 9

Summary of Themes for Four Research Questions

RQ1: Strategies and Practices	RQ 2: Challenges	RQ3: Measurement of success	RQ4: Recommendations
Transformational Leadership	Competing priorities (*)	Team Development and Success	Emotional Intelligence
Team Leadership	Resistance	Organizational Success	Be a Lifelong Learner
Authentic Leadership (2)	Time	Personal Achievement	Make an Impact
Servant Leadership (*)	Limited resources/capital	Reduced Staff	Be an Authentic Leader
Emotional Intelligence	Fear of change	Turnover	Find a Mentor
Patient Centered	Regulatory Changes (*)	Engaged Workforce	Work Hard
Change Management	Healthcare Reform	Focus on Quality	Professional Support Network
Educate people on reason for change	Patient Expectations / Engagement	Focus on patient experience	Follow your Passion
Engage people in the process	Competition	Cost Conscious	Take Your Time, Be Patient
Listen and Empathize	Managing Human Capital	Financial Growth and Stability	Good Decision Making Skills
Build a guiding coalition	Managing Change	Key Performance Indicators	I wound not change anything
Democratic	Managing Financial Capital	Transparency of data	Each Experience Fostered Learning
Tenacious Work Ethic	Proving Credibility	Dashboards/Reports	More Confidence
Ego-less	Level of Experience/ Knowledge	Balanced Scorecard	Work life balance
	Perceptions of Youth		
	Next Career Move		

(continued)

Table 9. Summary of Themes for Four Research Questions. *Note*. * indicates the theme emerged an additional instance

Chapter 5: Conclusions and Recommendations

Healthcare organizations across the United States share the same mission to serve a sick and vulnerable population, and to keep others healthy through preventative care. In recent years, the mission of addressing the health of millions has been clouded by competing priorities and challenges incited by federal legislation and regulatory changes. Leaders in the healthcare industry have the difficult role of ensuring that continuous changes are handled appropriately at the system level, while balancing the pressures of diminishing financial capital, improving quality, reducing costs, and limited human capital to care for millions of Americans.

The type of individual leading a healthcare organization will make a difference in the performance and success of the organization. There are seasoned healthcare executives with years of experience behind them, with varying leadership styles. As the baby boomer generation continues to retire, there is a new class of up-and-coming leaders in healthcare who are classified as members of the millennial generation or Generation Y born between the years of 1977 and 1995. An exemplary group of young healthcare leaders who have been promoted into executive roles before the age of 40 have been highlighted in two well-known healthcare trade publications, *Becker's Healthcare* and *Modern Healthcare*.

In order to contribute to literature in the field of healthcare administration, leadership, and change management, this study served to gather advantageous and inspirational knowledge from members of the elite group of young healthcare leaders recognized in *Becker's* and *Modern Healthcare*. The goal of the study was to deliver current research on the challenges in healthcare and obstacles of being a young leader. It is helpful to understand successful strategies, practices, and measurements of success from a successful young leader's perspective. Furthermore, the results and recommendations from this study will benefit young healthcare leaders in their

current leadership roles and aspiring young healthcare leaders looking for career growth opportunities.

The objective of chapter 5 is to present the conclusions and recommendations of the research study. A summary of the study will be provided followed by highlights of the study results as they relate to existing literature. The outline of chapter 5 will continue with a discussion of implications of the study, recommendations for future research, study conclusions, and final thoughts.

Summary of the Study

This descriptive, phenomenological qualitative study was designed to gather firsthand thoughts, knowledge, and wisdom on the leadership practices, organizational challenges, and strategies of young leaders in healthcare. The research study consisted of five phases. The first phase involved defining the purpose and objectives of the study in chapter one. Four research questions with corresponding interview questions was foundational to the research study:

RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?

RQ2: What challenges are faced by healthcare leaders under the age of 40 in leading their respective organizations?

RQ3: How do healthcare leaders under the age of 40 measure their success and the performance of their respective organizations?

RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?

Phase two of the study involved a review of the existing literature that informed the researcher on the four research questions. First, the literature review cited prevailing challenges

for healthcare organizations and their leaders, including a discussion of healthcare reform initiatives and regulatory demands. This portion of the literature review informed research question two on the challenges faced by healthcare leaders under the age of 40. Secondly, the literature review delved into a discussion of the various conceptual frameworks that define high-performing organizations. This information served to substantiate some of the definitions provided by the participants in research question three, interview question 9, which asked participants to define what constitutes a high performing, successful healthcare organization.

Research question 1 was informed by the subsequent section of the literature review on the strategies and practices of healthcare leaders, which features three frameworks: Evidenced Based Leadership Framework (Studer, 2013), High Reliability Healthcare Maturity Model (Chassin & Loeb, 2013) and John Kotter's "Eight-stage process of creating major change" (Kotter, 2012, p. 23). Next, two frameworks, the Pillar Framework (Studer, 2013) and Balanced Scorecard (Kaplan & Norton, 2007) informed research question three on methods for measuring performance and success. Furthermore, several theories of leadership evident in healthcare were described, which informed research question one, as well as research question four. The leadership theories that were discussed in the literature review included lean leadership (Liker & Convis, 2011), transformational leadership (Bass & Riggio, 2006), servant leadership (Greenleaf & Spears, 2002), and leadership in self-managed teams (Yukl, 1997). The final section of the literature review conveyed implications for young aspiring leaders with a discussion on ageism, social dominance theory, reverse ageism, and discrimination in the workplace. This portion of the review informed research question two, specifically interview question seven, which asked participants to speak about the obstacles of being a young leader in healthcare.

The third phase of this research study was centered on the research design and methodology. For the purpose of this research study, the participants were recruited through the purposive sampling technique. The Becker's list of *Rising Starts: 25 Healthcare Leaders Under Age 40* and *Modern Healthcare's* annual "Up & Comers Award" from 2012 to 2016 served as the two sources to develop the master list, and subsequently the sampling frame. Based on the inclusion and exclusion criteria outlined in Chapter 3, the master list of 211 individuals was narrowed down to 26 individuals who were initially contacted via LinkedIn. Participants were engaged based on their characteristics, knowledge, time availability, inclination to participate, and involvement in healthcare leadership.

