# BUILDING ON PAST SUCCESS

## *A White Paper on Leadership Development*

BY MARY KATHRYN GRANT, PhD

*To emphasize the importance of leadership development to the Catholic health ministry, the Catholic Health Association (CHA) has named it as one of four "focus areas" in the next phase of the association's planning. To further advance the cause of ministry leadership development, highlight current successes, and generate a sense of urgency, CHA's Ministry Leadership Development Advisory Committee commissioned the writing of the following white paper. The paper is intended to:*

- *Trace the history of Catholic health ministry leadership development in general and, in particular, to highlight some of the successes resulting from the joint efforts of Catholic health systems and CHA*
- *Identify emerging major issues, challenges, directions*
- *Stimulate discussion of these major issues*
- *Facilitate networking*
- *Facilitate benchmarking of success factors*

"No time, no money, no option." This phrase aptly describes the current situation in Catholic health ministry regarding leadership development. Fiscal constraints, time limitations, critical shortages in certain clinical and professional areas—these, when combined with a passionate desire to secure a strong and vital future for the ministry, add up to the imperative that sponsors, trustees, and executives focus their attention, channel their resources, establish their preferred outcomes, and commit themselves to ministry leadership development.

*Dr. Grant, CHA's former executive director of ministry leadership development, is a consultant for Ministry Development Resources, Michigan City, IN.*

Leadership development has been a clarion call in Catholic health care for several decades, and solid progress has been made in several critical areas. These efforts—and the notable successes, which will be highlighted later in this paper—constitute the first stage or foundational platform for ministry leadership development. Many Catholic health care organizations are now focusing energy on second-stage activities. This paper will reflect on the lessons of the first initiatives in an effort to address, and perhaps eliminate, barriers to success for the current effort.

Very early in the evolution of Catholic health care leadership development, a continuum depicting the movement "from compliance to congruence to commitment and conversion" was proposed as a conceptual framework for the process. It might be helpful, as these efforts continue to evolve and mature, to keep this conceptual model in mind.

### Theology of Ministry

All theologies of ministry stress that a Christian is commissioned for ministry with baptism and that ministry is the prerogative not of the ordained alone but also of the baptized. Additionally, most would assert that the Christian faith is communal and that the Christian community is ministerial. These two realities, community and ministry, undergird all leadership development efforts in Catholic health care. Community impels people to seek the common good, however inadequately understood; ministry gives meaning and purpose to all the actions and activities in health care services.

The relationship of this calling to service is an essential grounding for any leadership program. This is not in any way to suggest that all leaders must be either Christian or Catholic. But all leaders in the Catholic health ministry must recognize that the core impetus to serve, to minister, comes from the Christian's commission at baptism. Given this foundation, leadership development initiatives must be rooted in and reflective of the mission and values of Catholic health care as incarnated in their organizational mission and values.

## The 1980s

In 1985 CHA convened a Blue Ribbon Leadership Development Task Force composed of representatives of Catholic health care systems and sponsors, all of which shared a common concern about leadership development. The task force brought together people specializing in mission, on one hand, and people specializing in human resources (HR), on the other, and facilitated networking between them. The task force also published *Healthcare Leadership: Shaping a Tomorrow* (1988), a catalogue of resources for a leadership "curriculum."

During this same period, several other efforts were initiated.

**Academy of Catholic Healthcare Leadership** Begun in the mid-1980s, this institution was modeled on the American College of Healthcare Executives. The academy, originally a stand-alone organization, was absorbed by CHA's Center for Leadership Excellence in the early 1990s and has subsequently been dissolved.

**Catholic Healthcare Administrative Personnel** This program, sponsored by St. John's University, Jamaica, NY, and the Catholic Medical Center of Brooklyn and Queens, continues to sponsor two annual weeklong programs in which well-known leaders address topics of current interest to Catholic health care leaders.

**Consolidated Catholic Health Care (CCHC)** CCHC was formed in 1979 to address the needs of Catholic health care systems. At one time CCHC had 24 system members and sponsored several annual events, most notably the Governance Forum, which brought together sponsors, trustees, and executive leaders to examine current critical issues facing Catholic systems. Meetings of the CCHC board, made up of system CEOs, provided a valuable opportunity for networking. CCHC has undergone several reorganizations in recent years. In 1999 the Governance Forum was transferred to CHA.

