CHAPTER 1

The Leadership Imperative

We are crossing a line into a territory with unpredictable turmoil and exponentially growing change—change for which we are not prepared.

—John Kotter (2014)

University Medical Center is hosting an annual reception for its retired employees. Jonathan Sneed, the medical center's CEO in the 1980s, is one of the special guests. Now in his 80s, Jonathan remains sharp as he sits at a table with Elizabeth Jankowski, the current CEO. The two are discussing the evolution of healthcare management.

Jonathan. Elizabeth, your challenges are more complex than ours were 40 years ago. Back then, we thought our issues were insurmountable! But I suspect that 25 years from now, you'll think your problems now are simple. There's one constant necessity for a leader throughout the years, however. Leaders have to be constantly learning and adjusting their skills and knowledge. They always have to anticipate what's coming just past the horizon. This leadership quality has kept this academic medical center at the forefront and contributed to its great reputation as a learning organization.

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Elizabeth. Great point! I do get concerned sometimes about some of our leaders. In fact, last week at our senior council meeting, we talked about how so many of us have become so busy that we haven't been able to invest time in leadership education. There are days we just put out fires. The constant e-mails and interruptions from our so-called smart phones rule more and more of our time. We just don't have the chance to do the strategic deep dive that I know we need.

Jonathan. Watch out for that. Not keeping up with the trends and the new realities is like not changing the oil in your car often enough. You won't see the negative effects until it's too late.

"It was the best of times, it was the worst of times," wrote Charles Dickens in his classic book, *A Tale of Two Cities.* The same can be said of constantly evolving healthcare. Consider some of the realities (both good and bad) in the field that confront healthcare leaders today:

- The shift from volume to value
- Clinical integration
- Transparency
- Population health management
- Management of the continuum of care—and care moving out of the acute care setting
- Consolidation, alliances, affiliations, and consortiums among providers
- Professional shortages and decreasing recruitment pools
- Retail incursion into healthcare
- The continuing pressures of Big Data—more and more issues with electronic health record systems and other clinical and information technologies

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- The impact of the Internet
- Patient use of smart phones
- An aging population
- Changes in worker and patient ethnic and cultural demographics
- Higher expectations from consumers; consumerism
- Loss of public respect for the healthcare field

These challenges, and those yet to come, are exactly why the leadership imperative exists. The leadership imperative is the need for healthcare executives to enhance their understanding of the forces at play in the field and the way they manage through these changes. Leaders must now build judicious forecasts by thinking in the long term and changing these forecasts more frequently than every three years (the current traditional strategic plan cycle). The imperative demands planning that goes past the current workday or budget year. Simply put, the healthcare field, its workers, and the people it serves need leaders who can rebuild trust; restore efficient processes; and ensure quality through uncertain environmental trends and practices, societal and economic flux, and organizational transitions.

EVOLVING ENVIRONMENT

Healthcare's evolution has brought not just improvements. In fact, it has created inefficiencies and disorganization. However, it has also ushered in more jobs, better operating standards and clinical outcomes, lifesaving advances, a focus on patients and disease management, improved services, and new sources of revenue (among other things).

Current trends (listed in exhibit 1.1) and common obstacles (discussed later in the chapter) shape the healthcare environment in which workers function and services are provided. In this landscape, physician–organization relations continue to be among the most challenging

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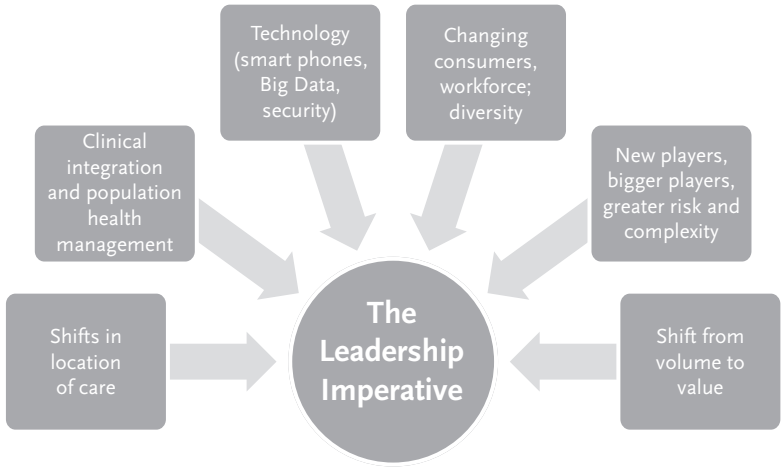
Exhibit 1.1 Current Trends in Healthcare



issues, along with strategic conflicts that could result from mergers or other steps to gain economies of scale or increase market share. Such conflicts may derail the flow of decisions and disrupt patient services.