A total of 15 participants agreed to participate in the research study after a total of 40 healthcare leaders were invited to participate via LinkedIn. Semi-structured interviews were conducted using an interview protocol vetted by two inter-raters (Pepperdine doctoral candidates), and an expert panel made up of dissertation committee members. Interviews were transcribed, and then coded. While coding, the researcher captured elements from each participant's transcribed interviews that responded to each interview question. Themes began to emerge for each interview question. To validate reliability of coding, two interraters reviewed the coding for the first three interviews and made suggestions to the naming conventions of themes, as well as the coded elements that fell under each theme. The fourth phase of the research study was captured in Chapter 4 in which all themes were presented and substantiated through participant statements. The final phase of the study entails a discussion of the research findings in the following sections.

Discussion of Key Findings

The main audience that may find the results of this study to be beneficial is young leaders in healthcare, whether they may be current leaders in a managerial or leadership role, or aspiring leaders looking to transition into a leadership role in the future. In the subsequent sections, the findings of the study will be reviewed and compared to existing literature. Moreover, added emphasis will be placed on specific themes for each research question that had the highest frequency of discussion among the 15 participants.

RQ 1: Strategies and practices employed by healthcare leaders. In research question one, participants shared their leadership strategies, practices, and characteristics that prove to be beneficial in their leadership roles. There were 14 different themes that emerged from three interview questions. The top three themes included the following leadership frameworks: servant leadership, transformational leadership, and authentic leadership. It is significant to note that the leaders conveyed strategies and practices that were more relational in nature versus task oriented, therefore demonstrating the importance of the people skills in the healthcare industry. To further corroborate this focus on people orientation, 93.3% of participants stated that characteristics of a servant leader were vital to their career growth.

Transformational leadership has been noted to demonstrate conceptual overlap with servant and authentic leadership, which are considered newer or emerging forms of leadership (Hoch, Bommer, Dulebohn, & Wu, 2016). Servant leadership, transformational leadership, and authentic leadership fall under an overarching category called positive leadership, which emphasizes "leaders behaviors and interpersonal dynamics that increase followers' confidence and result in positive outcomes" (Hoche et al., 2016, p. 2) As the three leadership categories have

similar traits, it was a challenge to differentiate some of the coded elements, which is why the inter-raters played a major role in helping to clarify themes.

To provide some distinction between the three leadership frameworks, further research needed to be conducted during the coding process. A meta-analyses study by Hoch et al (2016) helped guide the distinction between the three overlapping leadership forms. While there was a high correlation between authentic leadership and transformational leadership, it was revealed that servant leadership appears to demonstrate "a higher degree of conceptual and empirical distinctness from transformational leadership" (Hoch et al, 2016, p.26). Therefore, servant leadership stood as its own leadership framework, while authentic leadership had some context redundancies with transformational leadership.

While 73.3% of the participants shared characteristics indicative of transformational leadership, some research has demonstrated how transformational leaders may lack ethical or moral foundation, also exemplifying a self-serving character that is void of values (Bass & Steidlmeier, 1999; Tourish, 2013). Therefore, any mention of moral values by the participants of the study was grouped into the authentic leadership theme. The four components of transformational leadership (e.g. idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration) helped to clarify the coded elements that fell under the transformational leadership theme (Bass & Riggio, 2006).

It is important to note several consistent patterns in existing literature between servant leadership and authentic leadership, which further complicated the coding process in research question one. First, both types of leaders are positive in nature, and share positive psychological traits such as authenticity (Avolio & Gardner, 2005; Walumba et al., 2008), psychological maturity with regard to work ethics (Avolio & Garner, 2005). Consistent with findings, 66.7% of

the participants mentioned being authentic as a key practice. Second, morality is another concept

that ties the authentic and servant leaders together (Wu, E. C.-Y, Fu, Kwan, & Liu, 2013). The

participants of the study discussed moral characteristics such as integrity (P1, P11, P13),

humility (P6, P10), honesty (P11, P13), reliability (P9), and trust (P3, P4, P5, and P13). Ling et

al. (2017) describes how these moral values guide authentic and servant leader's decision

making. Third, an emphasis on leader-follower relationships and developing followers illustrates

another overlapping characteristic of a servant or authentic leader (Derue, Nahrgang, Wellman,

& Humphrey, 2011). Several participants in the study articulated their objective to lead by

example and to provide employees the support that they needed to be successful.

Although authentic and servant leaders carry similar and almost identical attributes, it

was necessary to differentiate between the descriptions of an authentic leader and servant leader

in order to better analyze participant responses. The servant leader was characterized by their

self-sacrificing and altruistic tendencies. For example, several leaders spoke about rolling up

their sleeves to work with their staff. While authentic leaders concentrate on personal

development and development of their followers, the servant leader balances responsibilities to

many stakeholders, including the staff, the organization, the patients, and to society at large

(Ehrhart, 2004; Walumbwa, Hartnell, & Oke, 2010). The servant leader's own personal

development is not a priority. Conversely, the needs of the leader's employees and the patients

served take precedence over their own personal desires.

Interview question two asked how participants would overcome resistance and opposition

to strategies and practices. Educating people on the reason for change, engaging people in the

process, and listening and empathizing were the top three strategies for overcoming resistance.

All three strategies relate back to a servant leadership mentality of considering the needs of the

people by raising their awareness, including them in the change to further develop their skills and understanding, and fostering trust between the leaders and the people.

In summation, there are three main leadership frameworks that emerged from two interview questions under research question one. Servant leadership was mentioned by all but one participant. Transformational leadership and authentic leadership were the other top leadership styles that were acknowledged by participants. Each participant did not subscribe solely to one leadership style, but rather they mentioned different aspects of each of the three leadership styles making them multi-faceted leaders. Lastly, to prevent resistance and opposition to a new strategy, it is best to involve the workforce pre-and post strategy implementation to listen to their feedback and concerns.