**Mercy Leadership Development Program** This program, created by members of the Mercy Health Conference (1980-1984), inspired several systems to launch their own leadership programs. In the 1990s, the Mercy effort also provided the initial vision for CHA's Foundations of Catholic Healthcare Leadership program.

In the late 1980s, the Commission on Catholic Health Care Ministry issued a report, *A New Vision for a New Century*, that called upon all those engaged in Catholic health ministry to address the critical issue of leadership development. (The report ultimately led to the New Covenant initiative of 1995.) Catholic health care conferences at the state level, which usually focused on legislative and regulatory issues, began to offer leadership development programs at their meetings.

Meanwhile, some Catholic health care systems, seeking to create a common culture and sense of community among their members, formed their own internal education and development programs for executives, managers, trustees, and physicians.

> Leadership development initiatives must be rooted in and reflective of the mission and values of Catholic health care as incarnated in organizational mission and values.

## The 1990s

Several new leadership development initiatives were launched in the 1990s.

**CHA's Center for Leadership Excellence (CLE)** This initiative grew out of the work of the 1985 Blue Ribbon Task Force. In 1993 CLE commissioned Hay McBer, a Boston consulting firm, and the Center for Applied Social Research at DePaul University, Chicago, to conduct research into the behavioral competencies shown by outstanding leaders of Catholic health care organizations. The next year, at CHA's annual Catholic Health Assembly, the researchers presented their findings in a report entitled "Transformational Leadership for the Healing Ministry: Competencies for the Future."[1] That study, as a CLE staff member noted, gave the ministry its first opportunity "to quantify with empirical evidence the competencies that distinguish the outstanding leaders in Catholic healthcare."[2]

The researchers found such leaders to possess 18 observable and measurable competencies. CLE incorporated this concept in several products and programs:

- *Dossier,* a multirater (360-degree) tool for measuring leadership competencies.
- *Leadership Enrichment through Assessment and Development (LEAD),* a five-day program that assessed leaders' management styles, motivations, and competencies, and the organizational climates they had created.
- *The Advanced Institute,* a competency-based forum for the development of leaders. Institute participants first underwent the LEAD program and then attended three annual leadership retreats.

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# LEADERS ON LEADERSHIP DEVELOPMENT

## "Leadership Development Is Integral"

If you're really serious about having an organization that is on the cutting edge—a forward-looking, exciting organization—you need to attract, retain, and develop the right leadership. If you want to build on "something special," you have to have a high-quality leadership group.

We started our leadership development program—"Leadership That Shapes the Future," a five-day, competency-based program with strong team-building and spirituality components—in August 1999 with our corporate office senior staff. Soon after we began, we learned our "financials" for that fiscal year were devastating. But we continued with the program anyway. We might have said, "We'll get back to leadership development later," but decided that doing so might be dangerous. Leadership development needs to be seen as integral to the organization, not ancillary. If you let it drop off the agenda because of other pressures, it becomes ancillary.

In January 2000, as we were focusing on problems in our local facilities, one of our senior operations people called me. He was scheduled to attend that month's leadership development session, but he really wanted to get out of it. "We're *drowning* out here!" he told me. "We can't afford to take a week off." But I said, "Yes, you *can* take a week off." In the end, I think, he and the others went back to their jobs refreshed. The message was: "Good times or bad times, leadership development is going to continue."

About 200 of CHI's leaders have gone through the program, including half of our CEOs. Now entire leadership teams are attending the programs together. Through the program, they bond as teams in a way that's hard to do when you're struggling with day-to-day problems in the facility. So many people have said to me, "Thank you for spending the money on me for that leadership development program." They appreciate the interest the organization takes in them.

Our program has been a significant part of our really coming together as one unified organization. A national leadership development program such as ours welds these leaders to you as an employer. Of course they have a natural affinity for their local organization—it's where they work. But our program has been excellent for "wiring" them to the national organization. They feel, "I'm part of CHI, not just this hospital." That's another payoff.

