PROFILING CATHOLIC HEALTH CARE LEADERS

A Denver Consulting Firm Has Developed a "Snapshot" of the Typical Ministry Leader

BY DIANE IRVIN & BLAIR GAWTHROP

A recent study shows that leaders in Catholic health care are strongly committed to the mission, vision, and values of the ministry. They are smart, know their business, and demonstrate their commitment daily in workplace behavior. They are good, professional role models and are typically polite, self-controlled, and willing to lead by example.

The study was conducted by Strategic Programs, a national research and consulting firm based in Denver. We have assisted numerous Catholic health care systems in the design and implementation of "360-degree" assessment programs for leadership development. Indeed, having conducted more than 2,500 assessments of leaders in the health ministry, our firm possesses a significant database of leadership behaviors demonstrated by executives and other managers in Catholic health care. The study described here, conducted for CHA, analyzed data from more than 1,000 assessments in order to establish a benchmark behavioral profile for the 21st century leader in Catholic health care.

The aggregated results—involving managers, senior managers, and executives in 10 Catholic health care systems in 44 states—provides a clear picture of the qualities embodied in today's Catholic health care leader. The results present normative data that can serve as a comparison for individual leadership styles, competencies, and subcultures in the Catholic health care community.

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Defining "360-Degree" Assessment

A "360-degree" assessment provides a leader or manager (the *subject*) with job-specific performance feedback from people in his or her circle of impact (the *respondents*). This feedback comes from superiors, peers, direct reports, customers, board members, and others related to the subject, as well as from the subject himself or herself. The use of multiple respondents in performance feedback increases the reliability of the results.[1]

When the 360-degree process is customized to the culture of an organization, the resulting reports provide individuals with information regarding others' perceptions of their workplace behavior, thereby revealing both areas of strength and areas for development. We at Strategic Programs work with client organizations to customize 360-degree assessment programs so as to incorporate subjects' input in developing job-specific questions, reflect performance expectations aligned with the organization's mission and values, form respondent groups sizable enough to ensure respondents' anonymity, and provide easily interpreted reports that include recommendations for development planning.

The Catholic health care systems that are our clients consistently use 360-degree assessment for professional development planning. (A few are moving conservatively toward other applications, such as performance review and succession planning.) Data collected in 360-degree assessments can also provide useful information for the selection of new hires for specific positions and to establish benchmarks for progress.