RQ2: Challenges Faced by Healthcare Leaders Under the Age of 40. Participants reported the internal and environmental challenges they face in implementing strategies and practices in their respective healthcare organizations. Three interview questions focused on organizational and operational challenges, while a fourth interview question focused on individual challenges faced by young leaders under the age of 40. In total, research question two facilitated the emergence of 19 themes.

Interview question 4 focused on challenges faced while implementing strategies and practices. Competing priorities was a top theme, along with lack of time as a complementary theme. Both go hand-in-hand with regulatory changes that cause priorities to shift. Three participants commented on how healthcare is changing so rapidly, which is apparent in existing literature and in the current events mentioned in the media. P12 notes how federal, state, and local regulation changes can cause the organization, leadership, and workforce to go in multiple

directions. Regulatory changes will be further evaluated as a theme under external environmental challenges.

Consistent with the literature, regulatory changes represent external environmental challenges that are tied to healthcare reform, a theme that emerged in interview question 5. The literature on healthcare administration and economics contain information on a widely-used term called the Triple Aim, which is comprised of three main goals meant to improve the overall status of the American healthcare system. Improving quality outcomes for patients, enhancing patient satisfaction, and decreasing costs for the population served make up the Triple Aim goals that govern many of the regulatory changes (Berwick et al., 2008).

Three participants (P1, P5, P7) mentioned Medicare Access and CHIP Reauthorization Act ("MACRA") as an example of a regulatory change, which was enacted by Center for Medicare and Medicaid Services (CMS) in 2015. It institutes a true form of a fee-for-value reimbursement model that adjusts how providers will receive Medicare Part B professional payments based on different measurable outcomes, with quality as a priority (cms.gov, 2016). Under MACRA, providers will be paid under Merit-Based Incentive Payment System (MIPS) or Advanced Payment Model (APMs), which are examples of pay-for-performance (P4P) models (Santilli & Vogenberg, 2015). Healthcare organizations must ultimately adapt to the requirements governed by either payment model to ensure they can maintain sustainable Medicare reimbursements for the organization (Studer Group, 2016). MACRA and CMS initiatives brought about the need to record, track, and report on additional measures to federal levels.

Healthcare reform is another external environmental challenge that 60% of the participants cited. Before data collection commenced, the healthcare reform stage was different

from what it is post data collection, which further substantiates the notion of how the healthcare landscape is rapidly evolving. The first participant interview for the research study was conducted just a few days after the inauguration of the 45th president of the United States of America, Donald Trump. Prior to president Trump taking office, former president Barack Obama was known for the Affordable Care Act, which provided millions of uninsured Americans with health insurance between 2010 and early 2016 (U.S. Department of Health & Human Services, 2016). While the intent of the historic healthcare reform initiative granted millions of uninsured individuals health care coverage (Blumenthal, Abrams, & Nuzum, 2015; Keehan, et al., 2011), the literature cites the increase in national health care spending to $2.6 trillion in 2010, and the expectation of an additional 5.8% increase annually from 2010 to 2020 (Keehan, et al., 2011).

In response to the federal deficit, President Trump and the Republican party is working towards passing the GOP health care bill, named the American Health Care Act, which by 2018, 5 million less Americans would be covered by Medicaid (Lee & Luhby, 2017). Furthermore, 14 million Americans would be uninsured by 2018 and up to 52 million in 2026. The economic impact would be a reduction in the federal deficit by $337 billion over a 10-year period. Several of the participants referenced the uncertainty of healthcare reform at the time of their interviews. Now the fear for healthcare leaders is that more uninsured Americans could drive up the costs in healthcare organizations, as more people will not seek preventative care, and will show up to hospitals sicker and at higher acuity levels. Essentially the finances of a healthcare organization could take a hit based on dwindling reimbursements, or no reimbursements for uninsured patients. Managing financial capital is an internal environmental challenge that emerged as a theme in IQ6.

In IQ6, four internal environmental challenges were mentioned by the participants: managing human capital, managing change, managing financial capital, and competing priorities. First, 46.6% of the participants viewed managing human capital as a main internal environmental challenge. Before ACA was implemented, there was a pre-existing shortage of healthcare professionals including primary care physicians and nurses. As millions of previously uninsured Americans gained health insurance, the literature states that there was a rising demand for healthcare services, which subsequently exacerbated the ongoing shortage of healthcare professionals (Anderson, 2016; Health Resources and Services Administration, 2016; Stefl, 2008). The healthcare workforce shortage and increased demand for services has created additional stress for health professionals, resulting in burnout, dissatisfaction and even resignation of healthcare providers.

Healthcare leaders are called to lead with fewer resources and reduce costs because of decreasing and fluctuating reimbursements rates (Anderson, 2016; McAlerney, 2006; Stefl, 2008). As such, another internal environmental challenge was managing financial capital, which 40% of the participants reported. With the efficiencies being imposed due to regulatory demands, workforce shortages, and the financial constraints, leadership must create changes that have an impact on the organization and employees. P12 spoke about the lean management strategy, which according to the literature is a widely used management approach to identify and remove waste from an organization (MacInnes, 2002), improve productivity (Lewis, 2000), decrease overall cost of a process (Lewis, 2000; MacInnes, 2002). Lean management emphasizes the value assigned to any process by differentiating between value-added steps and non-value-added steps, and removing any non-value add steps from the process (Institute for Healthcare Improvement, 2005, p. 2).

Change creates fear (P8), anxiety (P10), and a resistance due to shifting norms. These employee sentiments all fall under the third internal environmental challenge of managing change. Ultimately, it comes back to managing the change by reminding the employees of meeting patient needs, and following some of the themes that emerged in IQ2 of educating, engaging, and empathizing with staff concerns.

To wrap up the challenges section of the research study, participants candidly spoke about the specific obstacles of being a young leader. Due to one's level of experience or knowledge in leadership and healthcare, participants spoke about the need to prove credibility. Participants were forthright and accepting of the fact that when they started early in their careers that they lacked the experience and knowledge of their colleagues and superiors. Because of the higher standard that younger healthcare leaders are held to in the beginning of their careers, it is imperative that they place more effort, time, and energy into gaining the wisdom and level of expertise of colleagues.

