



The Blue Ridge

ACADEMIC HEALTH GROUP

Report 4

In Pursuit of Greater Value: Stronger Leadership in and by Academic Health Centers

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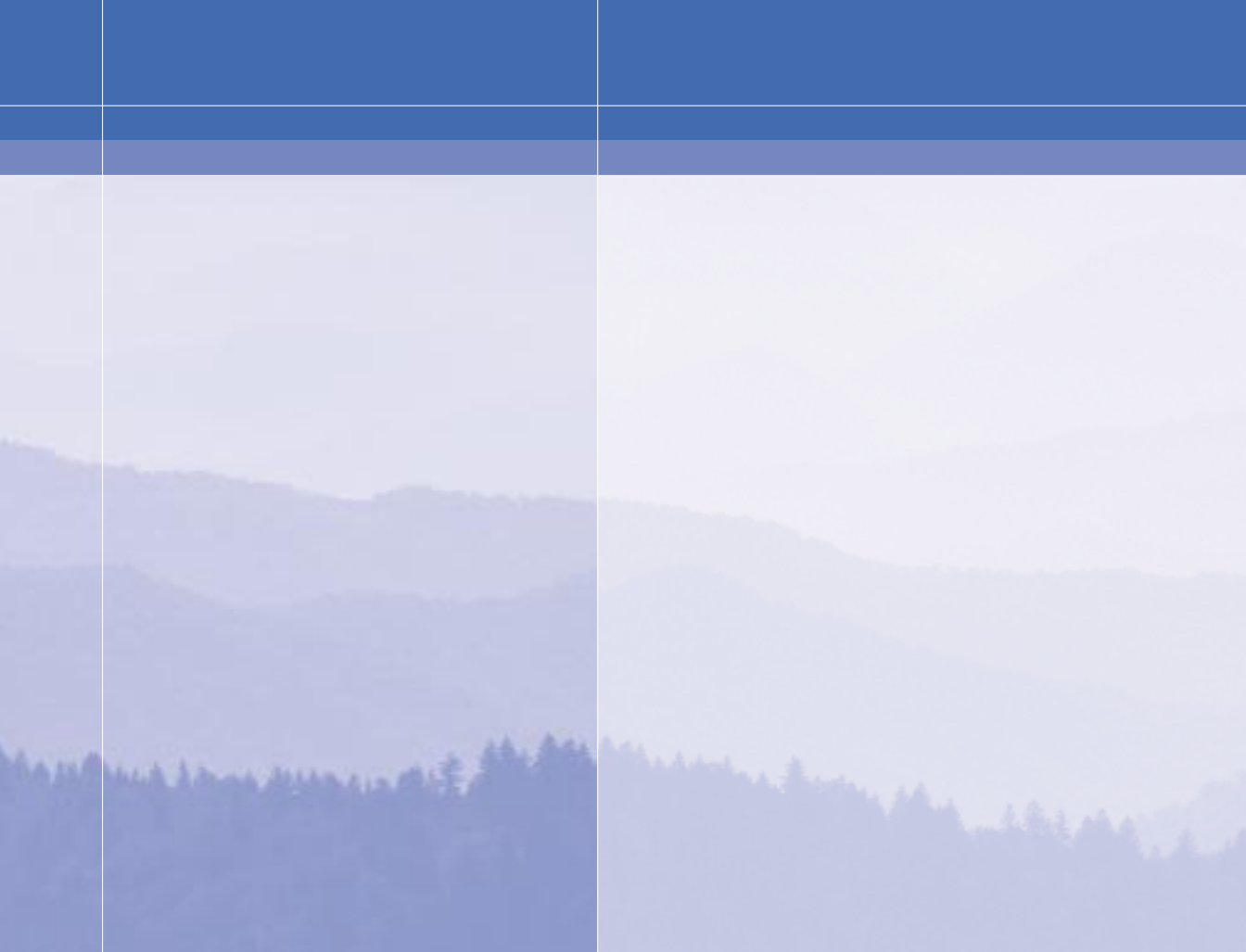
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Academic Health Group

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Stronger Leadership in and
by Academic Health Centers

The Blue Ridge Academic Health Group



Mission

The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for Academic Health Centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

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It is axiomatic that what is needed is the delivery of health care via a seamless web of health professional services oriented to the patients' and the public's best interests rather than each profession's self-interest.

– Roger J. Bulger, *The Quest for the Therapeutic Organization*, 2000

The unprecedented challenge for AHC leadership is this: to supply the vision and direction necessary to catalyze the appropriate reengineering and reinvigoration of the AHC so that its extraordinary talents, resources, and services can best be realized in the pursuit of new discoveries, improved health professions training, and better health care services and policy.

– Michael Johns and Thomas J. Lawley, *Leading Academic Health Centers*, 1999

Leaders of academic health centers (AHCs) have always experienced a wide-range of formidable challenges during their tenure. AHCs are complex organizations to lead because of their multiple missions, substantial size, highly specialized products and services, diverse internal and external constituencies, and culture marked by autonomy of faculty and departments. They operate as academic, business, and (in many cases) public organizations simultaneously, in an industry that is in the midst of evolving

its production modes (i.e., from cottage to manufacturing to knowledge-based). Across AHCs, financial threats abound as a result of reduced government support and declining clinical revenues.

In many cases, governance structures are being or need to be modified because governing boards do not always operate to facilitate needed change and internal decision-making processes are not always efficient. Moreover, the career path of AHC leaders is often antithetical to the development of skills necessary for effective leadership. Further, a coherent strategy to build future leaders is lacking in most AHCs. Planning for future leadership is often equivalent to establishing a search committee when a key position becomes vacant.

An array of societal, economic, and technological forces are creating a new and as yet uncharted terrain for AHCs. AHC leaders must address demographic shifts, new capabilities arising from information and communications technology, and growing consumer expectations for speed and customized products and services. These changes require that organizations assume new roles, acquire new capabilities, develop new business models, and interact with both customers and staff in new ways.

AHC leaders are facing a new frontier where they need the ability to cope with a different landscape from week to week. An organizational vision that motivates staff is more important than ever. Leaders need to predict and direct change rather than just react to it. They need to interpret myriad messages from the environment and convert them into a framework that

guides both long-term strategies and routine operations. They must forge an organizational culture that embraces constant change and successfully adapt and transform their organizations while preserving core values.

Leaders have no option but to assess and in some cases add to their own skills to keep pace with the changing environment and facilitate excellence in others as they strive to achieve organizational success. For example, electronic connectivity and greater reliance on relationships beyond organizational lines require new technical and communications skills and knowledge. Changes in the composition of the workforce, consumer expectations, and interactions with the media are increasing the importance of humanistic dimensions of leadership (i.e., leaders must care about more than the bottom line). Organizational members not only need to participate in shaping their jobs and developing clearly defined performance expectations, but they must also be offered opportunities to develop the skills needed to meet their job requirements and expectations.

If these already complex organizations are to succeed in meeting these new challenges, adroit leadership is essential at a variety of levels, not just at the top. Formal and informal leaders throughout the enterprise need to be given opportunities to make decisions as a means of developing and practicing leadership skills. Otherwise organizations risk a shortage of future leaders or discontinuity during inevitable leadership transitions.

Previously, the Blue Ridge Academic Health Group (Blue Ridge Group) concluded that AHCs:

- can and should provide greater value to society.
- must transform themselves in response to the changing needs of society and changing market forces.
- can achieve the needed transformation by taking greater advantage of business practices used in other industries, leveraging the capabilities of information technology and electronic commerce, expanding their focus on managing population health, and partnering with a range of external parties within their regions.
- should be active participants in the effort to build a value-driven health system (Blue Ridge Academic Health Group 1998a, 1998b, 2000, and 2001) (see Exhibit 1).

To achieve these objectives AHC leaders will need to possess the full set of essential leadership skills for contemporary organizations and to apply those skills to transforming their organizations for success in the 21st century. Moreover, AHCs will need a cadre of individuals throughout the organization with these leadership skills.

Against this backdrop, the Blue Ridge Group explored the issue of what AHC leadership should look like today and in the coming decade. This examination was accomplished through review of the literature and a two-day meeting at which the Blue Ridge Group heard presentations on leadership models and discussed leadership challenges facing AHCs. This report presents the Group's findings and seeks to address three questions. What notable challenges do AHC leaders face? What are the relevant leadership skills for AHC leaders? How can AHCs cultivate leadership skills within their organizations?

During the course of its work, the Blue Ridge Group concluded that effective leadership within AHCs requires that AHCs learn from and help to shape the environment in which they operate by also providing leadership beyond their organizations. Thus, not only does this report call on AHCs to strengthen leadership within their institutions, it also encourages AHCs to demonstrate value-driven leadership within their communities, regions, and the entire health care sector (see recommendations in Exhibit 2).

For purposes of this report, the senior ranking AHC official (e.g., vice president or dean) is considered to be the AHC leader. The leadership of AHCs is considered to include the senior ranking AHC official, other senior administrators, the governing board, and president of the parent university (if applicable). At the same time, leaders exist throughout all levels of AHCs. Some of these are formally appointed (e.g., department chair); others assume their position by default; still others appear

in the form of teams or individual work units.

In addition, the AHC as an organization is recognized as having the potential to be a leader because of the number and size of its spheres of influence. Despite the dominance of market forces and accompanying increased visibility of third-party payors in shaping the health care sector, AHCs continue to influence the health care

community through their roles as developers and disseminators of new knowledge, educators of future health professionals, and providers of highly specialized care. Moreover, many AHCs represent a significant share (i.e., budget and personnel) of their parent university, qualify as large employers, and provide significant percentages of patient care within their communities and regions.

Exhibit 1:

A Value-Driven Health System
(Blue Ridge Academic Health Group, 1998a)

A value-driven health system is grounded in the principle that a healthy population is a paramount social good. The system promotes and improves the health of the population by providing incentives to health care providers (both public and private), payors, communities and states to optimize population health status and by rewarding cost-effective population health management. Such a health system would achieve better health outcomes and improve the health of citizens over the long-term while achieving cost savings for all stakeholders.

Two kinds of incentives exist within a value-driven health system. First, there are incentives for individual citizens (patients), health care professionals, health delivery organizations, payors, and communities to seek and maintain health. Health insurance premiums, reimbursement rates, and grants to communities can all be structured to reward behaviors and strategies that advance health. Second, providers compete for populations to manage on the basis of quality and efficiency (where quality is defined in terms of health of the community or region as well as health of individuals). To do so, however, requires a fully insured population (universal coverage) so that population health management strategies can be implemented. It is anticipated that in a mature value-driven evidence-based system, universal coverage will be less expensive than in the current system.