Amid changes and problems, healthcare leaders plow through. Some are weary and doubtful of their ability to rebuild trust and continue to guide their organizations. Some, however, are energized by the challenges. When asked about the current state of the field, several healthcare executives make the following comments:

- "These are very tough times to be leading a hospital, but I would not have it any other way. This is a good test of my leadership."
- "Well, when the going gets tough, the tough get going—that is certainly true today. I am really up for the challenge."
- "After 35 years in this field, I thought I had seen it all, but the changes keep coming. I am OK with that, but it certainly gets tiring many days."

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- "I have a better view and sense of direction here at the top. But I am concerned about my middle managers who are down in the trenches. I need to do whatever I can to help them keep holding on."

As these responses articulate, this era is both an exhausting and an exciting time to be a leader in healthcare.

COMMON OBSTACLES AND IMPERATIVE ACTIONS

Aside from coping with the current realities of the field, healthcare leaders also navigate the common obstacles of running multifaceted operations. In this section, these obstacles are listed along with an appropriate imperative action. An imperative action is a step that a leader may take to overcome the obstacle.

Obstacle 1: Organizations Today Are More Complex

Until the 1990s, healthcare organizations were structured in a relatively simple manner. Free-standing hospitals, private doctor's offices, nursing homes, and local pharmacies were the most ubiquitous embodiments of organizations. Healthcare *systems* did not exist, nor did integrated delivery networks and nursing home chains, and few mergers and acquisitions took place. Physicians were not employed by health systems; instead, they ran small, independent practices.

A hospital was not a conglomerate; it existed solely to provide care for the hospitalized patient. Therefore, its leaders were not mired in the politics

> The problems of making healthcare work are large. The complexities are overwhelming governments, economies, and societies around the world. We have every indication, however, that where people in medicine combine their talents and efforts to design organized service to patients and local communities, extraordinary change can result.
>
> **—Atul Gawande (2011)**

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of multiple business partners or the bureaucracy of multiple service lines. A hospital's mission and vision were clear.

"The more complex the system, the less efficient its operation" is an adage that is true of today's healthcare systems. Decreased efficiency results in less satisfaction not only for the system's patients but also for its workers. Complex systems exhaust leaders and resources because they require more attention and focus.

Imperative action: Restore the simplicity of the healthcare organization by clarifying its structure, mission and vision, and future direction. Work to minimize the complexities of intricate organizational structures.

Obstacle 2: Employee Engagement and Loyalty Are Low

Opinion surveys continue to reveal that employee commitment and engagement are decreasing. According to Gallup (2016), "A staggering 87% of employees worldwide are not engaged at work. The world has a crisis of engagement—one with serious and potentially long-lasting repercussions for the global economy."

Job security is one of the most important elements of a high-performance work environment. For a long time, healthcare offered just that: job security. Employees, in turn, showed their appreciation for this security by being loyal to the organization. Employees stayed at their jobs longer, performed harder and better, recommended family members and friends to apply for open positions, missed fewer workdays, and participated more in the activities of the organization. Gallup has developed a well-known employee engagement tool and has shown that engaged employees are more productive (Adkins 2016).

Today, even the hardiest healthcare systems cannot ensure jobs for their employees. One CEO suggests that the high levels of trust between management and staff that once existed in the healthcare field may never return: "I remember the first time I faced a room full of hospital employees who were to be laid off. That was 15 years ago, and I personally talked to all of them. However, the last three

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times my organization has laid employees off, I did not even go to the sessions. I was told that it was legally risky and that it could be better handled by our human resources staff. We handed the laid-off employees to an outplacement firm. I feel like I abandoned them and feel really bad, but I don't know what to do about it."

Imperative action: Enlist the engagement of strong employees by boosting trust levels and encouraging their participation in organizational initiatives, such as by giving them increased personal control and decision-making roles.