The perception of youth was the third obstacle mentioned by one third of the participants, which is where the literature on perceived age discrimination is tied in. Participants shared how they were addressed as the "*kid,*" and others were questioned about their knowledge and ability to run a clinical enterprise. Another healthcare leader mentioned being acknowledged as the intern or secretary, which made it difficult to be taken seriously by colleagues. Existing literature states that perceived age discrimination is associated with higher psychological distress (Yuan, 2007), and diminished organizational commitment and stress. While participants faced doubt from colleagues and some discrimination based on their age, there was not a discussion of stress or losing commitment due to this particular obstacle. Instead, participants were eager to share how they overcame the doubt and rose above it. They were motivated to work harder to

prove their credibility. The participants worked to build relationships and utilize mentors along the way. Others were humble, approached things with an open mind, and listened.

RQ 3: Measurement of success and performance. To respond to research question 3, participants were asked three interview questions to define three concepts: (a) their definition of personal success as a leader, (b) what constitutes a high-performing, successful healthcare organization, and (c) how they measure and track the organization's performance and success. A total of 14 themes emerged from the responses to the three interview questions.

Participants defined and measured their personal success as healthcare leaders based on their team's development and success, as well as the organization's success. The two other themes that emerged included personal achievement of goals set by the organization and superiors, and reduced staff turnover. It is noteworthy to point out that two of the themes had to do with employee engagement, which included measuring development, success, and willingness of the employees to stay with the organization. 60% of the participants stated that their team's development and success was the defining aspect of their success a leader, which coincides with 93% of the participants demonstrating servant leader characteristics. Team development and success and organizational success together more closely aligns with a transformational leader's purpose.

In IQ9, high performing and successful healthcare organization was defined by six themes: good quality outcomes, an engaged workforce, patient experience, cost consciousness, financial growth and stability, and community outreach. These six themes were in alignment with the five influential factors of high performing healthcare organizations as defined by Alliance for Health Care Research (2005), namely, quality indicators benchmark above 25% of outcomes; turnover is below 12%; patient satisfaction scores fall in or above the 85th percentile;

operating income is more than 6%; growth from previous year is more than 5%. The one area

that was not in alignment was community outreach. With the majority of the participants being

of servant leadership mindset, it is no surprise that community outreach emerged as a theme.

Per the extensive review of literature on high performing organizations in Chapter 2,

there are several comparable terms that mirror high performing organizations including high

performing hospitals (Taylor et al., 2015), high performance work systems (Harley et al., 2007),

high performance work practices (HPWP Garman et al., 2011), high-involvement work systems

(HIWS Harmon, et al., 2003), and high-reliability organizations (HROs Chassin & Loeb, 2013;

Weick & Sutcliffe, 2007). The one aspect that connects all of these different frameworks for high

performing organizations is the emphasis of human resource functions and leadership and

management interactions that directly impacts employee engagement and organizational

performance. In comparison, the participants of the study placed emphasis on an engaged

workforce as being an indicator of high performance. Furthermore, one can relate back to the

findings in research question 1 that emphasized leadership practices and characteristics that

focused on supporting, developing, coaching, and motivating employees to be successful.

In interview question 10 healthcare leaders communicated the methods used to measure

and track the organization's performance and success. A strong majority, 93.3% of the

participants, directly or indirectly mentioned the utilization of key performance indicators

(KPIs), which is a method for quantitatively measuring and assessing the organizational health

and performance related to organizational goals (Abujudeh, Kaewlai, Asfaw, & Thrall, 2010).

KPIs help in assessing quality, and other strategic goals including targets and benchmarks related

to strategy and vision. Participants named actual KPIs in their responses such as turnover rate,

patient satisfaction scores, volume metrics, and employee engagement scores. Other participants

reported specific quality metrics such as readmission rates in the hospital, stroke measures, or cardiac measures. Per Abjudeh et al (2010), progress with KPIs can be tracked using a balanced scorecard (Kaplan & Norton, 2007) or performance dashboards.

Consistent with the literature on the performance measuring methodologies currently used in healthcare organizations, balanced scorecard was mentioned explicitly by 40% of the participants, while dashboards were mentioned by 46.7% of the participants. Also in alignment with the literature review was the pillar framework by Studer (2013), which focuses on quality, finance, service, people, and community involvement. While leadership can have balanced scorecards and dashboards to monitor and evaluate the organization, the data cannot be actionable without sharing it with staff. 60% of the participants believed in transparency and receiving input from frontline staff regarding the KPIs. With transparency as a key theme that emerged in this question, it provides an opportunity to discuss action plans for areas of improvement and celebrations for areas of success.

RQ 4: Recommendations for aspiring leaders. The wide array of recommendations that emerged from a total of 92 coded elements in research question 4, authenticates a key lesson that there is not one path for every single aspiring leader, but rather multiple pathways to becoming a successful leader. The 92 coded elements were funneled down to 14 themes based on two interview questions. As the healthcare leaders under the age of 40 emerged into their current executive roles early on in their careers, it would be advantageous for young aspiring leaders to hear their wise recommendations for leadership success. The advice provided to aspiring young leaders is the following: display emotional intelligence; be a lifelong learner; be an authentic leader; make an impact; find a mentor; work hard; develop a professional and support network; follow your passion, take your time and be patient; and possess good decision making skills.

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Emotional intelligence (Goleman, 2000) and authentic leadership are the two recommendations that are validated in existing literature.

In the final interview question, participants were asked what they would do differently. More than half of the participants, 53.3%, felt that they would not change anything. Everything that has occurred in their journey, whether positive or negative, fostered some type of learning. Aspiring young leaders can find comfort in knowing that obstacles and missteps along the way helped foster the growth and development of an exemplary group of leaders.

Implications of the Study

Implications for aspiring and current leaders. As a few studies explore the experiences of healthcare leaders under the age 40, a phenomenological study dedicated to discovering their lived experiences, best practices, challenges, and recommendations was key to enhancing the existing research and providing young aspiring leaders guidance on getting to the next step in one's career. One of the themes of the study is the idea of servant leadership as a dominant trait among these young, bright healthcare leaders. Aspiring leaders can see the value in supporting employees, coaching them, and working alongside them in a service oriented industry, such as healthcare.