The AHC Leadership Milieu

Medical school deans are serving an average of 2.8 years, down from an average of 3.6 years between 1980 and 1992, and 5.8 years between 1960 and 1979 (Aschenbrener, 1998; Petersdorf, 1997; Sheldon, 2000). An estimated 20 percent of medical schools are currently without deans (Sheldon, 2000). Department chair positions are in a similar situation with approximately 40 chairs of surgery being vacant and some being open for long periods of time. These statistics suggest that at least some AHCs are experiencing significant management gaps and lack of leadership continuity. These disconcerting statistics are not surprising when viewed in terms of the nature of the job. AHC leaders face high expectations, multiple roles (i.e., clinician, scientist, educator, administrator, entrepreneur, fund raiser, organizational merger specialist), a diverse constituency, responsibility without commensurate authority and resources, and a faculty that is not easily led (Petersdorf, 1997).

AHC leadership challenges are complicated by eroding revenue streams which have resulted in some AHCs experiencing budget deficits, staff turnover and reduction, and organizational restructuring (Commonwealth Fund Task Force on Academic Health Centers, 2000; Pardes 2000). All AHCs face difficulties in finding resources to make needed investments. AHC educational structures that lag developments in the clinical arena require overhaul. Greater demands on health care professionals to manage an ever-growing base of knowledge and apply new methodologies (e.g., evidence-based medicine or population

health management) create new challenges for both health professional school curricula and investment in information systems that support the clinical enterprise. For example, AHC leaders must determine how much to invest in knowledge management and e-health initiatives to keep pace with the burgeoning information economy (Blue Ridge Academic Health Group 2000 and 2001).

Funding is not the only challenge facing AHC leaders. Some schools are experiencing difficulty recruiting faculty to teach core undergraduate courses and finding ambulatory placements for their students (Blumenthal, Weissman, and Griner, 1999). Schools also face uncertainty surrounding the appropriate numbers, mix, appropriate training for, and availability of future health professionals (e.g., 18 percent drop in medical school applications between 1996 and 1999 and a 3.6

Exhibit 2:

Leadership Recommendations

1. AHCs should seek leaders with the ability (i.e., qualities and experience) to transform their organizations and to work with their communities to build value-driven health systems.
2. AHCs should develop the leadership skills of their professionals and students to build stronger organizations and value-driven health systems for their communities.
3. AHCs should work with and develop the capacity of their governance bodies to provide strong leadership, sound guidance, and effective decision making for their institutions.
4. AHCs should partner with professional organizations and specialty societies to strengthen leadership skills of their faculty and students, to help create and support needed change within AHCs, and to advocate for necessary changes in the health care system.

percent decrease between 1999 and 2000) (Association of American Medical Colleges, 2000; Pardes, 2000). Industry thought leaders calling for patient-centered, interdisciplinary care, patients increasingly involved in managing their own care (largely through better access to medical knowledge and electronic connections to their health care providers), and evidence that varying levels of quality and safety are being achieved by health care provider institutions point to the need for change within the clinical arena (Institute of Medicine, 1999). Growing competition for research funding from private industry along with demands for better accountability are driving efforts to manage the

research enterprise (for the first time in many institutions). Finally, AHCs must confront issues of collective responsibility (e.g., excess capacity) and competition from new sources or risk cutbacks and outcomes imposed by regulation or competition (Fein, 2000).

AHCs are part of an industry whose production modes are still evolving. While retaining aspects of its original cottage or craft production mode, health care has adopted and continues to adopt elements of a manufacturing production mode. Simultaneously health care is being driven into a knowledge or learning production mode by advances in information technology and consumer expectations

(Maccoby, 1999; Blue Ridge Academic Health Group 2000). As a result, like all health care organizations, AHCs are confronting changes in the means of their work, values, definition of quality, and roles of health professionals, as well as organizational structures, systems, and skills. Organizations in the learning production mode are likely to be interactive rather than bureaucratic, rely on cross-functional teams rather than hierarchy, use interactive dialogue and shared goals rather than top-down commands, and require leaders who are synthesizers and socializers rather than analyzers or energizers.

Exhibit 3:

The Transformation of Health Care

	CRAFT →	MANUFACTURING →	LEARNING
Structures/Roles			
• Organization	Cottage industry	Factory/bureaucracy	Interactive system
• Economic role of physician	Sole proprietor, small partnerships	Employee Entrepreneur	Large-system stakeholder
• Physician role in team	Authority	+Provider	Partner-teacher
• Patient role	Submissive, trusting	Customer-client	+Partner-learner
Values			
	Caring	Efficiency	Knowledge creation
	Personal trust	Scale	Individual development
	Expertise	Uniformity	Social development
Model of Care			
	Biomedical	+Prevention	+Epidemiological
	Individual skill	+Outcome measures	+Psychosocial
Focus	Individual	+Institutional	+Community -> Global
Technology	Hand tools	+Electromechanical +Chemical	+Information +Biogenetic
Systems			
• Quality control	Peer review	+Statistical processes	+Continuous improvement
• Cost control	Unregulated	Profit-based	Shared responsibility
• Learning	Individual	+Organizational	+Community
Organizational Skills	Mentoring	Monitoring	Team Competence
Leadership Model	Master-apprentice Functional expertise	Administration Visionary-interactive	Distributed leadership dialogue
Leadership Thinking	Analyzer	Energizer	Humanizer

Note: The (+) symbol indicates that the characteristic in the column to its left also holds true for this column.

Source: Reprinted with permission from the Association of Academic Health Centers. Originally published in M. Maccoby, On creating the organization for the age of learning, in *Creating the Future: Innovative Programs and Structures in Academic Health Centers*, C. H. Evans and E.R. Rubin, editors, Washington, D.C.: Association of Academic Health Centers, 1999, p. 7.

AHCs clearly need to embrace, adopt, and sustain profound changes for long term success. They are, however, diverse organizations and at varying stages of preparedness to embark upon large-scale and deep organizational change. There is no single strategy or set of strategies that will assure success for all AHCs. It is essential that AHC leaders identify needed changes, assess their organizations' capacity for transformation, and evaluate their personal readiness to lead such an effort. Reflecting upon the state of AHCs (to the extent that they can be generalized) and the framework provided by the Leadership Mirror (see Appendix 1), the Blue Ridge Group identified specific challenges AHC leaders face as they plan and implement desired changes.

Shared values and a clear vision provide a sense of purpose and continuity, motivate staff, and contribute to organizational success (Collins and Porras, 1994). These foundational elements of the organization are growing in importance as organizations move away from command and con-

trol style operations towards decentralized decision making as a means of being responsive to customer needs through both speed and ability to customize. Yet, in many AHCs, core values may seem to be contradictory or under siege from external forces.

As identified in Exhibit 3, the values associated with the three production modes evident within health care differ (i.e., personal trust and expertise versus efficiency and uniformity versus knowledge creation and social development). AHCs operate in both the business and academic realms. Faculty members are often troubled when the market views the fruit of their labor as commodities and are uncomfortable when patients are called customers. Autonomy and academic freedom are second nature to most faculty, but they are being asked to demonstrate accountability and respond to organizational enterprise needs. Health professionals, particularly physicians, are taught to assume responsibility and function independently. Meanwhile, health care is evolving toward patient-

centered, interdisciplinary services.

Identifying and articulating core values is a necessary task for AHC leaders. During a Johns Hopkins Medicine leadership retreat, senior executives were divided into five groups and asked to identify core values of the organization. Working independently, each group identified the same set of values – integrity, honesty, collegiality; excellence (being number one in all that we do); innovation; transmitting knowledge to the world; and alleviating suffering by translating basic information. This exercise provided the AHC executive with a means of determining how well established and clear the organization's values were at that point in time. It also reinforced the institution's values among senior leaders.

The process of identifying or clarifying AHC core values may require considerable effort. AHC leaders can begin by initiating dialogue about the organization's true core values versus habits or norms erroneously assumed to be core values. Subsequently, AHC

leaders and staff can focus on identifying new approaches that can be used to achieve core values in the changing environment. For example, improving health might be an AHC core value. Excellence in the clinical arena previously relied upon a great deal of physician independence and focused predominantly on care given to individual patients without consideration of aggregated results. Now it is far more likely to depend on teamwork, interdisciplinary approaches, patient involvement, explicit assessment of satisfaction as well as a focus on value and population health outcomes. Achieving this core value will depend on actions of AHC staff and investment by the AHC in needed training and information technology capabilities.

Once identified, core values provide the foundation for the organization's vision and mission and underlie all of its strategies and policies. Values and vision need to be shared throughout the organization. Continued promotion of the vision has been linked to success of collaborative projects and will become more important as collaboration becomes more prevalent within AHCs (Bland et. al, 1999). The high rate of routine turnover within AHCs (e.g., new students and residents) makes articulating core values and vision an ongoing task for AHC leaders. Moreover, as the AHC workforce becomes more diverse, greater effort is needed to bridge generational and cultural differences among staff to achieve shared values throughout the institution. Some AHC leaders are using new communication approaches to communicate with faculty and staff that provide both timely information as well as opportunity for input (e.g., town meetings involving fac-

ulty and staff, electronic bulletins) (Griner and Blumenthal, 1998a).

Achieving a shared vision among top leaders – including the governing body – increases the likelihood of securing creative change (Bulger, Osterweiss, and Rubin, 1999). For example, the board and university president along with the vice president of the University of Cincinnati Medical Center provided a united front in advocating large scale changes that placed corporate need over that of individual units. This joint commitment overcame well-entrenched departmental resistance and provided a springboard for future enterprise-wide changes (e.g., privatization of the hospital and closing of one facility).

Although a solid relationship with the AHC governing body is pivotal for AHC leaders, AHC experience with effective governance varies widely. Private institutions often have the opportunity to build the boards that preside over them. In contrast, public AHCs or universities do not have the same level of influence over governance. Although governing boards are expected to serve as trustees, acting to protect and preserve the institution for future generations, boards of public institutions may see themselves not as guardians of the institution but as representatives of the special interests that led to their appointment (Duderstadt, 2000).

The current climate increasingly requires quick decisions from governing bodies that are often accustomed to acting with great deliberation rather than speed. An important challenge for public higher education today is assuring lay boards of the experience, quality, and clarity of role

necessary to govern complex institutions. Each AHC (and university) needs a core of influential trustees who understand the institution, can provide useful criticism, and support its efforts.

Achieving a more “sophisticated level of governance” may require continued educational efforts by the senior AHC executive and university president (Bulger, Osterweis, and Rubin, 1999). Alternately, it might entail creating a sub-board of the overall university that has specific responsibility for overseeing the AHC (Commonwealth Fund Task Force on Academic Health Centers, 2000). Some AHCs have sought to strengthen governance and improve the flexibility and speed of decision making by reducing the role of the state or parent university through restructuring. For example, Oregon Health Sciences University (OHSU) has become a quasi-public corporation (Blumenthal, Weissman, and Griner, 1999).