*Patricia A. Cahill, JD*
*President and CEO*
*Catholic Health Initiatives*
*Denver*

## "We Discuss Ministry Issues Together"

We have a lot of conversation around here about succession planning. I think it's hard to do good succession planning in organizations that are as lean as ours. The models from other corporate sectors don't translate very well to not-for-profit environments such as ours. Our board will have the responsibility for picking my successor. The best I can do is make sure there is a group of people here that can manage until the board selects a leader.

The best way to do so is to get the group really addressing ministry issues together. If we do it right, then the strategy person can be as comfortable talking about social justice as the mission person; and the CFO, when asked about juridic status, can be comfortable answering the question.

At present, the seven officers here at the corporate office get together for a half-day every other month to study and discuss issues important to Catholic health care. We take turns planning these sessions, selecting the materials to be read beforehand, facilitating the conversations, and so on. We've looked at the recent changes in the *Ethical and Religious Directives for Catholic Health Care Services* and at Catholic social teaching on labor issues and other justice issues. As a group, we learn together. We have conversations about what we know and don't know.

For us, the next step is to replicate this kind of development experience for Covenant's senior management group—the CEOs and COOs in the system's hospitals. We have a responsibility as a juridic person, just as religious congregations do, to ensure continuity of the ministry. The only way we're going to do that is to find the best people who share our values and allow them to grow in their understanding of and commitment to the ministry. We have to take on the responsibility for sharing our learning with those who come after us.

*David R. Lincoln*
*President and CEO*
*Covenant Health Systems*
*Lexington, MA*

## "Lay Leaders in a Ministry of the Church"

From my vantage point, leadership development is critical because we need people who know what it means to carry on the ministry of Jesus and also to operate a successful business. Historically, we selected people based on their business expertise and relied on the sisters to carry on the ministry. But all the activities of a health care system are the mission and the ministry, requiring that every leader understand and be committed to what it means to minister.

We need people who have an understanding of their own call and how they are living out that call publicly as lay leaders in this ministry of the church.

As a sponsor, we have become very intentional about the key things we want lay leaders to know, understand, and act upon. We are taking a more formal approach in the education and development of our leaders. For example, all senior leaders and those who are on a path to become senior leaders are required to attend a Foundations of Catholic Health Care Leadership program that is offered several times during the year. Leaders have been very positive, if not enlivened, by their participation in the Foundations program.

Chris Carney, our president and CEO,

and I visit each of our local systems and their board of directors every year. During our visits last year, I offered a reflection on the shared statement of Catholic identity as a prayer for the opening of the board meetings. After the reflection, we spent some time discussing "What does this mean for us?" We also discussed the Mission-Centered Leadership Competency Model to explore how leadership must be values-based and founded in our Catholic identity. The organization can only remain true to its mission when each leader understands and lives this competency model, choosing to be part of a ministry, not just a business.

*Sr. Patricia A. Eck, CBS*
*Chairperson, Board of Directors*
*Bon Secours Health System*
*Marriottsville, MD*

## "We Will Identify 'High-Potential' People"

Last week, I was at a Healthcare Research and Development Institute meeting, for CEOs of both for-profit and not-for-profit health care organizations, at which this very topic—leadership development—was discussed. When you look at the ages of leaders in Catholic and other health care organizations, you see that the average age is "up there." We need to be proactive, to identify our upcoming leaders, and make sure these people are ready.

Earlier in my career, I worked in a large pharmaceutical company, in sales and marketing first, then later in operations as an executive vice president. Once the leaders of that company have identified a person with leadership potential by assessing the person's strengths and opportunities for growth, they put a plan together and track the person throughout his or her career with the company. "High-potential" people are given opportunities to learn through both internal training programs and external, formal programs, such as those offered at the Kellogg School of Management at Northwestern University. Potential leaders are also given projects that stretch them, opportunities to work and learn with other more seasoned executives on new ventures.

This company also assigns the high-potential person a mentor, someone in a position above you who can answer your questions, ensure that you get exposure to senior executives, provide you with entrée into learning opportunities that you wouldn't otherwise be invited to.

We're going to try to duplicate that sort of development program at CHW. We're just in the early stages of building it, but we are going to start identifying our high-potential executives and do a "mini" version of what I experienced at the pharmaceutical company. It's critical that we take the initiative and begin to work with such people to develop the skill sets they'll need in this environment and in the future. I believe it's a leader's responsibility to find and form the leaders of the future. I believe very strongly that leadership development is imperative for the ministry.