While discrimination against the older generation (40 or older) is protected under the Age Discrimination in Employment Act (1967), the same protection for individuals who are under 40 does not exist to the same degree. Therefore, one of objectives of the study was to see what societal obstacles were faced by young adults taking on leadership positions at early stages of their careers. The hurdles the participants overcame, or in some instances continue to face, include the following: having to prove their credibility in the organization, lack of experience and knowledge, and perceptions of youth. Aspiring and current leaders from all industries can

benefit from the pearls of wisdom from the young healthcare leaders who became leaders in their twenties and early thirties and learned to rise above the backlash of social dominance theory (Sidanius et al., 2004).

As the participants conveyed how being successful as a young leader comes with its set of challenges, the key lesson is that every obstacle that is overcome creates an opportunity for learning. Because of this incentive for development and growth, more than half of the participants would not change anything about their journey, no matter how difficult. The advice for aspiring leaders is to always cultivate key relationships despite pushback, unwillingness, and doubt from the other party.

Building and maintaining relationships is the central idea of the research study. These significant relationships refer to individuals encountered across the continuum of a leader's career, from inception to their current role. Moreover, fostering relationships with people whom they plan to meet in the future is qualified by building one's professional network. When revisiting the purpose of this study, the four research questions helped facilitate the process for understanding the best strategies and practices of young healthcare leaders under the age of 40. Therefore, the key finding that was shared by the participants can be traced back to the underlying theme of building and maintaining relationships (see Figure 18):

Figure 18: Key Finding: Building and Maintaining Relationships

- The premise of research question 1 was to determine the strategies, practices, and leadership characteristics of young healthcare leaders. Participants shared leadership theories that resonated with the idea of engaging and developing the entire workforce. For example, servant leadership, transformational leadership, authentic leadership, and team leadership share the common goal of developing the team or individuals. Emotional intelligence was also an emerging theme that demonstrates the importance of empathy, social skills, motivating others, and awareness of others' needs or concerns. These characteristics all boil down to how a leader cultivates a relationship with a superior, subordinate, peer, or the other stakeholders in healthcare, such as the patients. Almost half of the participants spoke about tying all decisions and strategies back to the patient, which highlights the significance of the patient and provider relationship.

- In research question 2, participants expressed the challenges they experienced in leading the day-to-day operations, as well as in implementing strategies. With healthcare rapidly changing, there are different priorities taking up people's limited time causing resistance

or chaos depending on the regulatory change inciting immediate action or changes to people's comfort zone. As such, handling the fear, anxiety, or resistance of people due to change starts with a foundation of trust and confidence in managing the change appropriately. The participants shared wisdom on dealing with resistance and opposition in research question 1: 1) Educate people on the reason for change, 2) Engage people in the process, 3) Listen and empathize, and 4) Build a guiding coalition of individuals who could partner as a champion in the change effort. These four themes again refer back to how one utilizes their relationship skills to introduce and implement a new change or strategy. As for obstacles faced by a young leader, proving one's credibility among individuals 20 or 30 years older was the main challenge. A solid level of interpersonal skills in fostering relationships is needed to earn the trust, respect, and confidence of others.

- Research question 3 is centered around defining the success of an individual leader, the success of an organization, and then measuring the organization's results. To track and monitor superior results of a leader, the participants of the study articulated that the primary indicator of one's success is team development and the team's success. Developing other individuals requires mentorship and coaching, which begins with establishing a relationship between leader and follower.

From the lens of the participants, a high performing organization is defined by whether results reveal a culture that engages workforce, focuses on patient experience, engages in community outreach, focuses on quality, cost savings, and financial growth and stability. The first three themes relate to fostering commitment among employees and ensuring there is an overall shared vision to serve the patients and the community. To engage the

workforce in a consistent mission and vision requires communication skills and setting

clear expectations from a leader who has strong people skills. The latter three identifiers

of a high performing organization that focus on quality and the financial status of the

organization require the influence of employees and physicians. Leaders spoke about

rounding (Studer, 2013), or speaking to the frontline and providers about the

organization's performance on these goals, and receiving their feedback on how their

department could improve. Again, it takes a leader who is willing to invest the time to

listen and also be transparent with the entire workforce.

- Some of the advice that participants can impart through research question 4 is also

  relationship based. Demonstrating emotional intelligence in interactions was the main

  advice shared. One participant advised to be a lifelong learner by being open to learning

  from individuals who one would not expect to learn from. Several leaders spoke about

  the importance about finding mentors who could provide an aspiring leader with

  guidance. Discovering a suitable mentor and developing a professional network requires

  building and maintaining fruitful relationships with other individuals.

There is a clear lesson learned from 15 successful healthcare leaders who embody servant leader,

authentic, transformational, team-oriented, and emotionally intelligent characteristics. By having

the ability to communicate, listen, and empathize with different levels of the organization,

developing trust and confidence between leaders and employees is critical during unpredictable

times of change. Essentially, in an industry where change is the norm, overcoming internal and

external challenges is simplified for leaders who maintain solid connections with people of the

organization.

Implication for healthcare organizations. Resistance and opposition is common in organizations undergoing immeasurable change on a constant basis. A new change framework has emerged in this research study, which can be used to overcome challenges related to changes in healthcare, or in any organization. It combines the servant leadership aspects of educating the people on change and including them in the process, as well as the emotional intelligence aspect of listening and empathizing with people on their concerns (see Figure 19).

Educate people on reason for change: how will the patient be impacted?	Engage people in the process
An Engaged Workforce	
Listen and Empathize	Build a guiding coalition

Figure 19: A Change Management Framework for Healthcare Organizations: Dealing with Resistance and Opposition to Change

For leaders educating physicians and the frontline on the change, data speaks volumes when trying to substantiate the reasons behind the strategy for change. Part of the theme of educating people on the change included commentary on relating the change back to how it will positively impact the patients. Being patient-centric speaks to physicians and employees who care about the wellbeing and experience of their patients.