Equally important, AHCs require rational organizational structures that facilitate internal decision

making (Griner and Blumenthal, 1998b). Both changing organizational configurations (e.g., mergers or alliances with external partners) and the need for enterprise-wide decision making are driving changes in AHC organizational structures. For example, Emory Healthcare was created through the consolidation of Emory’s clinical facilities (including The Emory Clinic, The Children’s Center, Emory University Hospital, Crawford W. Long Hospital, Emory/Adventist Hospital, Wesley Woods Center of Emory University, and a limited partnership with Columbia/HCA’s metropolitan Atlanta facilities) (Saxton et al., 2000). This structure provides administration consolidation and coordination, but allows each entity to operate as a distinct business unit. Emory’s Woodruff Health Sciences Center (WHSC) has implemented a new governance structure that is headed by the executive vice president for health affairs and WHSC director, who is also chairman and chief executive officer of Emory Healthcare. Within the clinical enterprise, Emory has also

implemented a decision making structure comprised of ten teams of 15 members (e.g., operations, clinical performance improvement, marketing, managed care, clinical research). These teams serve as a resource to business units, have decision-making authority on matters within their purview, and make recommendations on broader issues to senior leadership.

AHCs often fail to deliberately develop, communicate, or apply their operating model (i.e., the concrete plan of how the organization will operate in the marketplace) (Nackel, 2000). Rather than articulating how leaders want the organization to behave, the kinds of relationships they want to establish with business partners, how they will interact with staff, and what they want to be known for in the marketplace, AHCs may have relied on traditional practices as the basis for their operations. As a result, translating strategies into daily activities and defining the organization’s culture become more difficult within these organizations. Moreover, AHC organizational struc-

tures (e.g., clinical departments or financial reporting systems) may inhibit implementation of the chosen operating model (e.g., multi-disciplinary curriculum or an enterprise-wide approach to resource allocation).

Several AHCs are collaborating on a project with the University HealthSystem Consortium and Cap Gemini Ernst & Young U.S. LLC (e.g., UAB, OHSU, University of Cincinnati) and have begun to make explicit use of an operating model. This project, known as the Funds Flow Study, strives to enable AHCs to align their business practices with mission-driven initiatives. As part of this

process, AHCs have articulated an operating model and identified how various organizational characteristics need to be transformed (see Exhibit 4). These AHCs are now working to educate their organizations on the need for change as well as implementing new processes (e.g., routine use of performance measures) to support their new operating model (Blue Ridge Group, 1998a; Garson, 1999; Geheb, 1999; Geheb, 2000; Harrison, 1999).

The Blue Ridge Group identified three cultural issues that will likely impede AHCs' ability to implement profound changes. First, AHC leaders need to continue to promote the shift away from "a loose

Exhibit 4:
Changing AHC Operating Model

CHARACTERISTICS	TRADITION	TRANSFORMATION
Accountability	Individual personal goals	Individuals with personal goals aligned with enterprise goals
Governance	Individual Units (SOM, departments, hospital, practice plan)	Common oversight to establish and oversee enterprise goals
Culture	<ul style="list-style-type: none"> • "Religious" defense of noble work • Individual objectives • Cacophony (multiple voices) • Innovation with inconsistent application • Entitlement 	<ul style="list-style-type: none"> • "Business-like" defense of noble work • Common objective • Polyphony (multiple voices) • Innovation with consistent results • Risk
Organization	Fiefdoms	Collaborative units
Finances	<ul style="list-style-type: none"> • Independent financial models • Variable accounting standards • Risk held centrally • Deal making • Unclear view of funds flow • Secrecy • Confusion 	<ul style="list-style-type: none"> • Common financial language • Single accounting standards • Risk at operating unit • Strategic investment (Return on Investment) • Clear view of funds flow • Openness • Clarity
Other metrics	Poorly defined	Defined by mission
Decision making	Slow, imprecise, chaotic, idiosyncratic, and non-strategic	Deliberate, precise, organized, paced, and strategic

Source: Reprinted with permission from the University HealthSystem Consortium. Originally published in M. Geheb, *Transforming AHCs: Operating in a New Economic Environment*, Oak Brook, IL: University HealthSystem Consortium, 2000, p. 4.

confederation of independent faculty members and autonomous departments” toward an organizational culture that “acknowledges the exquisite interdependence of diverse units” and an organization focused on the needs of the enterprise (Blue Ridge Academic Health Group, 1998a; Kirch, 1999). By increasing collaboration among and accountability from individuals and units, AHC leaders will reduce the time spent mediating disputes. To do so, however, AHC leaders will need to create and communicate a vision that appeals to the common interests among diverse disciplines so that they will be willing to cross traditional barriers.

In some instances, AHC leaders can take advantage of external factors to shape organizational culture. The University of Massachusetts Medical Center (UMMC) developed “a genuine sense of community” among its faculty and administrators from its inception as a result of external skepticism about its formation (Bulger, Osterweis, and Rubin, 1999). This hostile environment combined with intense political and public scrutiny resulted in both department leaders and faculty members being more team-oriented than those at some AHCs. This team orientation has proved to be a strategic strength for the institution. In addition, UMMC understands and is driven by its mission to educate health professionals for the state and provide care to central and western Massachusetts. It recognizes that it is different from medical schools in the Boston area and does not seek to copy them. Clarity of mission and an institutionally-focused organizational structure have provided a solid foundation for innovation and robust performance at UMMC.

The attitudes and styles of leaders within an AHC can promote or impede a collaborative culture. Although never mandated to do so, the primary care departments at the University of California, Irvine, College of Medicine (i.e., family medicine, general internal medicine, and general pediatrics) cooperate extensively in education, patient care, and research (Scherger et al., 2000). This model evolved gradually over many years. As faculty experienced success collaborating on multidisciplinary medical school courses and eventually residency programs, they realized that “working together not only makes sense educationally, but also saves crucial amounts of time and resources” and serves as a model of professionalism for students. Today the primary care faculty “share educational resources, a research infrastructure, and clinical systems, thus avoiding duplicative use of valuable resources while maximizing collective negotiating abilities and mutual success.”

Second, AHC leaders need to foster a learning environment for all organizational members. Beyond being educational institutions, AHCs need to be “organizations where people continually expand their capacity to create the results they truly desire... where people are continually learning how to learn together” (Senge, 1990). To achieve sustained high performance, AHCs need to take full advantage of their organizational knowledge and provide sufficient opportunities for all staff to develop fully. This issue is particularly important in the learning production mode where organizations need to learn “how to change and adapt to competition, information technology, and new values of customers and employees” (Maccoby,

1999). In this mode, front line staff focus on meeting customer needs while their supervisors focus on translating front-line experiences into organizational learning.

Both formal training and informal incentive programs can contribute to success in this area. Emory Healthcare formed the Learning Council to anticipate and coordinate learning needs of the components of its integrated delivery system (Franklin and Moore, 1999). The Learning Council created a competency assessment feedback program to facilitate learning among staff. This program is based on a 360-degree feedback approach and includes a survey tool, a survey feedback report, a guidebook, and a coaching process to assist participants in formulating and completing a personal strategic plan. The Mayo Clinic has established the Clinician-Educator award to promote educational innovation and scholarship by funding the development of educational projects (Viaggiano, Shub, and Giere, 2000). Similarly, the University of Virginia Health System provided grants to faculty to encourage informatics development and innovative use of information resources (Watson, 1997).

Third, strengthening institutional citizenship is another important cultural shift for AHCs. AHC faculty need to develop strong identification with their institutions and not just with their disciplines. AHC success requires that faculty support the enterprise and contribute to its advancement. While AHC leaders need to provide a shared vision around which the organization can rally, individual members need to be ready to be a part of the team.

These cultural shifts can be reinforced through development and use of explicit performance measures at the organizational, unit, and individual level. Faculty performance evaluations are becoming routine in many AHCs and appointment letters are becoming more explicit about the institution's expectations for faculty performance (Griner and Blumenthal, 1998a). To influence culture and desired behavior, robust evaluations need to incorporate the full set of desired behaviors (e.g., institutional citizenship, mentoring, establishing external relationships) and not just those criteria traditionally considered for promotion and tenure decisions. In addition, these cultural issues can be incorporated into educational curricula for students and health professionals. For example, medical schools can expose their students to the need for institutional citizenship when they address professional values in the curriculum.

The complexity of leadership is growing in contemporary organizations, yet "few people who become leaders in academic medicine aspire to, plan for, or seek training to develop leadership skills" (Daugherty, 1998). Unlike the corporate world, past experiences of AHC leaders do not necessarily translate into leadership preparation. The traditional route for AHC leadership is through academic achievement rather than business experience or training. Young faculty may be discouraged from pursuing mid-level management positions that provide needed experience for future leaders because of a perception that management is "something that academics do when they can no longer cut it as investigators or clinicians" (Commonwealth Fund Task Force on Academic Health Centers,

2000). Moreover, some of the attributes and cultural processes associated with a skilled clinician or researcher may be counter productive in the leadership arena (Schwartz et al., 2000).

For example, most vice presidents and deans were medical students who trained to be assertive, independent physicians. These same leaders were likely medical school faculty in an environment that traditionally values individual autonomy and rewards individual achievement, not behavior that supports a larger community of interests. Many AHC leaders were practicing physicians who experienced the autonomy of decision making and emphasis on the singularity of the physician-patient relationship. Once in a leadership position, however, these same individuals must be skilled at collaborative behavior. Academic advancement and recognition usually comes with achievements in a specialized research or clinical domain. After ascending the ladder of academic reward and recognition, however, AHC CEOs find themselves in a web of relationships and in need of breadth to relate to diverse constituencies, not depth of medical specialization. As a result, typically AHCs are not known for having strong leadership habits, the vocabulary of leadership does not pervade these institutions, and leaders often learn on the job.

Training can play a significant role in leadership development when it focuses on conceptual ability, teachable interpersonal skills, and personal growth. Attempting to develop leadership skills is not, however, likely to yield significant benefits while learners are focused on mastering their discipline or before they have professional experience on which to

draw (Chow, Coffman, and Morjikian, 1999). Undergraduate health professional education can contribute to leadership development through student contact with faculty who model effective leadership behaviors and varying leadership styles, discussions of the nature of professionalism and values of health professionals, and assigned projects that require use of leadership skills (e.g., communication, collaboration, understanding diverse perspectives). A limited number of medical schools offer dual-degree programs in medicine and business, but these students appear to be most interested in careers directing hospitals and insurance companies rather than the public sector (Sherrill, 2000).

Several AHCs have leadership programs focused on residents. The University of Washington School of Medicine developed a course that helps senior residents to refine teaching and supervisory skills. Leadership, problem-solving, managerial techniques (e.g., setting goals and providing feedback), and communication among various team members are explored through sample cases and videotaped vignettes of situations likely to be encountered (Wipf, Pinsky, and Burke, 1995). The University of Minnesota Internal Medicine Residency Program offers residents the Physician Management Pathway (PMP) to expose them to medical administration and leadership (Paller et al., 2000). PMP exposes interested residents to management concepts, provides them the opportunity to begin developing leadership skills, and provides career mentoring through a monthly seminar series, a preceptorship with a physician-executive, and a supervised project.

