Today's Health Leadership Challenges

Many of us see surprise events and talk about the crisis ahead. Really good leaders see these challenges as opportunities to shepherd people and organizations toward a successful future.
Major General (Ret.) David Rubenstein

Change is inevitable. Industry and organizational change are necessary for organizations and professions to remain relevant and serve the external environment well. The health industry is no different when it comes to change except for one key aspect—the speed and volume of change in the health industry have been defined as "white water change"—that is, changes that come fast and with great volume. The health industry has gone through vast changes and continues to change at a staggering pace, since the passing of the Social Security Amendments (Titles 18 and 19) that instituted Medicare and Medicaid in the mid-1960s. Today's health organizations are trying to successfully navigate the Patient Protection and Affordable Care Act (ACA), value-based purchasing, community health needs assessment, transition from ICD-9 to ICD-10 coding systems, electronic health records, meaningful use criteria, and the like. In order for organizations to successfully navigate change while continually improving health outcomes within the communities they serve, leadership at multiple levels of the industry and within the organization is critical. Leaders must become efficient, effective, and efficacious in leading people and managing resources. Competencies for today's health leader must be continually honed, improved, and mastered to propel health organizations to greater and greater levels of value.

LEARNING OBJECTIVES

1. Outline why the dynamic forces within the industry are important to professionals in the health industry, and identify challenges that require quality leadership intervention strategies.

2. Explain and give an example of one aspect of change in the industry today, and link the leadership competencies that are necessary for successfully navigating the organizational changes required to deal with this change.

3. Relate, discuss, and explain the importance of the application of a leadership competency model to contemporary health industry change.

4. Distinguish the different aspects or domains of change in the health industry and how those domains impact leadership capability, and explain how the synergy of those changes impacts leadership capability and organizational success.

5. Relate the health reform efforts of the past decade to leadership needs at the health organization level.

6. Evaluate the health industry's needs for leadership today and into the next decade.

INTRODUCTION

There are a multitude of challenges facing the health organization leader today. This chapter will serve as an introduction for the concepts that we will revisit throughout our discussions of leadership for health professionals. Two contributing authors, Drs. William Mase and Dave Schott, collaborated with Drs. Ledlow and Stephens on this chapter; Drs. Mase and Schott are professionally trained in public health policy. Because the health industry is integrating public health and healthcare delivery (along with shared financial and service risk) it is prudent to attend to the aspects of integration between these two vital segments of the industry. This chapter intends to provide a foreshadowing of what health leaders need to understand, be aware of, and strategically and operationally plan for in order to successfully lead people and manage resources amid this dynamic turbulence. To support the introduction of the complex challenges facing today's health leaders, we have developed a visual representation of the current situation; this visual representation structures the discussion. The discussion is focused on health leadership over the next decade.

Figure 3–1 illustrates the flow of information and the interconnected nature of the health leadership competencies and how policy affects and is affected by the various domains of healthcare leadership. The second half of the chapter presents major contemporary leadership development and competency domains. These domains are presented as they relate to the various challenges discussed in the first half of the chapter.

POLITICAL INFLUENCE

Political influence is the ability of those wielding the political power to shape and control the political behavior of others and to lead and guide the behavior of others in a desired direction. Political behavior can include many different activities, all of which are concerned with public policy.[1] Because the ultimate purpose of obtaining political influence is to shape and control public policy, the policies of an organization or nation will change over time depending on the views and influence of those with political power. The primary tools by which government officials shape and control public policy are legislation and statutes.