As the workforce are on the frontline experiencing the day-to-day obstacles, their feedback is valuable and immensely applicable. The practice of engaging people in the process and seeking feedback from employees is consistent with the aligned behavior component of the Evidenced-Based Leadership Framework by Studer (2013). Rounding for outcomes is the

practice in which leaders actively engage in conversations with frontline staff in the work setting to receive feedback on opportunities for improvement in clinical processes (Studer, 2004).

When information is presented, leaders should open the floor to the people to speak about opportunities for improvements. Leaders need to actively listen and engage in what physicians and employees have to say. Building a guiding coalition per Kotter's change theory is the other theme that arose from the participants' responses. When it is time to deliver on an agreed upon strategy, it is helpful to get physician champions and frontline champions involved to engender more positive uptake of the change effort. Therefore, the overall framework that emerged included the following: (1) educate people on reason for change, (2) engage people in the process, (3) listen and empathize, and (4) build a guiding coalition.

Implications for health administration education. Findings of the study can benefit academic institutions and their students in healthcare majors. Specifically, there are master's programs in healthcare administration (MHA) throughout the United States with students seeking guidance and mentorship post-graduation. The research findings and the key advice shared by the healthcare leaders could be developed into a lecture that can be shared with MHA programs, and even Bachelors programs focused on healthcare management. Students could benefit from the lessons, strategies, and practices shared by the healthcare leaders who were candid and sincere with their responses.

As people of various ages must coexist in healthcare organizations for the benefit of the patients they serve, it is critical that individuals from different generations are able to communicate effectively with one another. Generational awareness training was an idea that emerged through this research study through one of the participants. The general profile of the different generations (millennials, Generation X and baby boomers) and their communication

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preferences would be advantageous for all employees and clinicians to receive in a training. Additionally, any generational stereotypes should be dispelled in the training session. Such information on how these various generations prefer to communicate and to receive communication will help foster team building through improved communication techniques.

Recommendations for Future Research

The research study employed a qualitative approach by interviewing 15 healthcare leaders under the age of 40 in senior level roles ranging from vice presidents to chief executive officers. Although their candid and enlightening perspectives bring valuable insights to the body of literature in health administration and management, leadership, and change management, there are opportunities to explore future research. The following are recommendations for future research that may broaden the findings and advice that can be shared with young aspiring leaders:

1. Conduct a similar study with female participants only: There were 211 individuals in the master list, of which only 27%, or 58 were women. Lantz (2008) cites the underrepresentation of women in senior leadership positions in healthcare, as well as the salary disparity with their male counterparts. A more recent phenomenological study by Baker (2015) investigated the challenges and experiences faced by women during their journey towards earning senior leadership roles in healthcare. In a future research study, it would be interesting to compare the themes shared by the male versus female healthcare leaders, while still controlling for age (those under 40). For the question on obstacles of being a young leader, it would be revised to state: What are the obstacles of being a young female leader in healthcare?

2. Conduct a similar study with healthcare leaders of different age categories, such

as those 40 years and older, and those who have retired: It would be enlightening to understand how the perspectives, challenges, and leadership styles faced by older and more seasoned healthcare leaders compare to young leaders today. Rosenberg (2012) highlights the revolutionary changes that are occurring in healthcare, including the technological and patient centered movement that healthcare leaders must be equipped to embrace. Consumers have immediate access to information on health services and quality, which gives them more choices for healthcare. Rosenberg (2012) asks the question: "Are healthcare leaders ready for the real revolution?" (p. 215). Therefore, the proposed study would focus on how the healthcare leaders of different age categories are dealing with, or have dealt with the "revolution" occurring in the healthcare industry.

3.   Develop a research study from the frontline and workforce perspective to provide insight on what they look for in a leader: In a case study on lean management in three healthcare organizations, it was further substantiated that a coaching and supportive leadership style is critical for inspiring acceptance of change and continuous improvement initiatives (Drotz & Poksinska, 2014).

4.   Develop a research study capturing the perspective of clinical workforce, including physicians and nurses, to provide insight on what they look for in a leader: Research by the Studer Group demonstrates better physician engagement with greater frequency of leadership rounding (Studer, 2013). With every subsequent rounding session with a physician, leaders begin to develop a "human connection" that leads to greater physician engagement. Following rounding with clinicians, it is imperative to work on fixing issues and following up on all concerns that emerge.

5.   Compare and contrast the best practices, strategies, and challenges of healthcare

leaders in different countries: One study explores the value-based interventions in

healthcare in countries such as South Korea, Taiwan, Thailand and Japan (Kamae, 2010).

Goodwin (2006) provides insight into leadership in the context of European healthcare.

The proposed research study would involve interviewing Asian and European healthcare

leaders, and reviewing and comparing their insights with the trends that emerged in this

research study featuring American healthcare leaders.

6.   Develop a quantitative study that identifies what relationships, if any, exist

between the degree of perceived age discrimination, level of organizational commitment,

level of stress, self-esteem, and life satisfaction among early healthcare professionals

under the age of 40: One known quantitative study by Kwesiga (2006) evaluates a similar

population of workers under the age of 40. The research study measured the extent of

perceived age discrimination among workers under the age of 40 and the impact on job

satisfaction, intentions to resign from the organization, self-esteem, and career

development opportunities. The study found that those who experienced age

discrimination also experienced decreased job satisfaction, intentions to quit, increased

levels of stress, and reduced self-esteem.

7.   As mentorship is a key piece of advice shared by the participants of this study,

a qualitative study aimed at developing an ideal healthcare leadership mentoring program

would be beneficial for aspiring healthcare leaders. Four of the participants shared

matriculating through a COO/CEO development program at different healthcare

organizations, which includes preceptorship or mentorship from executives. In previous

research, Finley (2005) performed a descriptive study that explored the benefits of

mentoring by senior level healthcare leaders as a pathway for developing future chief

executive leaders. To design a healthcare leadership mentoring program, past and current members of such COO/CEO development programs would be ideal participants for the study, as well as the senior level executives who are invested in mentoring aspiring leaders.

