



A "SECOND GENERATION"

of Ministry Leadership

How Do We Form Leaders Who Have Not Experienced Working Directly with Religious?



BY PETER J. GIAMMALVO, PhD

Dr. Giammalvo is vice president, leadership formation, Catholic Health East, Newtown Square, PA.

Business books and journals are replete with anecdotes and advice concerning the "hows" and "whats" of successful leadership. Although the criteria for measuring success are many and varied, there appears to be ample evidence that successful leadership is outwardly focused and is defined primarily by service. The distinguished leader is one who serves, not the one who is served.

Although this description may be aptly applied to leadership in Catholic health care, it is incomplete. Leadership in Catholic health care requires a commitment to sustain and enhance the healing ministry of Jesus through the organizations entrusted to those leaders. In signing on for ministry leadership, Catholic health care leaders are expected to serve as Jesus served, teach as Jesus taught, and lead as Jesus led, in order to heal as Jesus healed.

CHANGES FOR LAY LEADERS

Most leaders who serve in the ministry today know and live this. For lay leaders, especially those who are of the baby-boomer generation, the call to serve the mission of Catholic health care came to them through diverse channels. A strong influence, one that is often overlooked, is the partnership that most such leaders experienced with the vowed religious then serving in sponsorship, governance, and management roles in the hospitals, nursing homes, and other health care ministries. This "first generation" of lay leaders was privileged to work alongside the religious, learning from them through osmosis, so to speak, especially in the period stretching from the 1960s through the 1980s. Lay leaders, both Catholic and those from other faith traditions, have truly come a long way, in many cases because of the impact of those early partnerships.

In recent years, as leadership of Catholic health care

NEXT GENERATION OF LEADERS

has evolved and as management and governance roles have been filled increasingly by laypeople, the important role of leadership formation and leadership development has become even more critical. For the first-generation lay leaders, the normal path of their development was marked by the mentoring, coaching, and role modeling of the religious with whom and for whom they worked. Now these “boomers” themselves are responsible for the recruitment, selection, formation, and development of the next cadre of leaders—a *second* generation.

These younger men and women will not have had the experience of walking hand in hand with the religious sponsors who served in governance and management roles. Instead, they will learn from the lay leaders who did have that experience. Mentoring, coaching, and role modeling will look very different.

The implications of this “second generation” phenomenon are quite profound, not only for those charged with the preparation and delivery of formal leadership formation and development programs, but for all who serve in leadership roles in Catholic health care.

It goes without saying that a concerted response by current leaders, sponsors, boards, and executives is essential to sustaining the integrity of the ministry over time. It may be helpful to view this challenge—and frame a response to it—through the lens of core human resources (HR) processes. A fully integrated approach offers the greatest opportunity for success.

RECRUITMENT AND SELECTION

First and foremost, hiring managers and human resources professionals, along with their colleagues in mission leadership roles, must facilitate a recruitment and selection process that screens candidates for leadership positions in two different dimensions.

Professional Competency The first dimension, the one in which most current lay leaders have significant experience, is professional competency. Does the candidate have the academic preparation, requisite experience, and demonstrated competencies to fulfill the role?

Commitment and Core Values The second dimension can be more challenging, but is critical. Does the candidate demonstrate a commitment to the ministry as evidenced by an experience-based understanding of the mission and a behavioral demonstration of core values? Has this commitment been demonstrated in visioning, goal setting, operations management, financial management, and other activities that support the ministry?

Several years ago, the leaders of Catholic Health East (CHE), Newtown Square, PA, developed a *Leadership Profile*, a set of 15 competencies that had been determined to lie at the core of successful executive leadership of CHE ministries (see **Figure**, p. 17; see also Peter J. Giammalvo and George F. Longshore, “Building Leadership That Endures,” *Health Progress*, May-June 2001, pp. 50-53, 64). Seven of the 15 competencies *are* the core values of CHE.

(Although some purists may say that organizational values cannot in themselves be leadership competencies, a leadership development advisory committee believed otherwise). If competencies are understood to be the knowledge, skills, attitudes, traits, and intentions that are predictors of successful performance in a role, then these core values are indeed competencies. The core values and their behavioral descriptions are at the heart of CHE’s expectations for leaders, and are combined with other expectations regarding the more commonly understood professional/technical leadership competencies.

To screen for these leadership competencies, CHE uses a recruitment and interviewing process

SUMMARY

Catholic health care leaders differ from others in the field in that “they are expected to serve as Jesus served, teach as Jesus taught, and lead as Jesus led, in order to heal as Jesus healed.”

The Catholic health ministry today is led largely by laypeople—what might be called the “first generation” of lay leaders. This first generation was privileged in that it was tutored by and worked alongside women and men religious. Those religious are now mostly gone from the ministry, and that first generation of lay leaders will also be retiring in the not too distant future. Leadership will then

pass to a “second generation,” laypeople who have not worked alongside religious. How is this new generation to learn “to heal as Jesus healed”?

Catholic Health East (CHE), Newtown Square, PA, has developed a program explicitly directed at the recruitment and development of second-generation leaders. In its efforts to fill a position, the system first assembles a preferred candidate profile, based on 15 competencies, including seven core competencies. CHE then employs a recruitment process based on behavioral event interviewing. All involved stakeholders participate in the interviews.

Figure

CHE's Leadership Profile

At Catholic Health East, Newtown Square, PA, leadership is understood to be based on 15 interlocking core competencies: seven Core Value Competencies (at left) and eight Leadership Competencies (at right). The demonstration of these competencies will lead, over time, to the four Mission and Performance outcomes (center).



based on behavioral-event interviewing. This process—currently applied to the recruitment and selection of system executives, including local CEOs—begins with the development of a preferred candidate profile. The profile, assembled with input from key stakeholders, includes the core leadership competencies, additional role-specific competencies, basic qualifications (e.g., education, experience, etc.), market or organization-specific requirements, and other preferences (e.g., diversity, promotion from within, etc.).