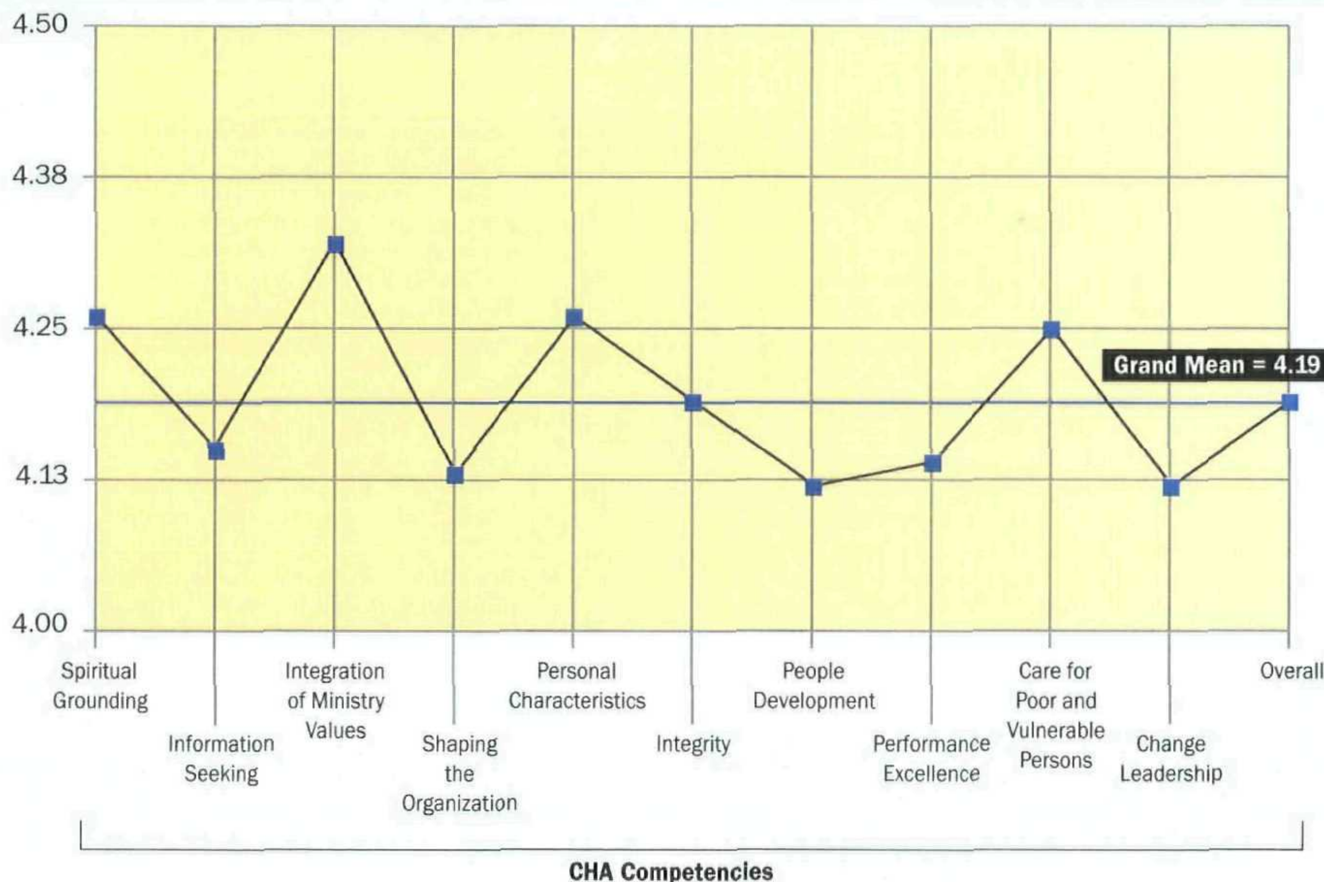
RESEARCH METHODOLOGY

In this project, our team was assisted by researchers from the Industrial and Organizational Psychology Masters Program at the University of Colorado at Denver and the Social Science Department at Regis University, which is also in Denver. After mapping the more than 2,000 behavioral questions in the customized assessment questionnaires used by our Catholic health care clients, we standardized the questions to reflect 108 core behaviors. (CHA's Ministry Leadership Development Committee reviewed the mapping.) There was sufficient data to report on 103 of these behaviors; this data was included in the study.

These behaviors were then linked to 10 competencies, eight of which are included in CHA's Mission-Centered Leadership Competency Model: *Spiritual Grounding, Integrity, Integration of Ministry Values, Care for Poor and Vulnerable Persons, Performance Excellence, Information Seeking, Change Leadership,* and *Shaping the Organization.* Two other competencies, *People Development* and *Personal Characteristics,* were added to house the remaining behaviors.

Following the mapping of behaviors, all scores in the database were converted to a five-point scale; and respondent groups were mapped into five core relationships (*self, supervisor, peer, direct report,* and *other*). Various leadership levels in the database were identified as *executive, senior manager, or manager.* The *executives* were CEOs, chief operating officers, chief financial officers, and others with "chief" in their titles. Senior vice presidents also were included if they were responsible for setting their organization's direction and strategy. *Senior managers* report to executives and are responsible for key departments or functions. *Managers* report to senior managers and supervise supervisors. Although we have, for Catholic health care clients, developed assessment tools for all three leadership levels, the majority of assessments in this study concerned the executive level.