8.   Conduct a research study on rural healthcare leaders versus healthcare leaders in urban settings. 27% percent of the participants represent a rural community hospital. According to the American Hospital Association (2017), there are 1,829 rural community hospitals compared to 3,033 urban community hospitals. Almost two decades ago, Smith (1994) conducted research on the issues and attitudes of rural and urban healthcare leaders on healthcare reform. Current research on the same topic would incorporate the recent healthcare reform trends, which would bring some relevance to the topic in modern times. It would be advantageous to understand the specific challenges, strategies and practices that are employed specifically in rural settings amidst healthcare reform changes. Aspiring leaders could benefit from learning about leadership in rural community hospitals and as a result be open to leadership opportunities in rural areas.

All of these proposed studies can add tremendous value to the existing literature and to aspiring leaders in healthcare.

Final Thoughts

It is the hope of the researcher that this study provides valuable information for aspiring and current leaders, especially those in the health sector. One's age should never be a deterrent in envisioning one's career. These 15 healthcare leaders are prime examples of being promoted into senior executive roles in their twenties or thirties. However, a few of the participants also cautioned against ascending too quickly. They state that if you are in your twenties or thirties and

have reached a top level executive position, the obstacle becomes a question of where do you go from there. It is a good problem to have, but nevertheless requires personal reflection and perhaps some guided mentorship.

Another key takeaway is that one should not be motivated solely by position title. Passion for the work that one does should be a main motivating factor for career planning. A participant from the study spoke about writing out their own leadership philosophy as requested by a mentor. At the time, the participant had no direct reports, and therefore never managed anyone, but it proved to be a worthwhile exercise. It is beneficial to think introspectively as to the core values that will guide one's leadership style, as well as what will define one's personal leadership success, as well as the success of the organization. Will you be authentic? Will you be transformational? Will you be a team leader? Or will you be like one of these participants who exuded the profile of a servant leader? Or will you be a combination of these leaders? Perhaps in the future you look back on your initial leadership philosophy and compare how you remained consistent with it, or deviated from it throughout your career. The idea is to reflect about who you want to be in the future, and set realistic goals that aligns with one's individual career development.

One final concept is related to change management. As healthcare reform continues to be the topic of yesterday, today, and tomorrow, it is vital that healthcare leaders, new and seasoned, stay informed on the changes, and what it means for their respective organization, and for the patients that they serve. It is important to keep the entire workforce engaged and educated on the legislation enacted and the regulatory changes imposed by federal agencies. When changes must occur due to the regulatory changes or breakdown in processes, the workforce should be engaged in the process so that they may better understand their part in the effort, the reasons for workflow

or process changes, and the impact it will have on the patients. Lastly, it is vital to have a guiding coalition made up of physicians and frontline staff to reinforce the significance of the changes.

Thank you to all interview participants who shared their time, wisdom, and experiences to contribute to the success of this research study. The vital perspectives gathered from the sincere and candid accounts of successful healthcare leaders is now captured in writing and will contribute to the literature on healthcare administration and leadership strategies for years to come.

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APPENDIX A

IRB Approval Notice

PEPPERDINE

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: December 23, 2016

Protocol Investigator Name: Rizalyn Reynaldo

Protocol #: 16-10-431

Project Title: HEALTHCARE LEADERS UNDER THE AGE OF 40 - SUCCESSFUL STRATEGIES AND PRACTICES FOR LEADING HEALTHCARE ORGANIZATIONS

School: Graduate School of Education and Psychology

Dear Rizalyn Reynaldo:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

Informed Consent for Participation in Research Activities

PEPPERDINE UNIVERSITY

(Graduate School of Education and Psychology)

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

HEALTHCARE LEADERS UNDER THE AGE OF 40 - SUCCESSFUL STRATEGIES AND PRACTICES FOR LEADING HEALTHCARE ORGANIZATIONS

You are invited to participate in a research study conducted by **Rizalyn Reynaldo, M.H.A, M.S.G. and Farzin Madjidi, Ed.D.** at Pepperdine University, because you fit the following eligibility criteria: (a) has at least a Master's degree or medical degree, (b) is currently under the age of 40, and (c) lives within the United States of America. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

<u>PURPOSE OF THE STUDY</u>

The purpose of this study is to explore best strategies and practices that healthcare leaders under the age of 40 can adopt for their respective organizations amidst a rapidly changing industry. The purpose will be achieved by identifying the challenges and successes that current healthcare leaders under the age of 40 have experienced while leading the workforce and managing the complexities and demands of the field. The study will also examine how healthcare leaders under 40 measure their leadership success. Finally, aspiring young leaders will gain fundamental knowledge and wisdom from the lived experiences of healthcare leaders who earned leadership positions early in their careers.

<u>STUDY PROCEDURES</u>

If you volunteer to participate in this study, you will be asked to participate in a semi-structured interview that will last for approximately 60 minutes. The semi-structured interview includes the use of 10 to 12 open-ended questions that are designed in advance, with probes that are either planned or unplanned to clarify your responses. The types of questions will elicit valuable practices, leadership styles, and strategies that current healthcare leaders can utilize in leading

their respective organizations. During this interview your answers will be recorded. If you choose not to have your answers recorded, you will not be eligible to participate in this study

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include feeling uncomfortable with questions, issues with self-esteem, boredom, and fatigue from sitting for a long period.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society which include including raising awareness of discrimination of adults under the age of 40 and creating some movement to revising the American Discrimination in Employment Act (1967) that only protects those 40 and older.