A variety of leadership and management development programs are offered nationally and internationally for organizational leaders in health care generally and AHCs specifically (Association of American Medical Colleges, 2000b; Cambridge University, 2000). Some institutions have developed in-house programs to meet the needs of their faculty and staff. The University of Virginia (UVA) Darden Graduate School of Business Administration developed a program for department chairs in the UVA School of Medicine. Participants meet one weekend per month for a year and cover topics such as strategic thinking, marketing, finance, operations, organizational behavior, leadership skills, and managing education.

The American Council on Education (ACE) offers a professional development program for faculty and senior administrators to become skilled in the leadership of change that could serve as a model for AHC leadership development programs (American Council on Education, 2000). The ACE Fellows Program provides individualized, long-term (i.e., a semester or year), on-the-job professional development. Fellows are mentored by a team of experienced administrators (usually the president and vice presidents) of another institution, participate in seminars with other fellows, attend national meetings, and are encouraged to visit other campuses, corporate settings, or universities abroad as part of the program.

It is important to assure that such programs meet leadership development needs through consistency with starting point and culture of learners and alignment with strategic organizational priorities,

desired work force competencies, and the planned work products of the organization (Morahan et al., 1998). In particular, leadership training should relate knowledgeably to the health professions and their evolving societal roles. For example, the Johnson & Johnson-Wharton Fellows Program in Management for Nurse Executives focuses on developing leadership skills needed for collaborative and innovative partnerships. Toward that end, it addresses self-knowledge, strategic vision, risk taking and creativity, interpersonal skills and communication effectiveness, and managing change (Chow, Coffman, and Morjikian, 1999).

The ultimate test for a leader is not whether he or she makes smart decisions and takes decisive action, but whether he or she teaches others to be leaders and builds an organization that can sustain success even when he or she is not around.

– [The Leadership Engine: How Winning Companies Build Leaders at Every Level](#), Noel M. Tichey and Eli Cohen, 1997

Coaching and mentoring of individual and teams of faculty and staff are necessary to prepare them for future leadership opportunities but are more often used for technical skills than leadership skills. Both coaching and mentoring offer AHC leaders an opportunity to convey organizational values and emphasize desired cultural attributes (e.g., collaboration) while responding to the specific needs of individuals (Henry and Gilkey, 1999).

The most effective mentoring occurs through example (e.g., solve problems as a team with leader as head). Departments that do not have regular departmental meetings or in which attendance is irregular are missing an important opportunity for the chair and senior faculty to mentor younger staff.

There is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful of success, than to step up as a leader in the introduction of change. For he who innovates will have for his enemies those who are well off under the existing order of things, and only lukewarm support in those who might be better off under the new.

– *The Prince*, Niccolò Machiavelli, 1532

Succession planning is critical to the continued development of leadership capability and ability of an organization to sustain high performance. Rarely do very successful large corporations recruit their leaders from outside the firm; they groom their own leaders and, in so doing, maintain and align institutional vision and goals (Collins and Porras, 1994). Yet with rare exceptions succession planning does not occur within AHCs. Typically, AHCs conduct national searches to fill key vacancies and emphasize “intellectual firepower” over understanding of culture or interpersonal skills (Commonwealth Fund Task Force on Academic Health Centers, 2000). This kind of tactical decision making can lead to a lack of continu-

ity of institutional vision or goals. In contrast, Baylor College of Medicine has a strong leadership tradition (Bulger, Osterweis, and Rubin, 1999). It relies heavily on internal appointments for leadership positions, actively plans for leader succession, and uses former CEOs as advisors to ensure smooth, short transitions with minimal uncertainty.

The need for AHC leaders to reach beyond their organizations has been growing over time. They have gone from gathering data about their markets, to working on targeted community projects, to establishing informal and formal relationships with a variety of groups (such as employers, third-party payors, industry, other parts of the university). It is increasingly important that AHCs not only respond to but also influence their environments. External structural barriers that inhibit internal collaboration (e.g., accreditation requirements that do not keep pace with changing clinical care structures) require attention by AHC leaders. It is also important that AHCs attend to the development and strengthening of external relationships. A 1997 study by the Association of Academic Health Centers concluded that “the relationship between an AHC and its community is a critical leverage point as the AHC undergoes transformational change” because that relationship “can facilitate or sidetrack efforts by the academic health center to create partnerships, increase cost effectiveness, reshape the workforce, introduce new products, or modify the class sizes or composition of health professions schools” (Bulger, Osterweis, and Rubin, 1999).

The Shape of Leadership

There are myriad definitions of leadership. Senge describes it as “the capacity of a human community to shape its future, and specifically sustain the significant processes of change required to do so.” He believes that leadership grows from the “energy generated when people articulate a vision and tell the truth (to the best of their ability) about current reality” (Senge et al, 1999). Thus, leadership entails “defining a vision that people can rally around, developing a strategy to achieve the vision, and motivating a group of people to achieve the vision” (Kotter, 1996; Nackel, 2000). Some scholars link the purpose of leadership with specific kinds of change such as reducing the gap between a group’s values and its practices, or increasing social capital (i.e., the communal bonds, moral resources, and collective goods that people invest in one another as members of a community) (Couto, forthcoming).

Organizations typically have three kinds of leaders (Senge, 1999). *Local line leaders* focus on creating better results within their unit. They have “accountability for results and sufficient authority to undertake changes in the way that work is organized.” *Network leaders or community builders* move about the organization carrying ideas, support, and stories. They participate in broad networks of alliances with other like-minded individuals, help line leaders directly and by putting them in contact with others from whom they can learn, and make executive leaders aware of the support change initiatives need from them. *Executive leaders* have overall accountability for organizational performance but less ability to influence work processes directly. Their primary role is to create an organizational environ-

ment for continual innovation and knowledge creation; they do so by investing in new infrastructure, through support and inquiry, and through leadership by example – establishing new norms and behaviors within their own teams.

Leaders who seek change that extends beyond organizational lines or confront diverse groups within their organization require additional capabilities. *Innovative leaders* use stories that permit organizations to build new practices or fundamental beliefs and values. Their stories may also question taken-for-granted assumptions that stifle any organization’s ability to adapt to a changed environment. Their stories and values may be taken from one domain (such as faculty meetings) and told in simpler fashion in another (such as legislative hearings).

Leaders reach a wide range of groups most successfully by framing their stories to appeal to basic concepts common to different domains (Gardner, 1994). The more diffuse a group, the more a leader must reach for common ground. For example, Albert Einstein could not administer Princeton University based on a shared knowledge of theoretical physics. He would need to know the minds and motives of administrators, faculty, students, board members, alumni, and other organizational constituents. Genius does not make this leap from one domain to another; leadership does.

Transforming leaders shape and are shaped by their followers in the pursuit of significant change. They raise expectations for themselves and others. Transforming leaders achieve success by conveying new stories to and learning

new stories from others (Couto, 2000; Couto, Forthcoming). Innovative, transforming leadership uses “new stories about the nature of problems and solutions that permit people to conduct tasks of significant change” (Couto, forthcoming). It attempts to raise the level of a group’s practices to its values and may increase the amounts and improve the forms of social capital. Innovative, transforming leadership expresses old and new truths through familiar and new stories. Such stories move us from exchanges of mutual benefit that further common interest to willingness to sacrifice for a new state of affairs. This form of leadership is particularly relevant for AHCs in light of the challenges and changes they face (such as achieving a shared vision among diverse constituencies, strengthening the AHC through enterprise-wide decision making, or creation of a value-driven health system).

Whatever their end goal, effective leaders use tangible processes and behaviors to convert their vision into reality and manage the conflict and

collaboration needed for change (Couto, Forthcoming; Nackel, 2000). Leaders seeking to transform their organization face both organizational and personnel development activities as well as leadership and management tasks. Generally, these activities comprise:

- setting direction for the organization through vision, strategy, an operating model, and stretch goals
- shaping the culture
- ensuring competency development (including both technical and leadership skills for staff and self)
- establishing connections to the environment
- providing sound management of routine operations and new initiatives (i.e., change management)

These leadership activities are primarily derived from the Leadership Mirror, a leadership model that can be used to assess organizational readiness for successful business transformation. (See Appendix 1 for a full description of the Leadership Mirror).

Expectations for leaders are growing. A series of consumer focus groups concluded that leaders in the twenty-first century

should have integrity, provide genuine attention to the customer and employees, be constantly learning and updating technology and expertise, and offer adequate and useful information for employees and customers. In addition, health leaders are expected to demonstrate caring and compassion, involvement in the community, and financial health for their organizations (Health Forum, 1999).

AHC leaders also face growing expectations. For example, deans previously ensured that educational programs met accreditation standards, distributed resources (without having to disclose how much was given to whom), aided department chairs in recruiting faculty, attempted to keep people happy, promoted the school, and rewarded outstanding achievement (Aschenbrener, 1998). Today, deans must design educational programs to address societal and workforce needs, reduce costs, right-size the faculty, establish direction and encourage collaboration, promote integration with other AHC units and outside partners, and foster institutional alignment.

Similarly, in addition to bearing responsibility for the performance, reputation, and success of academic and clinical programs, department chairs are now expected to:

- share collective responsibility for success of the AHC (by being well-informed about the environmental context, participating in strategic planning, and modeling core values of the AHC)
- assume more responsibility for managing the cost of education and research
- explore new relationships with industry, health care partners, or community agencies
- develop people (i.e., select people whose competencies match the needs of the organization, set expectations for performance and assess productivity in relation to those expectations, and ensure that faculty and staff have the coaching, mentoring, and opportunities for learning necessary to continue their professional and personal growth) and
- participate in succession planning (Aschenbrener, 1998; Johns and Lawley, 1999)

Not surprisingly, these new expectations are driving the need for leaders to possess additional skills. Whereas in the past, academic and clinical achievement were primary selection factors for AHC leaders, interviews with current and former deans revealed that interpersonal skills and personality characteristics as well as management training and experience contributed to success in their roles (Yedidia, 1998) (see Exhibit 5). These findings are consistent with research by Goleman, who found that although technical skills and cognitive abilities are threshold capabilities, effective leaders are distinguished by their emotional intelligence (see Exhibit 5). Analysis of the literature on successful educational curricular change and organizational change identified a series of leadership characteristics and actions that

contribute to success. These include advocacy of the vision by the leader, promotion of a cooperative environment, assurance of real participation, ongoing evaluation of a project, and using human resource development effectively (i.e., training and aligning rewards with desired behaviors) (Bland et al., 2000).

Analysis of the leadership literature from the perspective of AHCs reveals several themes (see Exhibit 5). First, the confusion generated by the rapidly changing environment requires that leaders orient their organizations through articulation of core values and motivate their staff through creation and effective communication of a creative vision. Second, collaboration within and beyond AHCs will continue to increase and requires specific skills for AHC leaders and organizations. Third, ongoing personal development or transformation is a component of effective leadership (Goleman 1998a and 1998b; Nackel, 2000) (see Appendix 1).