The data analyzed included average scores for



base questions, regardless of how the questions were expressed. For example, "committed to professional development" might be expressed as "fosters professional development" for one organization and as "supports professional development" in another. In short, the intent or spirit of the question, rather than its precise wording, was the determinant for how questions were mapped.

Study Findings

We created a profile of the participating Catholic health care leaders based on composite scores by competency (see **Table**, p. 31). The profile shows an overall score of 4.19 on a 1-to-5 (low-to-high) scale. The study results suggest that no single competency stands out as either an overwhelming strength or an area for serious improvement.

As noted earlier, a consistently strong characteristic of Catholic health care leaders is "commitment to the mission, vision, and values of Catholic health care." These leaders are smart, know their business, and demonstrate their commitment daily through workplace behavior. They are good professional role models and are typically polite, self-controlled, and willing to lead by example. Not surprisingly, they score highly in the competencies *Integration of Ministry Values, Performance Excellence,* and *Personal Characteristics.*

On the other hand, health ministry leaders have development opportunities in the behaviors of "holding people accountable" and "being more aware of the impact of their power on people in order to lead more effectively."

The competencies with the lowest average scores are *People Development, Change Leadership,* and *Integrity.* Readers alarmed to find that the *Integrity* competency is not a salient strength among Catholic health care should note that, in the mapping, *Integrity* included 10 different behaviors, with the lowest scoring behavior being "holds people accountable." In some industry sectors, only one behavior would be assessed for *Integrity.* Clearly, Catholic health ministry organizations hold this characteristic in such high regard that they measure it more rigorously than other organizations do.

David Black, vice president, leadership development, Catholic Health Initiatives, Denver, observed, "All of us as employees desire an opportunity to excel, to learn and grow, and to be recognized for having made a difference. We all desire open, direct feedback; in fact, we crave it. However, our cultural patterns are such that we are overly cognizant of people's feelings. We refer to this as being 'Catholic nice.' As a consequence, we may not be inspiring employees to greater levels of contribution." Keeping Black's words in mind, it is easy to understand how Catholic health care leaders might be perceived as not "consistently holding others accountable to high standards." The study showed that senior managers and managers of Catholic organizations received *higher* scores in this behavior than executives did.

Ministry leaders are relatively weak in the "people development" competency.

The competency *People Development* is currently an area of relative weakness in ministry leaders at all levels, the study showed. Although leaders at all levels experience similar challenges, expectations concerning performance rise with a person's responsibilities and position in the organizational hierarchy. People will rate a certain level of performance lower for an executive than for a manager simply because they expect more of the executive.

In examining the behavioral profiles of executives, we find their lowest scores in four behaviors: "champions the ideas of others," "holds direct reports accountable," "provides useful coaching and counseling," and "reinforces people for successful performance."

On the other hand, the competency of *Performance Excellence* is an overall strength of these leaders, and there is not much differentiation between levels of leadership with regard to this competency. However, executives are seen as being weaker in "establishing priorities," which could actually be a weakness in *communicating* priorities to those they lead.

Care for Poor and Vulnerable Persons is a competency of seven behaviors that reveals an apparent contradiction in perceptions. Executives score high in "conducting assessments identifying opportunities to provide services," yet they score low in "analyzing needs." This may suggest that they are seen by respondents as more competent in gathering the necessary data than in acting on it. This competency often received the lowest *self* score, indicating that the subjects themselves feel that they are not doing enough and recognize that more action is needed.

Change Leadership includes 13 behaviors. A striking dissonance exists between executives and leaders at other levels in a single behavior, being "adaptable." Executives scored significantly lower than managers, which could reflect the perception that executives "stay the course" once they have made a decision. It is also true that organizations that change direction drastically often get new leadership. Conversely, new leadership may also be the catalyst for a change in direction.

The role of leader in Catholic health care requires proficiency in many competencies, including *Spiritual Grounding* (labeled *Spiritual Guidance* in some systems' competency models).