CONFIDENTIALITY

I will keep your records for this study confidential as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

To protect the identity of your responses, the recordings will be saved under a pseudonym and transferred to a USB flash drive, which will be kept in a safe, locked drawer within the researcher's residence for three years, after which it will be properly destroyed. The researcher will be transcribing and coding the interviews herself. The documents containing the transcribed interviews and coding analysis will also be transferred to the same USB flash drive and maintained in the same locked drawer at the researcher's residence, which will be destroyed after three years. Your name, affiliated organization, or any personal identifiable information will not be reported. Instead a pseudonym with a generic organization name will be used to protect your confidentiality.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

Your alternative is to not participate. Your relationship with your employer will not be affected whether you participate or not in this study.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Rizalyn Reynaldo at xxxxxxxx@pepperdine.edu, XXX-XXX-XXXX, or Dr. Farzin Madjidi, xxxxxx.xxxxxxx@pepperdine.edu if you have any other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, XXX-XXX-XXXX or xxxxxx@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

AUDIO

       □ *I agree to be audio-recorded*

       □ *I do not want to be audio-recorded*

_____

Name of Participant

_____   _____

Signature of Participant   Date

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

_____

Name of Person Obtaining Consent

_____   _____

Signature of Person Obtaining Consent   Date

APPENDIX C

Recruitment Script

Dear [Name],

My name is Riza Reynaldo.   I am a doctoral student in Organizational Leadership at Pepperdine University's Graduate School of Education and Psychology. I am conducting a study on leaders in healthcare and you are invited to participate in the study.

If you agree, you are invited to participate in an interview that intends to explore best strategies and practices that healthcare leaders under the age of 40 can adopt for their respective organizations amidst a rapidly changing industry. The purpose will be achieved by identifying the challenges and successes that current healthcare leaders under the age of 40 have experienced while leading the workforce and managing the complexities and demands of the field.

The interview is anticipated to take no more than 60 minutes to complete and the interview will be audio-taped with your consent. Participation in this study is voluntary. Your identity as a participant will remain confidential during and after the study. Your name, affiliated organization or any personal identifiable information will not be reported. Instead a pseudonym from a "generic organization" will be used to protect your confidentiality. Additionally, confidentiality and privacy of all participants will be fully protected through the reporting of data in aggregate form.

If you have questions or would like to participate, please contact me at XXX-XXX-XXXX or xxxxxxxx@pepperdine.edu

Thank you for your participation,

Rizalyn Reynaldo
Pepperdine University
Graduate School of Education and Psychology
Status: Doctoral Student

Peer Reviewer Form

Dear reviewer:

Thank you for agreeing to participate in my research study. The table below is designed to ensure that may research questions for the study are properly addressed with corresponding interview questions.

In the table below, please review each research question and the corresponding interview questions. For each interview question, consider how well the interview question addresses the research question. If the interview question is directly relevant to the research question, please mark "Keep as stated." If the interview question is irrelevant to the research question, please mark "Delete it." Finally, if the interview question can be modified to best fit with the research question, please suggest your modifications in the space provided. You may also recommend additional interview questions you deem necessary.

Once you have completed your analysis, please return the completed form to me via email to rreynald@pepperdine.edu. Thank you again for your participation.

Research Question	Corresponding Interview Question
RQ1: What strategies and practices are employed by healthcare leaders under the age of 40 in their respective organizations?	1. What strategies and practices do you employ in leading your organization? a. The question is directly relevant to Research question **- Keep as stated** b. The question is irrelevant to research question – **Delete it** c. The question should be **modified as suggested**: _____ _____ I recommend adding the following interview questions: _____ _____ _____

	2. What challenges do you face in implementing strategies and practices?
	a. The question is directly relevant to Research question **- Keep as stated**
	b. The question is irrelevant to research question – **Delete it**
	c. The question should be **modified as suggested**:
	_____ _____
	I recommend adding the following interview questions:
	_____ _____ _____
	3. How do you overcome resistance or opposition to strategies and practices?
	a. The question is directly relevant to Research question **- Keep as stated**
	b. The question is irrelevant to research question – **Delete it**
	c. The question should be **modified as suggested**:
	_____ _____
	I recommend adding the following interview questions:
	_____ _____ _____ _____ _____
RQ2: What challenges are faced by healthcare leaders under the age of 40 in	4. What healthcare market trends impact your current day to day operations?

implementing best strategies and practices for leading their respective organizations?	a. The question is directly relevant to Research question **- Keep as stated** b. The question is irrelevant to research question **– Delete it** c. The question should be **modified as suggested**: _____ I recommend adding the following interview questions: _____ 5. As a young healthcare leader under the age of 40, what have been some challenges you have encountered in leading your organization? a. The question is directly relevant to Research question **- Keep as stated** b. The question is irrelevant to research question **– Delete it** **c.** The question should be **modified as suggested**: _____ I recommend adding the following interview questions: _____
RQ3: How do healthcare leaders under the age of 40 measure the success of the strategies and practices employed to lead their respective organizations?	6. How do you define and measure your success as a leader? a. The question is directly relevant to Research question **- Keep as stated** b. The question is irrelevant to research question **– Delete it**

       c.   The question should be **modified as suggested**:

_____
_____

I recommend adding the following interview questions:

_____
_____
_____

      7.   What is your definition of a high performing healthcare organization?
          a.   The question is directly relevant to Research question **- Keep as stated**
          b.   The question is irrelevant to research question – **Delete it**
          c.   The question should be **modified as suggested**:

_____
_____

I recommend adding the following interview questions:

_____
_____

8: What methods do you employ to measure and track the organization's performance and success?
          a.   The question is directly relevant to Research question **- Keep as stated**
          b.   The question is irrelevant to research question – **Delete it**
          c.   The question should be **modified as suggested**:

_____
_____

I recommend adding the following interview questions:

	_____ _____

RQ4: What recommendations would healthcare leaders under the age of 40 provide to aspiring young leaders?	9. What leadership style/traits has helped you promote into your leadership role?
	 a. The question is directly relevant to Research question **- Keep as stated**
	 b. The question is irrelevant to research question – **Delete it**
	 c. The question should be **modified as suggested**:
	 _____
	 _____
	
	 I recommend adding the following interview questions:
	 _____
	 _____
	 _____
	
	 10. What advice would you give to aspiring young leaders entering into leadership positions?
	      a. The question is directly relevant to Research question **- Keep as stated**
	      b. The question is irrelevant to research question – **Delete it**
	      c. The question should be **modified as suggested**:
	 _____
	 _____
	
	 I recommend adding the following interview questions:
	 _____
	 _____
	 _____