In this period of transformation, when what was certain and established will become vague and unpredictable, the essential leadership task will be to bring coherence, structure, and meaning to a world of changing norms and expectations.

– Core Competencies for Physicians,
Edward O’Neil, 1999

Exhibit 5:

Leadership Competencies And Characteristics Identified In The Literature

SOURCE	HEALTH LEADER COMPETENCIES AND CHARACTERISTICS
<p>Goleman (1998a and 1998b) on Emotional Intelligence</p>	<p>Self-awareness: knowing one's preferences, resources, and intuitions</p> <ul style="list-style-type: none"> • emotional awareness, accurate self-assessment, self confidence <p>Self-regulation: managing one's internal states, impulses, and resources</p> <ul style="list-style-type: none"> • self-control, trustworthiness, conscientiousness, adaptability, innovation <p>Motivation: emotional tendencies that guide or facilitate reaching goals</p> <ul style="list-style-type: none"> • achievement drive, commitment, initiative, optimism <p>Empathy: awareness of the feelings, needs, and concerns of others</p> <ul style="list-style-type: none"> • understanding others, developing others, service orientation, leveraging diversity, political awareness <p>Social skills: adeptness at inducing desirable responses</p> <ul style="list-style-type: none"> • influence, communication, conflict management, leadership, change catalyst, building bonds, collaboration and cooperation, team capabilities
<p>Eastwood (1998) on Leadership in AHCs</p>	<p>Blend of "visionary, prophet, analyst, manager, coach, and mediator with skills informed by practical knowledge"</p> <p>Strongly motivated</p> <p>Possess a great deal of energy</p> <p>Self-knowledge</p> <p>Self-confidence</p> <p>Broad perspective</p> <p>Integrity</p> <p>Other directedness (including respect and ability to assess the abilities and motivations of others)</p> <p>Ability to communicate</p> <p>Ability to listen</p> <p>Ability to select good people</p> <p>Ability to handle uncertainty</p> <p>Ability to handle praise and criticism</p> <p>Ability to act and take risks</p> <p>Ability to use power</p> <p>Ability to make difficult decisions</p>
<p>Yedidia (1998) on Qualities to be Considered in Selecting a Dean</p>	<p>Academic and clinical achievements</p> <p>Personality traits:</p> <ul style="list-style-type: none"> • patience with process • openness to diverse points of view • capacity to act decisively • penchant for taking pride in the accomplishments of others <p>Management experience:</p> <ul style="list-style-type: none"> • prior experience in addressing complex, cross-cutting issues • ability to attend to a variety of issues at once • capacity to incorporate a view of institution-wide needs in decision making • insider status (both potential asset and potential liability)
<p>Franklin & Moore (1999) on Skills Needed to Lead Integrated Delivery Systems</p>	<p>Capacity to amass critical resources quickly</p> <p>Ability to cross traditional boundaries and form alliances</p> <p>Cognitive flexibility</p> <p>Ability to integrate and interpret information</p>

SOURCE	HEALTH LEADER COMPETENCIES AND CHARACTERISTICS
<p>O'Neil (1999) on Physician Leaders</p>	<p>Ability to develop creative vision and convey it using stories Ability to align organizational efforts with vision through communication, focus, and continued involvement Ability to develop partnerships, alliances, and acquisitions Ability to manage change, including</p> <ul style="list-style-type: none"> • self-knowledge • ability to resolve conflict (i.e., manage expectations, processes for decision making and participation, and commitment to broader organizational goals and vision) • create a culture that recognizes diversity of ability, provides training and environment, and ensures that people grow in their professional work • link the leadership agenda to the developing ability of its members • develop a diverse executive team that is aligned with the vision and strategy of the organization
<p>Chow, Coffman, & Morjikian (1999) on Nursing Leaders</p>	<p>Systems perspective as well as competencies in vision development, taking risks, innovating, and managing change</p>
<p>Bland et al. (1999) on Leadership of Collaborative Curricular Changes in Medical School</p>	<p>Ability to build a shared vision and keep it visible Ability to bring diverse partners together Ability to negotiate and handle conflict Project management capabilities (e.g., organizational skills, accountability systems) Knowledge about various domains involved in the project including the traditions and politics of each</p>
<p>Halverson (1999) on Skills Needed for an Integrated Community Health System</p>	<p>Inclusiveness: bring everyone who is part of problem or part of solution to the table</p> <ul style="list-style-type: none"> • be willing to share control • seek out new and different people to participate • listen carefully to community perceptions • gain common vision and agreement on goals <p>Innovation: overcome constituent traditions, harness collective ingenuity to arrive at new approaches</p> <ul style="list-style-type: none"> • explicitly discuss value of innovation • create an innovations fund • create structured ways to learn from failure <p>Integrity: provides the basis for trust and support among diverse participants</p> <ul style="list-style-type: none"> • communicate • use a policy of full disclosure • ensure actions are consistent with words

As our knowledge of the biological mechanics of health continues to deepen and our understanding of the social components of health continues to broaden, the U.S. health sector faces the opportunity to achieve a significantly higher standard of performance. This opportunity arises amidst a multitude of existing shortcomings and emerging technological capabilities that point to the need for and potential to achieve a new vision for and level of health in this country early in the 21st century. The continued existence of a large population of uninsured citizens, varying levels of quality and safety achieved by health care provider institutions, and continued escalation in costs of health care without accompanying improvement in health status of the population signal needed changes (Blue Ridge Academic Health Group, 1998b; Institute of Medicine, 1999). The possible shift in health care financing modes (i.e., from defined benefit to defined contribution) creates an opportunity to introduce changes (Goldsmith, 2000).

The health care community is just now beginning to reap the benefits of advances in information and communications technology, nanotechnology, robotics, tissue engineering, genomics, and pharmacogenetics. New models of health care management are emerging with growing involvement of patients in their own care. Increasing connectedness in the health care sector and the economy at-large reduces (although by no means eliminates) the difficulty associated with developing a systematic approach to managing the health of individuals and populations and creates opportunities for significant administrative cost savings (Blue Ridge Academic Health Group, 2001; Goldsmith, 2000). The potential to monitor population health, customize diagnostic and therapeutic services for individual patients, and offer facile routine interaction between health care professionals and patients could stimulate the next major transformation in the delivery of health care (on par with the introduction of sanitation techniques and discovery of antibiotics).

Yet, along with significant potential to improve health, these developments raise a complex set of issues (e.g., equity, efficacy, and funding) that must be addressed. The health sector will need to determine how to balance allocation of resources among these highly sophisticated technologies and primary health needs such as nutrition, screening, or immunization.

Health care in the future will be more than the illness care, illness prevention, and public health of the past. It will also include identification and treatment of the determinants of health at the societal level as well as value-driven services that meet the care needs of individuals. As the production modes of health care evolve, the industry will be able to draw upon the strengths offered by each. Ultimately, health care may successfully combine the trusting physician-patient relationship of the craft mode, outcome measures and efficiency of the manufacturing mode, and transformation of information and experience into useful knowledge in the learning mode (Maccoby, 1999).

Such profound change within the health care domain is, however, inhibited by limited and diffuse leadership of a sector populated by many diverse constituencies with well-entrenched interests. Thus, there is an urgent need to assimilate cutting-edge theories and proposals with nascent technological capabilities into a coherent vision that will motivate the myriad groups to coalesce and work collaboratively toward a radically different and dramatically improved future health system. In short, innovative transforming leaders are needed to take full advantage of imminent technological achievements to improve health in the U.S.

Progress is evident in some of the areas that would provide an infrastructure for a value-driven health system (e.g., tools for population health management, evidence-based medicine, robust information systems, health professionals as proficient knowledge managers) (Blue Ridge Academic Health Group, 1998b). Considerable work remains, however, in other areas such as:

- universal coverage
- reimbursement mechanisms that offer health maintenance incentives to both health professionals and patients
- expanded understanding of professionalism to include care of population as well as care of individuals
- willingness to shift resources away from medical applications towards other factors that contribute directly to the health of a population (e.g., housing, education, nutrition, employment)

Moreover, there is not yet a sustained effort to create a true health care system in the U.S. To drive such an effort, AHCs must articulate the vision for a new health

system, define and communicate the framework needed for a value-driven system, become value-driven organizations, model and assess value-driven behaviors, educate value-driven health professionals and patients, and advocate for value-driven health policies. First and foremost, AHCs need to envision the future clearly and convey it in different ways to reach a variety of audiences so that others can embrace it and will be motivated to create a “new world order” for health care.

Progress will also require that AHC leaders cultivate a culture of change within their own institutions so that their enterprises can be transformed into value-driven organizations. As such, they can develop, model, and evaluate health organization and professional behaviors consistent with value-driven health care. They can identify skills needed to practice in such a system, educate future health professionals about those behaviors and skills, and disseminate knowledge about best organizational practices across the entire health sector.

Unfortunately, physicians and scientists who currently hold key leadership positions in academic medicine are superbly knowledgeable within their disciplines, but have had little systematic management training, leadership education, or guided executive experiences.

– *Training Future Leaders of Academic Medicine*, Morahan et al., 1998

By providing innovative, transformational leadership in the health sector, AHCs necessarily position themselves amongst those at the forefront and sustain their ability to train future health professionals and develop future health leaders.

Alternatively, when AHCs respond in an ad hoc manner as forces buffet them, they risk damage to their organizations and to the public's health interests. Although this endeavor represents a huge stretch goal, AHCs are well-positioned to create a coherent platform for change and align the various interest groups for action. Their traditional role as educators, innovators, and thought leaders provides them with influence in the health community through connections to and credibility with many different constituencies.

Although AHCs can make significant contributions to the development of a value-driven health system, they cannot nor should not seek to bear the full burden of leadership. One of the key concepts of value-driven health is that risk and responsibility are shared by all participants and that contributors to the health system are defined broadly and extend to civic and business leadership as well as health leadership. AHCs should work with their commu-

nities and regions to communicate the concept of a value-driven health system, to develop strategies for increasing responsibility among local citizens for maintaining their health, and to share leadership opportunities associated with building a value-driven health system. Working collaboratively on this endeavor will increase the social capital of all participating parties with ultimate benefit accruing to the community as a whole. Success in this arena will depend on AHCs being open to ideas from their collaborators and seeking innovative approaches to community issues. The American Network of Health Promoting Universities, established by the Association of Academic Health Centers, can contribute to progress on this front as it seeks to raise health promotion on the agendas of AHCs, increase the effectiveness of AHCs' health promotion efforts, and strengthen partnerships between AHCs and local communities (Association of Academic Health Centers, 2000).

The logic for a new leadership paradigm is compelling. The order once provided by chains of command, spans of control, and standards of protocol becomes an impediment to action in time sensitive, competitive market environments. Power, authority, and decision making must all be dispersed before organizations can

provide responsive point of service delivery. As a result, ponderous structures and systems, and the authoritarian personalities that they sometimes spawned, are now dysfunctional.