LEGISLATION AND STATUTES

Legislation is a law that has been enacted by a governing body. A statute is the formal written enactment of a legislative authority at any level—city, state, or country.[2] Legislation and statutes related to health are of great concern to healthcare executives because they govern nearly every aspect of health care, from reimbursement for procedures to facility maintenance. Health policy includes the decisions, plans, and actions that are undertaken to achieve a specific healthcare goal within society. When
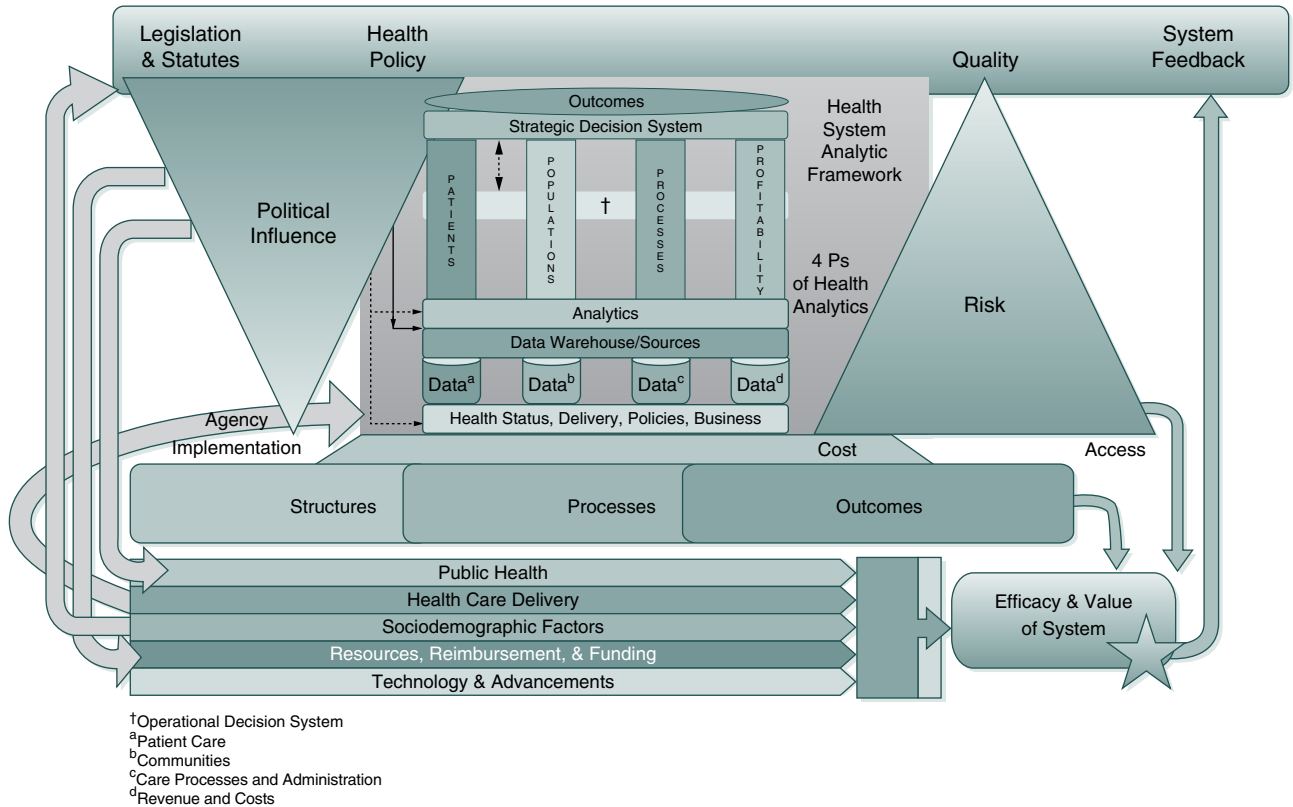
FIGURE 3-1 Today's health leadership challenges.

constructed successfully, health policy can achieve multiple aims. First, it can define a vision for the future, which in turn, helps to establish targets and reference points for the short and mid-term. Second, it can outline priorities and the expected roles for different groups and individuals.[3]

Once enacted, health policies are implemented by government agencies. When agencies implement policy, they do so through creation of regulations. Laws do not always include all of the details needed to explain how an individual or business must act to follow the law. Therefore, Congress authorizes certain government agencies to create regulations.[4] These regulations set specific requirements regarding what is legal and what is not. For the healthcare industry, many of the governing regulations are interpreted, "translated into practice," and put in place and enforced by the Centers for Medicare and Medicaid Services (CMS).