*Lloyd H. Dean*
*President and CEO*
*Catholic Healthcare West*
*San Francisco*

## "'Servant Leadership' Is Our Model"

At Providence, many of our leadership development activities have been aimed at the organizational and operational model we are applying—we call it a "relational model." Fundamentally, I'm a decentralist; I believe that authority and accountability belong at the local level. In our relational model, everything we do is for individual and community health, and it starts and stays where the action is, locally, close to the person served. Responsibility and accountability ought to be as close as possible to those we serve.

So what is leadership in a relational model? "Servant leadership" is the phrase that best describes it. The best leaders in our system are facilitators, teachers, and coaches. They spend most of their time helping individuals and teams achieve their potential.

We've built a competency model that includes the vocation and values competencies from CHA's Mission-Centered Leadership Model. That's a cornerstone of our work. It's used as part of a 360-degree evaluation process and as part of our talent stewardship process, which includes a focus on succession planning. We are making good use of the "360," we have a good cycle of evaluation working at the individual and team levels, and people quickly come to understand what's expected of them.

But there are lots of "next steps." We have miles to go. The process is ultimately about selection—getting people into the right roles, mentoring them, and building on their strengths. We are pretty good, but our potential is far more untapped than tapped. It's a great opportunity.

I think we have something really unique in Catholic health care in that we have both permission to bring our spirituality to work and the expectation that we will do so. This is true for everyone carrying out the ministry. They really are living it. For a person like me, who spent most of his life outside Catholic health care, it's wonderful to be able to live my own spiritual side in my work. I want all our 35,000 employees to have that opportunity.

I've worked very hard at understanding what it means to make this work *ministry,* to integrate it so that it's not just words. That's a constant journey. I've studied Catholic social teaching, and I do some spiritual reading. I've also been especially blessed in having Sr. Karin Dufault* and other Sisters of Providence provide for my formation. Not everybody gets the opportunity that I've had. One of the things I'm committed to is extending that opportunity to others.

*Henry G. Walker*
*President and CEO*
*Providence Health System*
*Seattle*

*Sr. Karin Dufault, SP, RN, PhD, former board chairperson, Sisters of Providence Health System.

• *Behavioral Event Interview (BEI)*, a tool for gathering the information used in the competency-measuring process.

CLE ceased to exist in 1999, but its competency model became the prototype for several systems' leadership initiatives.

**Sponsorship School** A twice-yearly program for religious sponsors, the school was offered by the Loyola University School of Law, Chicago, and McDermott, Will, & Emery, a Chicago firm specializing in health care law. The school ended in 1999.

**Partnership for Catholic Health Care Leadership** Sponsored by CHA and 18 Catholic systems, the partnership was created to identify common leadership needs and address them in a unified fashion. The partnership dissolved in 1999, but its work has been continued by CHA. Among the products created by the partnership are:

• A revised version of Dossier called the Mission-Centered Leadership Model*

• A revised curriculum for CHA's Foundations of Catholic Health Care Leadership program

• A BEI workshop with Hay McBer

**Medicine in Search of Meaning** The Catholic Health Association of Wisconsin developed this leadership program primarily for physicians. It is currently available on a contractual basis.

In addition, several Catholic systems have used the Mission-Centered Leadership Model to develop competency models. Others—most notably, the Sisters of Charity Health System, Cincinnati; the Sisters of St. Joseph of Orange Health System, Orange, CA; Holy Cross Health System, South Bend, IN; and Ascension Health, St. Louis—launched their own leadership development efforts, each of which included orientation to the history, mission, culture, and heritage of the sponsoring congregation. Both kinds of programs—those based on the Mission-Centered Leadership Model and those not—continue to be adapted by various Catholic systems.

Moreover, several colleges and universities have begun to develop postgraduate training (including courses in theology, mission, and ethics) for mission leaders and other executives.

## Leadership Development Survey

In early 2001, CHA conducted a survey of national and large regional systems concerning leadership development. Twenty-two such systems responded. The following are the highlights of the survey's results.

**CHA** conducted a survey concerning leadership development in early 2001.

**New Role** Thirteen systems had leadership development specialists who had been in their positions a year or less, usually because the system had recently undergone consolidation. Some specialists had had experience in leadership development in other organizations.