– Growing Effective Leadership in New Organizations, John D. Henry and Roderick W. Gilkey, 1999

There are many ways that AHCs can strengthen the leadership capabilities within their organizations. The Blue Ridge Group focused its recommendations on four areas likely to yield notable benefits – careful selection of AHC leaders, development of leadership skills among organizational members, working with governing bodies, and collaborating with communities to build value-driven health systems.

Recommendation 1

AHCs should seek leaders with the ability (i.e., qualities and experience) to transform their organizations and to work with their communities to build value-driven health systems.

Recommendation 2

AHCs should develop the leadership skills of their professionals and students to build stronger organizations and value-driven health systems for their communities.

AHCs can make progress toward strengthening their internal leadership capabilities by:

- articulating skills and characteristics critical for successful leadership and incorporating those criteria into recruitment and promotion efforts for all faculty and staff
- providing continual development opportunities for AHC professionals oriented to meeting both the needs of the organization and the individual's professional development plan
- identifying and nurturing potential future leaders through explicit mentoring, comprehensive appraisals with direct feedback from both supervisors and peers, and opportunities for both individuals and teams to attend leadership development programs

- developing team leader skills through mentoring, educational opportunities, and low risk projects
- attending to leadership abilities in the selection of faculty and staff who participate on committees, task forces, and project teams
- attending to succession preparation as part of strategic planning for the institution
- fostering institutional citizenship in faculty, staff, and students through educational programs, communication opportunities, explicit expectations, and performance evaluations
- strengthening formal and informal mentoring (e.g., include as part of performance expectations) and acknowledging individuals who serve as role models
- encouraging and rewarding collaboration across departments and disciplines
- considering leadership potential in the admissions process for health professional school candidates

AHCs can make progress toward strengthening their collaborative leadership capabilities and advancing development of a value-driven health system by:

- drawing upon experiences of a wide range of community representatives (e.g., community health, public health, and education professionals; public officials; philanthropic agencies; and other parts of the university)
- participating in assessment of community or regional health needs to determine how the AHC can contribute to the effort to advance the health status of the population (e.g., provide resources for development of a regional health database)
- advancing efforts to improve population health status through educational programs for students, professionals, and patients
- allocating institutional resources to encourage research on population health issues
- initiating health policy debate on the need for and requirements of value-driven health care at local, state, and national levels

Recommendation 3

AHCs should work with and develop the capacity of their governance bodies to provide strong leadership, sound guidance, and effective decision making for their institutions.

To make progress in this area, AHC leaders can:

- continue and strengthen efforts to educate governing boards about immediate and longer term challenges facing AHCs (e.g., visit other AHCs or attend national meetings together)
- initiate conversation with board members on their respective roles in the changing economic climate and boundary conditions that enable leaders to act effectively
- ensure that all members of governance bodies and the AHC leadership team clearly understand and acknowledge conflict of interest laws and issues
- continue development and use of performance measures that provide effective assessment of organizational and leadership performance
- encourage board members to play an active governance role while supporting the management team in its designated role as managers of the enterprise

Recommendation 4

AHCs should partner with professional organizations and specialty societies to strengthen leadership skills of their faculty and students, to help create and support needed change within AHCs, and to advocate for necessary changes in the health care system.

Effective leaders... translate the vision into stories that explain the changing environment, tie the organization's values to these changes, and point to ways in which the work of those inside the organization can and should change.

– Core Competencies for Physicians,
Edward O'Neil, 1999

To make progress in this area, AHCs and their partner organizations can:

- review curricula of existing leadership and related programs to determine if they are consistent with current climate and needs of AHCs (e.g., do the programs address relevant leadership skills and tasks and offer a balance between leadership and management issues)
- determine if the focus of leadership and management programs should be broadened to include emerging developments in health care and evolving nature of professionalism within health care (e.g., interdisciplinary care, population health management, knowledge management, health informatics including ehealth and bioinformatics)
- include institutional citizenship skills in both undergraduate and professional education programs
- evaluate the benefits of establishing a leadership fellow program for AHC faculty and staff based on the model provided by the ACE fellow program

Conclusion

Today's AHC leaders need more than technical expertise, extensive managerial experience, and strong people skills (i.e., emotional intelligence). They must have vision for where health care should be in the twenty-first century, be able to share that vision effectively with diverse audiences, and be able to develop alliances that will work towards that vision. They must also have a vision for where their organization fits in that future health system and be able to transform their organization for future success. Thus, they must attend to leadership tasks of:

- developing an operating model and implementation strategies
- forging a culture supportive of learning and change
- establishing stretch goals and performance measures for the organization, for themselves as individuals, and for their staff
- ensuring that professional development opportunities address both technical and leadership capabilities
- building solid relationships with their governing boards and
- planning for continued organizational success through future leaders

We are living at a time when a new form of leadership – leadership as the ability to inspire, empower, and exert broad influence – supplants leadership as the exercise of centralized power and control.

–Growing Effective Leadership in New Organizations, John D. Henry and Roderick W. Gilkey, 1999

Needless to say, energy, commitment, staying power, and a sense of humor are also prerequisites for the job.

AHCs face the challenge of transformation across each of their missions. They cannot, however, transform themselves within a vacuum. They must strive to shape the environment in which they operate so that they are better able to reach their ultimate goal of improving health in this country. The current climate requires that AHC leaders extend their role from their organizations to their community and health care generally. AHCs need to help define the attributes of the future health sector. The Blue Ridge Group believes that the potential to create a *health system* for the nation has never been greater and that AHCs should act on the opportunity to shape a system that truly meets the needs of the public.

Despite its daunting nature and considerable risks, the role of the AHC leader offers the potential to shape the future of health in this nation in the coming decade, perhaps for the rest of this century. By leading instead of reacting, AHC leaders can take advantage of the unique set of opportunities presenting itself to this generation of health professionals. The U.S. health sector needs transformation. With inspired leadership, AHCs can help to make it happen.

About the Blue Ridge Academic Health Group

The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to make recommendations to academic health centers to help them create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

Three basic premises underlie this mission. First, health care in the United States is experiencing a series of transformations that ultimately will require new approaches in health care delivery systems, education, and research. Second, the recent upheavals in health care have been largely driven by financial objectives. Yet, the potential exists for fundamental changes in health care to improve health and manage costs. Analysis and evaluation of the ongoing evolution in health care delivery must address this impact on the health of individuals and the population, as well as on cost. Third, AHCs play a unique role in the U.S. health care system as they develop, apply, and disseminate knowledge to improve health. In so doing, they have assumed responsibilities and encounter challenges other health care provider institutions do not bear. As a result, AHCs face greater risks and opportunities as the U.S. health care system continues to evolve.

The Blue Ridge Group was founded in March 1997 by the Health Policy Center at the University of Virginia and the Health Care Consulting leadership at Ernst & Young, LLP (now Cap Gemini Ernst & Young U.S. LLC, CGE&Y). Group members were selected to bring together seasoned, active leaders with a broad range of experience in and knowledge of academic health centers in the United States.

Other participants are invited to Blue Ridge Group meetings to bring additional expertise or perspectives on a specific topic.

Blue Ridge Group members collectively select the topics to be addressed at annual meetings. Criteria for selection of report topics include relevance to AHCs' operations, consistency with AHCs providing value to society, the likelihood of being able to make specific recommendations that will lead to productive action by AHCs or other organizations, and the ability to frame useful recommendations during two-day meetings.

Before each meeting, an extensive literature review is conducted. During the meeting, participants reflect on emerging trends, share experiences from AHCs, and hear presentations on specific issues. Most of the working session is dedicated to a discussion of what AHCs can and should be doing in a particular area to achieve visible progress, or a discussion of what public and private policy and philanthropic organizations can do to facilitate the efforts of AHCs to fulfill their societal mission. The results of the group's deliberations are presented in brief reports that are disseminated to targeted audiences.

About the Core Members

Enriqueta C. Bond, Ph.D.

President

Burroughs Wellcome Fund

Dr. Bond is the president of the Burroughs Wellcome Fund. She formerly held a number of research and administrative positions at the Institute of Medicine, National Academy of Sciences; Department of Medical Sciences, Southern Illinois University's School of Medicine; and the Biology Department at Chatham College. Dr. Bond also serves on several advisory committees and boards, some of which include the Council of the Institute of Medicine and the National Center for Infectious Diseases, Centers for Disease Control and Prevention. She has authored and co-authored more than 50 publications and reports in science policy.

Robert W. Cantrell, M.D.

Vice President and Provost

University of Virginia Health System

Dr. Cantrell is vice president and provost for the Health System at the University of Virginia. Also a surgeon-educator and medical administrator, he is the former president of the American Academy of Otolaryngology-Head and Neck Surgery. As a captain in the U.S. Navy, he served as chair of Otolaryngology-Head and Neck Surgery at the Naval Regional Medical Center in San Diego, California. Dr. Cantrell was also the Fitz Hugh Professor and chair of the Department of Otolaryngology-Head and Neck Surgery at the University of Virginia School of Medicine. He has been a consultant to the Surgeon General of the U.S. Navy and to the National Institutes of Health (NIH). Dr. Cantrell is a member or fellow of 33

otolaryngological societies and has taken an active leadership role in many, including the American College of Surgeons, the American Society for Head and Neck Surgery, and the American Broncho-Esophagological Association. Dr. Cantrell received the Mosher Award for clinical research, has published numerous articles, and lectured nationally and internationally.

Don E. Detmer, M.D.

*Dennis Gillings Professor of
Health Management*

*Director, Cambridge University Health
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Dr. Detmer heads the health policy and management center within the Judge Institute of Management at Cambridge University's business school. He chairs the Board on Health Care Services of the Institute of Medicine and is a board member of several organizations including the China Medical Board of New York, the Nuffield Trust in London, and the American Journal of Surgery. He has authored numerous scientific publications. Dr. Detmer earned his medical degree at the University of Kansas after undergraduate studies there and at Durham University of England. He conducts his work with the Blue Ridge Group through a professorship at the University of Virginia where in the past he served as vice president and provost for health sciences and university professor.

Michael A. Geheb, M.D.

Professor of Medicine and Senior Vice President for Clinical Programs Oregon Health Sciences University

Dr. Geheb is professor of medicine and senior vice president for Clinical Programs at Oregon Health Sciences University. Dr. Geheb has also served as professor of medicine, and was the first director and chief executive officer of the University of Alabama at Birmingham Health System. Prior to that, Dr. Geheb was associate dean for Clinical Affairs, and director of Clinical Services at the State University of New York at Stony Brook University Medical Center. Dr. Geheb's professional associations include the American Federation for Clinical Research; the Board of Directors of the University Hospital Consortium; and the American Board of Internal Medicine's Board of Directors. Dr. Geheb is co-editor of the textbook *Principles and Practice of Medical Intensive Care* and co-editor for the *Critical Care Clinics* series. He also speaks frequently to national audiences on health care policy issues related to academic productivity and financial models for academic clinical enterprises.

Jeff C. Goldsmith, Ph.D.

President Health Futures, Inc.