Obstacle 3: Physicians Are Increasingly Disengaged and Dissatisfied with the Field

Physicians aged 55 or older have different expectations from those who are just beginning medical practice. Older physicians have witnessed the growth of managed care and eventual drops in reimbursement. They have experienced financial and legal challenges to their role as the "captain of the ship" in patient care. They mourn the disappearance of the club-like atmosphere of medicine, filled with people with the same concerns and priorities. The transition to electronic health records has tried the patience of many. Some physicians even regret having entered the profession.

Younger physicians, on the other hand, have different expectations. Most, if not all, of them begin their careers with enormous student loan debts (some estimates suggest $170,000 or more; see Association of American Medical Colleges 2014), so they desire stable employment with set hours and salary. In addition, younger physicians believe that medicine is only one part of their life, while older physicians put most of their lives' focus on medicine. These divergent perspectives and work styles has caused tension between these two groups.

> The world is now changing at a rate at which the basic systems, structures, and cultures built over the past century cannot keep up with the demands being placed on them. Incremental adjustments to how you manage and strategize, no matter how clever, are not up to the job.
>
> **—John Kotter (2014)**

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The practice of employing physicians, which was the trend in the 1990s, has returned. While in the 1990s hospitals and health systems hired doctors in response to capitated care financing, today the reason is a combination of physicians' pursuit of a more secure employment (as opposed to the difficulty and expense of private practice and the high rates for malpractice insurance) and the organizations' need for physician loyalty (Accenture 2015). Although physician employment can help to align common interests and goals, it may also reduce the physicians' autonomy and complicate their decision-making. As a result, physicians, even employed ones, may end up losing faith in and loyalty to the organization. If given a choice, many physicians would rather have another physician as the leader of the organization, as this actual sentiment from a hospital physician board member underscores: "We seem to have forgotten our patients in our drive to build a bigger, more comprehensive healthcare system. At least having a physician as our CEO would bring back that patient focus."

The many significant changes within the field are enticing many physicians to move into leadership. Bisordi and Abouljoud (2015) report that "from payors and providers to facilities such as hospitals where services are delivered, healthcare reform has ushered in an era where physician leadership is, quite simply, essential for long-term success." Graduate schools throughout the country have developed management programs targeted at physicians. Multiple healthcare organizations have created physician leadership development academies. Many physicians enrolled in these courses are motivated by their dissatisfaction with how healthcare organizations are managed. These doctors seek to improve these facilities' operations and services as well as gaining more influence over the strategic directions of their organizations.

Imperative actions: Improve relations with the physician collective. Handle physician employment skillfully. Consider the fact that more and more physicians are needed in leadership roles. Build robust physician leadership development programs. Make room for

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the increasing number of part-time physician leaders who will still remain in some clinical practice.

Obstacle 4: Pay for Value and Clinical Integration

Perhaps there is no greater change to the healthcare field than the radical shift in payment methods brought about by the Affordable Care Act of 2010. Healthcare provision had been built on the concept of volume. It was a very simple-to-understand business in one respect: Bring more patients in the door, get paid for it, and your business was good. "More heads in beds" was the mantra. While talking about the so-called shift to a value-based reimbursement scheme is easy, guiding a real institution through the enormous changes it brought about— managing across that chasm—is almost frightening in its complexity. Feyman (2014) states, "Despite some shining examples of success, value-based payments have a nastier side as well." In fact, there is evidence to suggest that there are no savings at all in some programs.

Clinical integration will create benefits for patients but massive changes for the field. Improvements include "the elimination of duplicate clinical and administrative work, a common patient record that ensures that the status of the patient is tracked throughout the entire course of care with no continuity-of-care gaps, a reduced chance of errors, systematic support of best practices and evidence-based care, and full alignment of the goals of all providers" (Dye and Sokolov 2013, 104). But as Faber (2016) states, "Some systems that have invested in clinical integration will go out of business or be acquired by more successful systems, which in turn will downsize or divest those facilities."

Imperative action: Leaders must carefully craft logical strategic and tactical initiatives to shift toward value-based reimbursement and clinical integration without harming the care enterprise.

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Obstacle 5: Patients Are Dissatisfied with Healthcare

Staggering healthcare costs, high insurance premiums or narrow-network insurance plans, poor quality of care, limited access to care, and lack of attention or information from providers are just some concerns that cause patient dissatisfaction. A survey by Prophet and GE Healthcare Camden Group (2016) shows that "81 percent of consumers are dissatisfied with their health care experience" Moreover, the same study showed a 3 percent decline in patient satisfaction from 2013 to 2014 (chap. 1).