**Mission Base** Thirteen systems launched leadership development in their mission services function. Six incorporated it in organization development. Three made it part of HR. (In some cases, leadership development was part of more than one function.)

**Competency Model** Fourteen systems used a competency model; three others were in the process of developing such a model. As for the models themselves, 12 systems had designed (or were designing) their own, six used the CHA model, three used the Lominger Limited model, and three used the Personnel Decisions International model. Some used the CHA model in combination with an outside vendor.

**360-Degree Instrument** Nine systems were using a 360-degree multirater instrument; three others were developing one. The frequency with which the nine systems used the instrument varied from six months to two years. Seven systems used it for annual evaluation, five used it for development planning, and four used it for recruitment and selection. (Some systems used it for more than one purpose.)

One of the challenges in developing any competency model is the relationship between what are perceived to be mission-related competencies and business-outcome or performance-outcome competencies. Thirteen respondents indicated that "mission" and "performance" were one and the same; therefore, they said, all competencies related to mission fulfillment. Nine other respondents indicated separate mission competencies.

Thirteen systems integrated their competency model and the 360-degree instrument directly with their mission. Nine used other competency models. Five systems used neither a competency model nor a 360-degree instrument.

**Succession Planning** Although only five systems had included leadership development as part of their succession planning, 11 others said they intended to do so. Indeed, succession planning was the most frequently mentioned need for leadership development.

**Outcome Measures** All responding systems agreed that leadership development programs need a way to measure outcomes, but most had not yet created one.

**Mission and Values Integration** Most responding systems agreed that the first priority for a leadership

development program was the integration of mission and values. (Some said that this integration could be made part of a program component such as continuous quality improvement.) Other high priorities were sponsorship education, retention planning, executive management support, and mentoring.

## Four Challenges

The Catholic health ministry faces four major challenges, each of which underscores the need for leadership development.

**Sponsorship Evolution** The sponsorship of Catholic health care organizations, originally undertaken by the religious congregations that founded them, continues to evolve. Laypeople are increasingly assuming the sponsorship role. What do they need most? Immersion in the theology of ministry? Studies in canon law? Training in mission reflection or discernment? When should they receive such preparation? Should they be required to demonstrate that they possess certain competencies, skills, and knowlege before being considered for the role? Or is on-the-job development sufficient? Should such people be practicing Catholics? And isn't consideration of these questions increasingly vital as current sponsors prepare to pass the torch to their successors?

Sponsorship development is essential because sponsors shape the ministry and hold it accountable for mission and values. Without strong sponsorship, the whole fabric of the ministry is weakened.

**Executive Leadership** Catholic health care's executive workforce is both aging and growing more ethnically and religiously diverse. When the scarcity of professional mission executives is highlighted, the situation is even more critical. The ministry must therefore put greater emphasis on the selection, orientation, and development of new executives, preferably before they assume their posts.

At present, ministry organizations too often hurry to fill leadership vacancies, allowing the need for expeditiousness to override serious consideration of candidates' preparation, competence, and general fitness for the job. Selection of new leaders may at times be driven more by business imperatives than by careful screening of ministry leadership competencies. In choosing new leaders, some systems have reported that they emphasized management and business competencies over ministry leadership competencies.

Because ministry executives (such as sponsors) are aging, they should be carefully planning succession strategies. However, although most acknowledge this need, few felt they have addressed it adequately. Recognizing its importance, executives nevertheless often feel compelled to deal with what they see as more urgent business needs. And sometimes their tendency to delay succession planning is reinforced by board members, who—although certainly persons of goodwill, dedication, and generation—often lack experience in ministry development themselves.

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**Systemic Mission Integration** A third challenge is linked intrinsically to succession planning. Even after 20 years of effort and considerable successes, systemic mission integration still has a way to go. The question is, why? Several explanations have been advanced.

Some people say that full integration is difficult to achieve because systems' business concerns tend to override nonbusiness ones. Others say that sponsors and system boards fail to hold their organizations' leaders equally accountable for both mission and business outcomes. Still others trace the problem to mission leaders, many of whom came to the ministry with neither business nor health care experience and therefore lack credibility among leaders who did. And some say that systems' plans for mission integration are often poorly planned or poorly implemented.