Dr. Goldsmith's consulting firm assists a wide range of health care organizations with environmental analysis and strategy development. He is a director of Cerner Corporation, a health care informatics firm, and of Essent Healthcare, a hospital management firm, as well as a member of the Board of Advisors of Burrill and

Company, a private merchant bank in biotechnology and health sciences. He is currently an associate professor of medical education at the University of Virginia. He is a former lecturer in the Graduate School of Business at the University of Chicago. He has also lectured on health services management and policy at the Harvard Business School, the Wharton School of Finance, Johns Hopkins, Washington University and the University of California at Berkeley. Dr. Goldsmith has served as national advisor for health care for Ernst & Young LLP, was director of Planning and Government Affairs at the University of Chicago Medical Center, and special assistant to the Dean of the Pritzker School of Medicine. Dr. Goldsmith has written for the Harvard Business Review and has been a source for articles on medical technology and health services for *The Wall Street Journal*, *The New York Times*, *Business Week*, *Time* and other publications. He is a member of the editorial board of *Health Affairs*. He earned his doctorate in Sociology from the University of Chicago in 1973.

Michael M.E. Johns, M.D.

*Executive Vice President for Health Affairs
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Director
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Center
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Dr. Johns heads Emory's academic and clinical institutions and programs in the health sciences and is a professor in the Department of Surgery. A former dean of the Johns Hopkins School of Medicine, he was professor and chair of the Department of Otolaryngology-Head and Neck Surgery at Johns Hopkins. Before that he was assistant chief of the Otolaryngology Service at Walter Reed Army Medical Center. Dr. Johns is a member of the Institute of Medicine and the Executive Council of the Association of American Medical Colleges and a fellow of the American Association for the Advancement of Science. He serves on the Governing Boards of the National Research Council and the Clinical Center of the National Institutes of Health, and on the Advisory Committee for the Director of the Centers for Disease Control and Prevention. He is the president of the American Board of Otolaryngology, editor of the Archives of Otolaryngology-Head and Neck Surgery, and is a member of the Board of Trustees of Genuine Parts Company. Dr. Johns received his bachelor's degree and continued with graduate studies in biology at Wayne State University. He earned his M.D. at the University of Michigan School of Medicine.

Peter O. Kohler, M.D.

*President
Oregon Health Sciences University*

Dr. Kohler is president of Oregon Health Sciences University. After holding positions at the National Institutes of Health (NIH), he became professor of medicine and chief of the Endocrinology Division at Baylor College of Medicine. Later he served as chairman of the Department of Medicine at the University of Arkansas and then dean of the Medical School at the University of Texas Health Science Center in San Antonio. Dr. Kohler has served on several boards. He has been chairman of the NIH Endocrinology Study Section and chairman of the Board of Scientific Counselors for the National Institute of Child Health and Human Development. Currently, he is chairman of the Institute of Medicine Task Force on Quality in Long-term Care and past-chair of the Board of Directors of the Association of Academic Health Centers. Dr. Kohler received his B.A. from the University of Virginia and earned his M.D. at Duke Medical School.

Edward D. Miller, Jr., M.D.

*Dean and Chief Executive Officer
Johns Hopkins Medicine*

Dr. Miller is chief executive officer of Johns Hopkins Medicine. His former posts include chairman of the Department of Anesthesiology and Critical Care Medicine; interim dean of the School of Medicine; professor of anesthesiology and surgery and medical director of the Surgical Intensive Care Unit at the University of Virginia; E.M. Papper Professor at Columbia University; and

chairman of the Department of Anesthesiology in the College of Physicians and Surgeons. Dr. Miller has authored and co-authored more than 150 scientific abstracts and book chapters. He received his A.B. from Ohio Wesleyan University and his M.D. from the University of Rochester School of Medicine and Dentistry.

John G. Nackel, Ph.D.

*Vice President, New Ventures
Cap Gemini Ernst & Young U.S. LLC*

Dr. Nackel is the managing director, New Ventures with Cap Gemini Ernst & Young U.S. LLC. Prior to this position, he served as national director, Health Care Consulting. While with CGE&Y he has worked in various positions and directed numerous projects in the U.S. and internationally. He has served the pharmaceutical and life sciences, managed care, and provider segments of the health care industry. In his New Ventures position, he oversees the firm's spinoff companies and strategic investments. Dr. Nackel has presented papers and keynote addresses at more than 200 professional society and health care trade association meetings. He has published more than 30 articles on applications of cost and quality improvement, information systems and health systems engineering; and is the co-author of the award-winning book *Cost Management for Hospitals*. He was co-editor of the Society for Health Systems' special issue focused on Patient Care. Dr. Nackel received a B.S. from Tufts University and masters degrees in public health and industrial engineering from the University of Missouri-Columbia. Also from the

University of Missouri, he was awarded a Ph.D. in health care systems design from the Department of Industrial Engineering.

Mark L. Penkhus, M.H.A.

*Chief Executive Officer and Executive
Director
Vanderbilt University Hospital*

Mr. Penkhus is chief executive officer and executive director of Vanderbilt University Hospital. Prior to joining Vanderbilt, Mr. Penkhus was a partner and business unit leader for Healthcare Consulting (Mid-Atlantic area) in Washington, D.C. for Ernst and Young LLP, and served as a national leader for academic health centers. During his career he has worked with a variety of organizations as an innovator, and change agent with a special emphasis on strategic, operational and financial performance improvement. Mr. Penkhus received his B.S. degree from Iowa State University, a master's degree in Hospital and Health Care Administration from the University of Iowa, and his MBA from Rensselaer Polytechnic Institute in New York. He is also a graduate of the Advanced Management Program, Wharton School of Business, at the University of Pennsylvania.

He is a fellow of the American College of Healthcare Executives (ACHE), a fellow in Project HOPE, Washington, D.C. and a member of the Johns Hopkins University School of Hygiene and Public Health, Department of Health Policy and Management. Mr. Penkhus serves on several non-profit boards and for-profit boards in both Tennessee and nationally.

George F. Sheldon, M.D.

*Chairman and Professor
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Dr. Sheldon's background in graduate medical education spans four institutions: Kansas University, Mayo Clinic, University of California at San Francisco and Harvard University. He is currently chairman and professor, Department of Surgery at the University of North Carolina at Chapel Hill and was formerly professor of surgery in the Department of Surgery at the University of California - San Francisco. He has held several national appointments, including: president of the American Surgical Association; chairman, of the American Board of Surgery; and member of the Council on Graduate Medical Education. He is currently chair of the Association of American Medical Colleges, past president of the American College of Surgeons, and past chair of the Council of Academic Societies of the Association of American Medical Colleges. He has published 195 articles and book chapters and co-authored eight books.

Katherine W. Vestal, Ph.D.

*Vice President, Health/Managed Care
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Dr. Vestal leads the academic health center sector for Cap Gemini Ernst & Young's (CGE&Y) health consulting practice where she focuses on large-scale organizational change for a wide range of health care delivery organizations. Prior to joining CGE&Y, Dr. Vestal held several executive positions in academic health centers and taught at the graduate level at the University of Texas. Her background includes over 25 years of operations management and consulting in the areas of business transformation, post merger integration, and clinical management. She speaks nationally on issues of organizational improvement and is a Malcolm Baldrige National Quality Award Examiner. Dr. Vestal received her BSN from Texas Christian University, MS from Texas Women's University, and Ph.D. at Texas A & M University. She is a Fellow of the Johnson and Johnson Wharton School of Finance, American College of Healthcare Executives, and the American Academy of Nursing.

About the Invited Participants

Roger J. Bulger, M.D.

President and CEO

Association of Academic Health Centers

Dr. Bulger formerly served as president of the University of Texas Health Sciences Center at Houston, chancellor of the University of Massachusetts Medical Center, and dean of its Medical School. He has served as a member of numerous national advisory committees, has been chairman of two Institute of Medicine committees, and served on the board of the Association for Health Services Research. Dr. Bulger is a member of the Institute of Medicine and currently serves on the boards of the American International Health Alliance and the Living Centers of America. He has been elected to membership in the National Academy for Social Insurance and is a fellow in the Infectious Disease Society of America, the American College of Physicians, and the Royal College of Physicians. Over the last 25 years, he has authored numerous articles and essays on medical sciences and health policy.

Richard A. Couto, Ph.D.

Professor of Leadership Studies

Jepson School of the University of Richmond

Dr. Couto is one of the founding faculty of the Jepson School of Leadership Studies and currently holds the George M. and Virginia B. Modlin chair there. He teaches in the fields of community leadership, social movements, public policy, politics, and experiential education. He taught and served previously at Tennessee State University in the Institute of Government, where he developed and directed the Kaiser Family Foundation's

community-based health promotion program in Tennessee. He has also served as director for Vanderbilt University's Center for Health Services and chaired the Nashville Coalition for the Homeless.

Since 1991, he has published two award-winning books on the civil rights movement in the rural South, its historical roots, and its current course. He also served as the senior editor for a monograph of the National Institutes of Health on community-based interventions in health, *Sowing Seeds in the Mountains*. His book, *Making Democracy Work Better*, deals with community-based organizations in the Appalachian region and has received the Virginia Hodgkinson Award of the Independent Sector. In addition to these books, he has published articles in numerous journals and has lectured extensively. He has a BA from Marist College, a MA in political science from Boston College, and received his Ph.D. in political science from the University of Kentucky in 1974.

Mary Jane Kagarise, R.N., M.S.P.H.

Associate Chair and Professor of Surgery

Department of Surgery

University of North Carolina at Chapel Hill

With more than 25 years experience in healthcare, Mary Jane Kagarise formerly served as assistant director of operations at University of North Carolina Hospitals in Chapel Hill and as assistant director of patient services at Duke University Medical Center in Durham. The U.N.C. Hospitals Management Excellence Award and State of North Carolina Governor's Award for Excellence certificate recognized her leadership at UNC, and the

Duke Hospital Woman of Achievement Award acknowledged leadership at Duke. She is currently associate chair for the Department of Surgery at the University of North Carolina where she co-authored a book and several publications.

Ms. Kagarise earned her bachelors of science degree from Duke University and her masters of science degree in management from the University of North Carolina at Chapel Hill where she achieved appointment to Delta Omega. She was a founding board member of the Carolina Organ Procurement Agency, and served on the Board of Directors of the North Carolina Kidney Council and Board of Trustees for the National Kidney Foundation. She is an active member of the Faculty Council of the University and serves on two Institutional Review Boards for the School of Medicine.

The Means of Leadership

Leaders can transform their organizations to achieve sustained high-performance through a set of leadership and management tasks that require action on both the organizational and personal levels. *The Leadership Mirror* is a model that identifies 14 elements of successful business transformation and divides those tasks between leadership and management as well as between personal and organizational activities (see Figure 1; Nackel, 2000). The Blue Ridge Group found this model to be a useful construct in assessing the many facets of AHCs.