Moreover, despite calls for improvement, quality and patient safety remain a serious challenge in the United States. According to McCann (2014), "Preventable medical errors persist as the No. 3 killer in the U.S.—third only to heart disease and cancer—claiming the lives of some 400,000 people each year" (see also James 2013). Many patient safety advocates, including the Institute for Healthcare Improvement, have raised the level of awareness about dissatisfaction and have pushed various quality practices. The field has made some progress in this regard, but unfortunately, quality is just one of the many areas that need to be addressed.

Many healthcare systems have grown so large that patients report a lack of responsiveness similar to that experienced with large corporations. One educated patient compares her experiences with her health system to "calling an 800 customer service number in the middle of the night on Sunday." In a consumer-driven healthcare market, this type of treatment could lead to loss of revenue, at best, and loss of patient trust, at worst.

Imperative actions: Make quality of care and patient safety your number-one priority. Pay attention to consumer service, and establish good relationships with the communities you serve.

Obstacle 6: Succession Planning Is Not a Priority for Some Retiring Leaders

An increasing number of baby boomer executives will retire in the next few years. Despite these retirement plans, many leaders have

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not developed succession plans to ensure that their transitions are handled effectively.

Next-generation leaders are ready and waiting for their opportunity to learn and grow in these management roles. Many are aware of the leadership imperative and are confident and excited about the future, although some are fearful of current trends.

Imperative action: Invest time and resources in succession planning and leadership development programs to ensure that the new generation of leaders will make the significant inroads and positive contributions needed for high-quality patient care and service to our communities.

CONCLUSION

The title of this chapter, "The Leadership Imperative," stems from two of the most urgent issues in healthcare today. The first is the importance of leadership for healthcare. The field needs a leadership book solely dedicated to healthcare. Healthcare is, in fact, different from other fields. As Gawande (2014, 6) writes, "Scientific advances have turned the process of aging and dying into medical experiments, matters to be managed by health care professionals. And we in the medical world have proved alarmingly unprepared for it." Leadership must walk side by side with healers and help remove barriers to success. Second, many of the imperatives presented herein are the result of the massive changes transpiring in healthcare. Again, Gawande (2011) says it best: "You are the generation on the precipice of a transformation medicine has no choice but to undergo, the riders in the front car of the roller coaster clack-clack-clacking its way up to the drop. The revolution that remade how other fields handle complexity is coming to health care, and I think you sense it." Heeding the leadership imperative and taking up this mantle is what is required of leaders in healthcare today. Are you ready and willing?

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But while the challenges facing healthcare are exceptional, some problems of leadership are classic. Root, a firm that helps organizations bridge the gaps in strategy and foster employees' understanding of that strategy and willingness to engage in it, presents a very unusual visual it calls *The Canyon* (see exhibit 1.2). Jim Haudan (2016), CEO, describes it: "*The Canyon* reflects the reality of people's day-to-day jobs at all levels and functions of an organization. Dealing with those realities is the first step toward creating engaged employees and executing strategies like superstars. When leaders don't face reality head-on, it does not bode well for goal achievement."

He explains (2016):

> What the image really shows are these canyons between the leaders of an organization that can see what needs to be done, but don't have their hands on the levers of change every day; the managers stuck somewhere between the leaders and the doers, so that they must balance a lack of full information with a need for employee guidance ; and then the doers that have their hands on change every day but can't see what needs to be done. So what you find, and maybe even metaphorically, is that everybody is at a different altitude, and everybody sees the problems that we face very differently.
>
> You know we have this wonderful saying: "People will tolerate the conclusions of their leaders but they will act on their own." But if you are going to change the dynamic of that, which means that everybody is in a different corner, and that our conclusions are similar, then what we see in terms of our businesses must be explored equally. So everybody—leaders, managers, and individuals—must be able to see all the drama in the business and given the decency to compare and contrast, to check and recheck, to unlearn and to relearn; and when they are given that opportunity 99.9 percent of people come to very similar conclusions.
>
> The problem is what each of us sees is so different, our conclusions are so different, that again these canyons get perpetuated.