Leaders are expected to demonstrate their personal spirituality to all groups with whom they interface. In our study, leaders saw themselves as others saw them in such behaviors as "consistently exhibits caring and respectful behavior," "demonstrates self-awareness," "finds personal meaning in work," and "fosters a culture of spirituality." This congruence is additional evidence that these leaders do, in fact, lead by example.

Of the 103 behaviors examined in the study, "leads by example" was rated eighth highest and had the highest agreement overall among respondent groups. Therefore, we can say that this behavior is the most salient strength exhibited by leaders of Catholic health care.

DIFFERENCES IN LEVELS OF RESPONSIBILITY

The research also explored differences at specific behavioral levels and between levels of leadership and relationship to respondents.[2] We can therefore make a comparison of three different levels of leadership: executive, senior manager, and manager.

Overall, significant differences exist among the study's subjects, based on different levels of responsibility. These differences are partly due to behavioral expectations at each level: the higher the level, the higher the expectations. We also should note that the customizing of 360-degree assessments to different leadership levels produced different expressions of core questions. For example, "visionary" might be described at the executive level as "seeing the future of the organization as it will be impacted by trends in health care and the economy five years out." But senior managers might describe "visionary" as "meeting quarterly goals and fiscal year objectives." And managers might describe it as "addresses priorities for this week and next month." In general, peers tend to hold each other to higher standards, whereas direct reports tend to give their superiors higher scores. This suggests a competitive culture among peers and a motivational style of leadership among supervisors.

LOOKING FORWARD

Culturally, Catholic health care is, in general, a gentler, kinder, more polite workplace environment than other industry sectors, and, in such an environment, rating bias may influence the scores. As we noted, our study yielded an overall score of 4.19 out of 5. Based on our firm's research across all industries since 1988, this rating is a bit inflated. In implementing a 360-degree program for a client, Strategic Programs attempts to reduce rater bias by offering training for respondents. And in constructing the assessment questionnaires, we use descriptors such as "competent" or "meets expectations" for the midpoint in a rating scale, rather than the term "average." We do this because we have learned that respondents tend to interpret "average" as sub-par performance.

> Culturally, Catholic health care is a gentler, kinder, more polite workplace environment than others.

Moving respondents from being "Catholic nice" to being realistically candid, even in the anonymous feedback of 360-degree assessment, will take time. It is likely that a follow-up to this research, repeated in the next few years, will show respondents with a greater emphasis on candor, as a result of learned trust through successful 360-degree experiences.

"Often, 360 is not implemented well," said Rimas Yurkus, Strategic Programs' president. "Implemented ineffectively and with no follow-up, it is of little or no value. Done poorly, it can do more harm than good; done well, it is a truly powerful experience that can move an individual and an organization to the next level." The vital part of the successful 360-degree process is education. Over time, participants begin to trust the process and, as a result, are empowered by their ability to contribute candid feedback. A 360-degree subject is given a tool and a means of profiling his or her performance and charting a course for development, as well as a benchmark for measuring his or her growth.

This study of ministry leaders is a starting point from which to build. With additional demographic information, a more detailed profile of the leader in Catholic health care can be developed. In future research, assessments from individual facilities could be compared to the overall profile to uncover unique contributions and deficits. The profile of the leader can be monitored over time to identify growth and new challenges. There are many opportunities for greater understanding of leadership in Catholic health care and for growth and development of leaders. Meanwhile, these scores by core behaviors provide the first benchmark of Catholic health care leadership in the 21st century. □

For more information, contact Strategic Programs at www.strategic programsinc.com *or 800-800-5476.*

NOTES

1. J. M. Conway and A. I. Huffcutt, "Psychometric Properties of Multisource Performance Ratings: A Meta-Analysis of Subordinate, Supervisor, Peer, and Self Ratings," *Human Performance*, vol. 10, no. 4, 1997, pp. 331-360.
2. Statistical research conducted by Richard C. Williams, School of Professional Studies, Social Science Department, Regis University, Denver.