Pivotal leadership activities for sustained high-performance by an organization include the following leadership and management tasks:

1. Build the organizational transformation platform.

The transformation platform provides the framework by which an organization can be transformed (see Figure 2 and Exhibit 6). It defines the what, why, and how of an organization's role within a market, industry, or community. By detailing the kinds of behaviors necessary to achieve internally established goals, it provides the basis for an organization's culture.

Catalytic mechanisms are policies and practices that “are simple, easy to comprehend, and that result in substantially raising the bar over current levels of performance.” These simple procedural edicts are a potent way of reinforcing or achieving desired behaviors.

2. Develop a personal transformation framework.

Change must occur within people before it can occur within an organization, therefore a framework to support personal transformation is a critical element of creating an organization with sustained high performance. Such a framework is similar to the organizational transformation platform and includes a personal vision, mission, values, understanding of strengths, goals, and implementation actions to achieve personal goals. It helps leaders clarify what they want to achieve and ensures that decisions and actions are based on a clearly articulated set of core values.

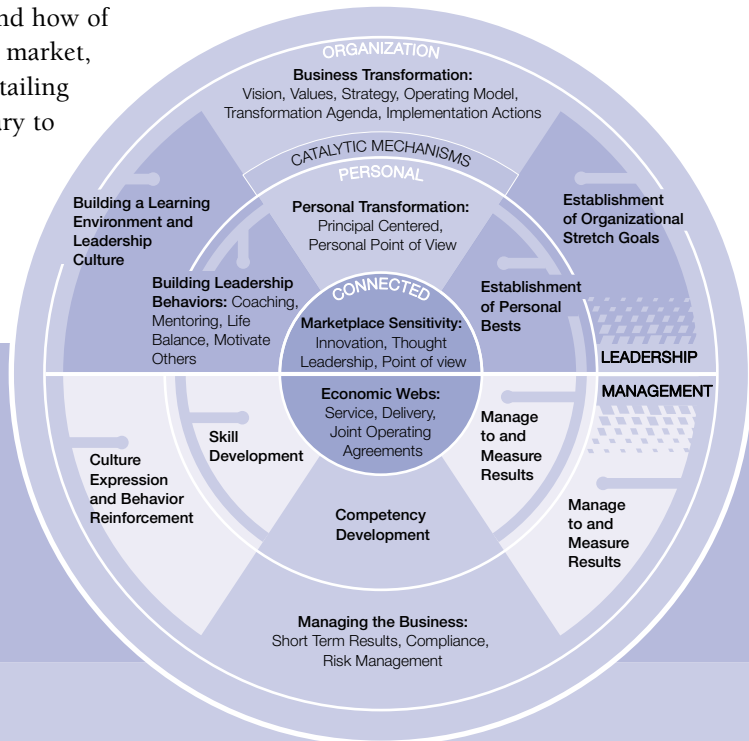


Figure 1:
The Leadership Mirror

3. Establish connections to the market.

Sensitivity to the environment and a framework for linkages to the marketplace enable sound decision making, provide the basis for future external relationships, and are critical for high-performing organizations. Organizational leaders should not only scan the environment constantly, but also generate thought leadership for their organization by generating and sharing new ideas, striving to be innovative, communicating with important players outside the organization, and developing a “point of view” on the marketplace.

4. Establish organizational stretch goals.

Organizational stretch goals are long-term, easy to understand, and flow from an organization’s vision and values. They are the “stratospheric heights to which all organizations who want long-term performance should aspire” and drive business transformation by motivating the organization to examine where it needs to change to achieve those goals. Creating these goals is an important part of leadership because it provides a tangible target to achieve while pursuing the organization’s vision. These goals should be achievable, but require substantial energy.

5. Establish personal bests.

Personal bests are organizational stretch goals on an individual level – long-term, easy to grasp, and vision-centered goals that individuals strive for as part of their own personal transformation process. Personal bests require an assessment of individual processes. They challenge individuals to consider how they currently operate and to determine how they need to change to reach their goals. Personal

bests should be aligned with the organization’s stretch goals. Leaders should not only develop their own set of personal bests, but also encourage other individuals to formulate and accomplish their own personal goals.

6. Create a leadership culture and a learning environment.

The combination of a leadership culture and a learning environment provides both the reason and means of constant organizational renewal. A leadership culture is one in which an organization’s beliefs, behaviors, norms, and standards are centered on transforming the work of the organization to address its opportunities effectively. It is an organization’s identity as an entity that is principled, proactive, and continually changing and prepared for changes in the marketplace.

Effective leadership cultures are constituted by diverse individuals with a shared understanding of the organization’s vision or purpose, values, and mission. In Nackel’s model, this shared understanding disperses responsibility to achieve the permanent aspects of the business transformation pyramid and guides actions without the requirement of managerial oversight. Diversity in the professional, experiential, and cultural background of staff is an organizational asset since it is likely to broaden the range of approaches to problems thereby increasing speed in designing solutions that ultimately strengthen the organization.

A leadership culture is characterized by balance among the various segments of the leadership mirror and commitment to long-term success. It is also balanced in

terms of the ability to implement organization-wide changes quickly while attending to human needs and sustained behavior reinforcement. Finally, a leadership culture assesses progress toward the vision and mission on a regular basis through established goals and measures and provides mechanisms to address shortcomings or develop needed competencies. A learning environment is one that is structured around the generation, acquisition, and application of new knowledge. Such an atmosphere stimulates learning about an organization's environment and thus strengthens an organization's capacity to change by connecting the individual and organization to the marketplace. It also empowers individuals to examine how they act and where they need to change as part of their personal transformation. Moreover, a learning environment provides staff with the skills necessary for change and helps to create the mindset for continual change.

7. Model personal leadership behaviors.

Personal leadership behaviors – including mentoring, sponsoring, coaching, and work-life balance – are important for the development of a learning organization and therefore contribute to the development of a sustained high-performing organization. These activities encourage learning, reinforce the vision, mission, and organizational goals, and build trust between a leader and individuals within the organization. (Tichey and Cohen, 1997).

8. Manage the business.

Ultimately, whether or not an organization is successfully transforming itself can be determined through its day-to-day operations and the actions that create short-term results. Tactical necessities must closely involve the elements of the transformation agenda. They are the concrete actions and tasks associated with fulfillment of the mission and vision. They include producing valued products and services as well as establishing and meeting quarterly earnings or other business projections.

9. Develop competency.

Competency development is a means to ensuring that leaders and others in the organization possess the managerial skills necessary to the achievement of the vision and values. By fostering competency development in themselves and in others, organizational leaders reinforce the learning environment at the same time as they acquire needed skills. Competency development is critical for ensuring the completion of tactical necessities and success in key business processes. Such competencies may include specific technical expertise, process enhancement, product development, sales and marketing, or service delivery.

10. Establish economic webs.

Leadership is interconnected and must not only link the personal and organizational spheres, but also the organizational and external spheres. Leaders must connect the organization to the economy through both its suppliers and customers and strive to cultivate new partnerships that support the transformation agenda.

11. Manage to and measure organizational results.

Robust performance measures allow leaders to determine if the organization is transforming successfully and whether it will reach its stretch goals. Leaders need to develop the correct set of performance measures (i.e., measures that matter and are aligned with an organization's goals) and ensure that these measures are continually assessed and acted upon. Some standards are traditional and fairly easy to measure such as revenues or profitability. Others reflect more intangible, but increasingly crucial elements of success (e.g., speed, use of intellectual capital). Effectively used performance measures provide accountability and communicate expectations to the organization thereby shaping how organization members behave and providing objective data needed to make judgments about how people, processes, and technology can be best aligned to achieve the organization's vision.

12. Manage to and measure personal results.

Personal performance measures enable individuals to track their progress toward personal stretch goals. These measures should be aligned with personal goals, identify desired behaviors, and include expectations for results. Organizational leaders can influence the development and use of personal performance measures through both voluntary (e.g., encouragement) and involuntary (e.g., requirement of employment) means.

13. Reinforce behaviors and cultural expression.

Behavior reinforcement entails the development of systems that support a learning environment on a daily basis. Such systems typically include human resources, communications and knowledge transfer, pay for performance or other reward systems, and educational and training programs. Both financial and non-financial mechanisms support behavior and contribute to employee satisfaction, so a combination of systems should be implemented to encourage employees to strive for excellence.

14. Develop behavior reinforcement skills.

In addition to business and technical competency, leaders need personal and social competencies such as self-awareness, self-regulation, motivation, empathy, and social skills. These soft skills include adaptability, commitment, optimism, understanding others, communication, team building, conflict management, and change catalyst, among others (Goleman, 1998a and 1998b). Developing and using these skills is more subtle and complex than developing and applying technical skills. Moreover, leaders must not only possess these skills, but also be willing to use them as part of the organizational change. Leaders must have the desire and ability to communicate, negotiate, or evaluate. Self-motivation is a critical element of personal management.

Exhibit 6:

The Transformation Platform

Nackel's Transformation Platform is the first necessary component of profound organizational or personal change (see Figure 2). The platform comprises 5 levels as described below. Virtually all organizations contain these levels, but vary in how well they articulate and use the levels. Defining a vision, mission, and operating model does not ensure that leaders will be able to transform their organization. They must attend to all of the leadership and management functions detailed in the leadership mirror (see Figure 1).

- The **vision** is an important source of an organization's (or individual's) identity and purpose and defines the desired future state. The vision should be based on the core values or set of beliefs and concepts that represent the ideal state for an organization or person. Both vision and values are long-term and largely unmalleable. They should be sustained by the business transformation process and provide a sense of continuity and purpose for actions that result from enterprise change.

- The **mission** is a strongly articulated directional statement about an organization's or an individual's current state. It is the expression of the vision for a period of time. It is more dynamic, fluid, and often shorter lived than the vision. The mission describes an organization's current business including the kinds of goods and services it offers. The mission will change over time in light of market influences and economic changes.

- **Strategy** stems from the vision and mission to inform how the organization will act. It translates the mission into an operating model. Both the mission and strategy should change as an organization transforms its business.

- The **operating model** is a concrete plan of how an organization will act in the marketplace. It outlines how organizational leaders want the organization to behave, what they want the organization to be known for in the marketplace, how they want to interact with employees, and desired relationships with business partners. The operating model converts strategy into daily activities and helps leaders define processes that support the desired culture. It plays a pivotal role in business transformation and is often the point of breakdown in a transformation effort.

- The **transformation agenda** defines which of the organization's functional areas will be involved in implementing the operating model and illustrates how the mega-processes fit together to support the operating model and identifies which individual competencies are required to enact the operating model. It does not, however, prescribe how the organization should be structured.

- **Implementation actions** are highly detailed plans of how individuals will operate on a day-to-day basis as they strive to execute the other levels of the pyramid. As a set, they are a more granular version of the operating model and describe the high-level activities needed to fulfill the transformation agenda. Implementation actions detail the relationships among competencies, solutions, and expected results but do not prescribe how an organization ought to be structured.

Figure 2:

The Transformation Platform



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