Once agreement on the profile is reached and the position description has been developed, the search begins, employing fairly traditional methods. For a CEO position at a regional health corporation (CHE's term for its local ministries), the local board appoints a search committee. In most cases, the board retains a search firm as well. For other executive positions, the search process may be more simple, but nonetheless rigorous. Once potential candidates have been screened, the stakeholders involved in the search begin the behavioral interviewing process. They use individual interviews (including interviews by CHE employees likely to be the candidate's peers), along with group interviews where appropriate. A valuable tool utilized in the process is the *CHE Interview and Selection Guide*, an internally developed set of sample interview questions and recommended screens based on

the 15 core competencies in the Leadership Profile. In reference checking, many of the same probes are applied in order to hear and understand responses from several different vantage points.

FORMATION AND DEVELOPMENT

Once an executive has signed on, key stakeholders—especially board members, the supervising executive, and an HR representative—should focus attention on a process for leadership formation and development. Often overlooked is the value of a comprehensive orientation program. Orientation for a new leader should include more than an introduction to the organization's mission, vision, values, strategic plan, and description of "how things get done around here."

Orientation is the first formal opportunity for a new leader to connect to the organization. It is the time when the new leader's personal spirit begins to bond with the spirit of the organization. This doesn't happen in just a day or two. It is a deliberate process and one that takes time. Some organizational development practitioners call it "assimilation"; others refer to it as "on boarding." I prefer to think of it as a merging of cultures and a mutual growth experience. Both the organization and the new leader bring an identity forward. Both are enriched in the new relationship. In any case, it is essential that the

new relationship be built on a firm foundation.

CHE, taking its lead from the work of CHA's Ministry Leadership Development Committee, understands leadership *formation* to be an ongoing, multifaceted process that enables current and future leaders to know and confidently act on behalf of the mission of Catholic health care (see Ed Giganti, "What Is 'Leadership Formation' Now?" *Health Progress*, September-October 2004, pp. 18-22). This process requires:

- Personal exploration of an individual's talents, call to service, and commitment to the mission and values of the healing ministry
- Understanding and engaging the Scripture and the living tradition of the Catholic Church
- Development and demonstration of those distinctive competencies required to lead a health care ministry

Leadership formation is mission-oriented and targets people's spirits and hearts.

Leadership *development* is also a continuing, multifaceted process. It facilitates current and future leaders' understanding and enrichment of the professional/technical skills required to lead the health care ministry. It includes:

- Periodic assessment of professional development needs
- Preparation and implementation of professional development plans
- Development and demonstration of those distinctive competencies needed to lead the health care ministry.

Leadership development is largely slanted toward improving professional skills, always within the framework of the mission, and targeting people's minds and hearts.

Ideally, leadership formation and development are fully integrated with each other and in the lives of individuals and the organization. However, to reach this ideal, organizational development and leadership development professionals are obliged to share with leaders an understanding of the nuanced differences and interdependency between leadership *formation* and leadership *development*.

For example, when leaders are engaged in planning and executing strategy, managing major initiatives, and similar activities, they are expected to demonstrate content competencies as well as values competencies. The rigorous process of strategic planning must include such steps as a community needs assessment, analysis of community benefit outcomes and measures, and an ethical decision-making process to identify and prioritize strategies. A long-range financial plan should include resource provisions to ensure care for the poor and underserved, as well as strategies to ensure capital requirements for the future. In day-to-day operations, policies and practices must be designed to serve the mission of the organization while also reinforcing

behaviors that demonstrate the core values.

Although they are beyond the scope of this article, the design and execution of the organization's performance management program must be aligned similarly. In other words, policies, goal development, measurements and rewards of the performance management system must reinforce the comprehensive, holistic understanding of leadership as described above. An organization that recruits and selects leaders and supports their development as above—but then encourages them to perform, and rewards them for inconsistent or incompatible behaviors—is an organization that calls its own integrity into question.

BEYOND THE "BOOMERS"

For the first generation of lay leaders, leadership formation and development included one seminal element that will soon be impossible to replicate. That, as mentioned earlier, was the opportunity to walk arm in arm with the religious sponsors who founded and nurtured the institutional ministries, who understood at the core of their being that their mission was a contemporary expression of the healing ministry of Jesus, and who dedicated their lives to serving that mission.

So what are leaders called to do at this time of transition from first- to second-generation lay leadership in Catholic health care? What they should *not* do is succumb to discouragement and defeatism in the face of fewer vowed religious in leadership roles. What leaders *are* called to do is to honor the heritage of the founding sponsors of these ministries, seek to understand what animated their dedication and hard work, internalize that animating force, and serve as role models for those who are coming after them.

To accomplish that, the first generation of Catholic lay leaders must focus on developing and implementing processes that ensure that the second generation will have the personal commitment, deep-seated values, and leadership competencies to carry on the ministry as the early sponsors intended. The many and varied programs for leadership formation and development that are currently offered are a necessary first step. What is now needed is for current senior leaders (the "boomers") to embrace their role as coaches, mentors, and role models; support and act as advocates for the formal programs now in place (or being developed); and utilize the core HR processes of recruitment and selection, formation and development, performance management, and succession management to ensure leaders for the next generation and beyond. ■

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September-October 2005
Copyright © 2005 by The Catholic Health Association of the United States