No doubt, some or all of these factors have contributed to mission integration's limited success. Whatever the cause, the problem is serious. A failure to fully integrate, coupled with a lack of understanding of or commitment to the notion of the common good, can significantly impact the ministry's future.

**The Common Good** The New Covenant initiative, which, starting in 1995, brought systems, independent hospitals, dioceses, Catholic Charities, and others into discussions of mission integration, was catalyzed by the successful incursion of for-profit organizations in health care. Urgency marked the moment. Systems and sponsors pored over maps, risk-benefit analyses, antitrust restrictions, and business case scenarios, exploring ways to strengthen and unify both Catholic health care and Catholic social services in various markets. Organizational independence and self-preservation were weighed against the threat of for-profit takeover.

Adversity brought competing providers to explore consolidation, collaboration, and affiliation. Unfortunately, the participants of that discussion seem, in retrospect, to have inadequately internalized the common-good concept that undergirded their efforts. Granted, the concept is ambiguous. Pride can strongly motivate an organization to defend its sense of identity. Insisting that it submerge itself in a generic or communal identity is to go against the grain.

The same tendency can be seen in the leadership arena. Systems have historically competed

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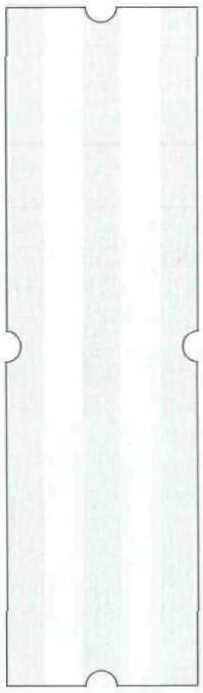

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with one another in their efforts to recruit and retain leaders. No executive likes to see a competent, successful manager leave the organization for a "competitor." Unfortunately, no organization has more than a limited number of leadership roles. Can Catholic health care embrace the notion of the common good in a way that allows it to retain scarce and valued human resources *in the ministry*, if not in particular systems or organizations?

The ministry needs all the talented human resources it can get. It also needs a model of leadership development that truly integrates mission, ministry principles, and ministry values with clinical, professional, executive competencies. Initial recruitment and selection, incorporation and development, reward and retention must embody a minimum set of ministry competencies and be applied to governance, clinical, managerial, financial, and sponsor selection. No arena is exempt from the need for careful attention to this central and critical area.

Clearly no magic formula for success in this area exists. All sectors of health care—religious, secular, not-for-profit, and for-profit—have grappled with one or more of the dimensions of the leadership issue, whether it be shortages of trained professionals; attracting and retaining committed individuals; or identifying the competencies needed by physician leaders, sponsors, trustees, and executives.

Because the Catholic health ministry is so integrally connected to the communities it serves, its future—its vitality as well as its very viability—is contingent on its ability to create and nurture communities of people committed to a common mission. What binds us together and gives us hope, in this pursuit of ministry leadership development, is that we share a common desire—to bring God's healing presence to our needy world. □

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"select" individuals. This plan allows for ongoing appraisal of the system's' "bench strength." Moreover, those being assessed are fully aware of the process and what it might mean to their futures. They know that the system makes personal and family circumstances a part of succession planning and that it has absolutely no bias against those who choose not to move or transfer, for instance.

Indeed, CHE sees its LFI as a way of developing leaders for Catholic health care in general, not just for CHE. We realize that we have a responsibility to others in Catholic health care, and we freely acknowledge that some of our potential leaders will inevitably decide to work elsewhere in the ministry. If other organizations seek their talents, they will find that our leadership development concepts and plans are transportable. Anyone who has participated in our LFI will be well prepared to serve as a leader in other areas of the ministry.

### WHAT'S NEXT?

Any sensible organization needs to develop leaders for the future. Doing so is especially important for a Catholic health care organization, in which the values of a healing ministry must be coupled with business and market success.

CHE's LFI continues. We want to be able to demonstrate to leaders at all levels exactly how they can move vertically or laterally through their hospitals, long-term care facilities, and other organizations and within the system itself. CHE's sponsors challenge us to adopt the program systemwide, not just because it contributes to achieving our mission as a Catholic health organization, but also because it builds leadership that lasts. □