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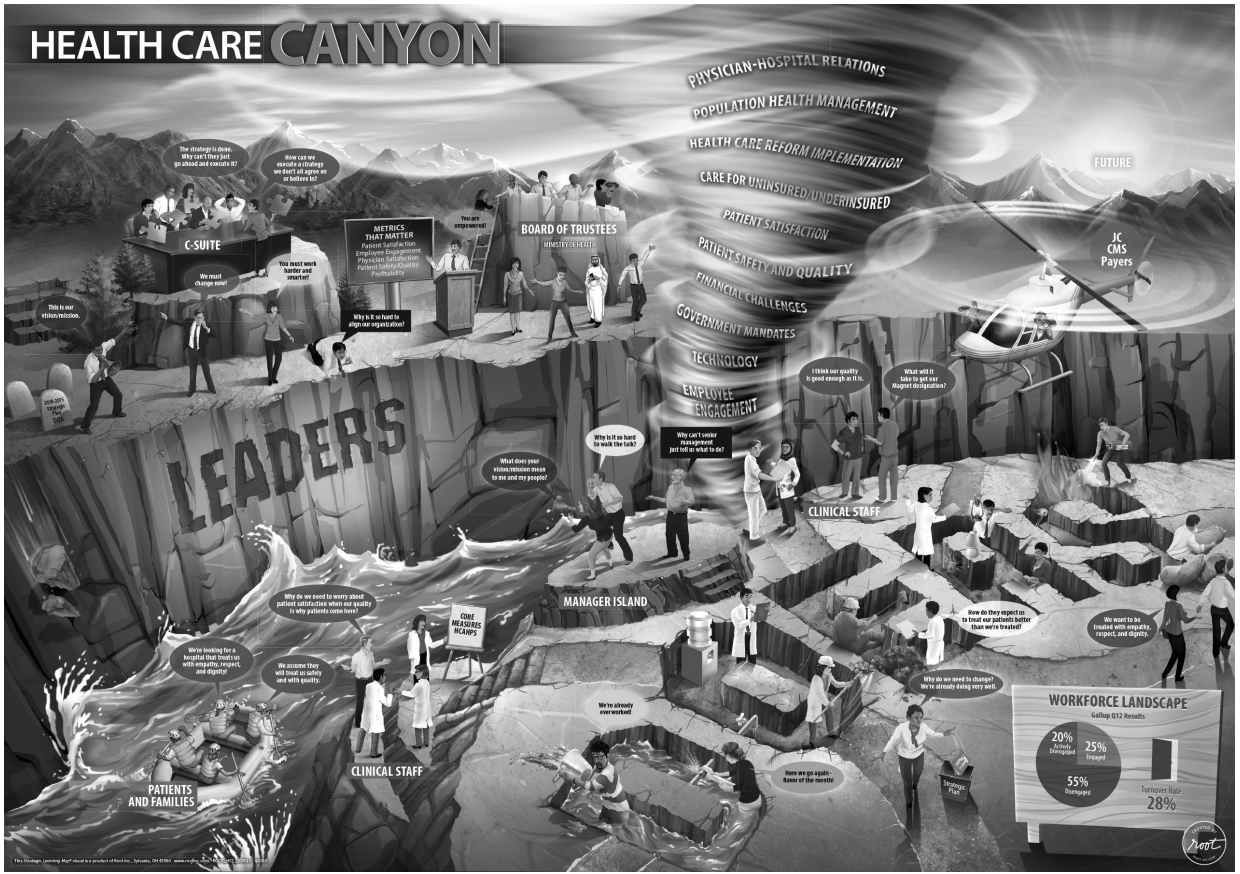
Exhibit 1.2: Root's *The Canyon*



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Building bridges across the Canyon is, I think, the Leadership Imperative.

Self-Evaluation Questions

- ❑ Do I view myself as a leader? If so, is my goal to bring about needed change or, in the words of one CEO, "to build palaces and monuments to my legacy"?
- ❑ Do I view leadership as an act, a process, or a skill?
- ❑ Do I, and other leaders I know, think that a leadership imperative exists today?
- ❑ Have I observed any significant shifts and trends in the field and popular culture that affect leadership in my organization?
- ❑ Does it seem more difficult to lead and manage change today?
- ❑ What does the illustration of the Canyon mean to you as a leader?

Exercises

Exercise 1.1

Read and reflect on the following article. Outline the primary areas of concern for healthcare leaders and suggest steps that could reduce the problems created by generation gaps.

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