The risks associated with the creation or implementation of new policy can be large. To help describe these risks, as well as quantify the benefits from policy programs, it is common to use models or theoretical frameworks to describe the process. When enacting policy that affects the U.S. health system, there are three main areas that should be impacted by the policy decision: cost, quality, and access. Theoretically,

these three areas are opposed to one other. This oppositional relationship is described as the "Iron Triangle" of health care.

THE IRON TRIANGLE OF HEALTH CARE

The first mention of the Iron Triangle model was in a 1994 book by physician William Kissick. The model describes the relationship between cost, quality, and access to care. In its purest form, the model states that if two of the components move in a positive direction, the third must move in a negative direction. For example, when cost and quality increase, access must decrease. Kissick postulated this model after reflecting on the major issues within the U.S. healthcare system.

Costs include any costs associated with providing health care. Total cost includes what is charged to patients, either directly or as an insurance deductible. Quality is typically measured in patient outcomes. Quality care leads to improved health status for the individual receiving the care. Access to care is the ease of obtaining care for a patient.

Factors that can negatively affect access include the number of physicians accepting patients, healthcare facilities, and availability of equipment.

The Iron Triangle model has been criticized as not being a rigid relationship but instead just a general guideline.[5] However, there are still very few instances that "break" the iron triangle relationship. The conditions that "break" the relationship described by Kissick are:

- Increasing efficiency
- Decreasing regulation
- Improving technology

These situations are the exception rather than the norm. The Iron Triangle model has been used to describe the cost increases that occurred after the passage of the ACA in 2010.[6]

THE DONABEDIAN MODEL

Postulated by Avedis Donabedian, a physician at the University of Michigan in 1966, the model provides a framework for examining health services and evaluating the quality of care. The purpose of the Donabedian model is to modify structures and processes in a healthcare delivery network to improve outcomes. According to Donabedian, *structures* include all factors that can change the context of care delivery.[7] *Processes* include every action that takes place to provide care. Typically this is thought to include all of the clinical steps, such as diagnosis, treatment, patient education, and preventive activities. Processes are further subdivided into technical and interpersonal processes. Outcomes include the impact of providing health care to individuals and the communities in which they live. This includes changes to health status, behavior changes, and knowledge changes.

The goal of any leadership initiative is positive outcomes for the organization. Drawing conclusions regarding program outcomes may require large sample sizes or long time periods to account for random variation. In an effort to ensure that outcomes and project goals are met, modern programs are data driven. Since 1986, the Joint Commission has worked to create an evaluation system based on continuous data collection and periodic feedback on specific performance measures.[8] Over time, performance measures and standard scores have been developed and are published for the public on affiliated websites, such as the Centers for Medicare and Medicaid Services Hospital Compare website located at (https://www.medicare.gov/hospitalcompare/search.html). Value is a main focus of the efforts in these areas. What is valuable to the community that you serve?

DISRUPTIVE INNOVATION

Disruptive innovation is a hot topic in health care today. At the American College of Healthcare Executives (ACHE) congress in 2016, disruptive innovation took center stage in a discussion regarding the federal goal to tie 20% of Medicare payments to value and quality through alternative payment models by the end of the year. This CMS goal is disruptive to the industry because it is the first time that explicit goals for alternative payment models have been set for Medicare. There are a few leading health systems well ahead of other organizations in this effort. Those leading systems have a three-part goal:

1. Improve the patient experience of care.
2. Improve the health of populations.
3. Reduce the cost per capita of health care.[9]

You may notice that these three goals are in direct conflict with the Iron Triangle relationship we just discussed. How are these health systems able to achieve these goals? Can change occur through disruptive innovation?

The healthcare industry moves at a rapid pace, and one of the more recent examples of disruptive innovation is robotic and laparoscopic surgery. Prior to laparoscopic techniques a cholecystectomy required a large incision in the abdomen. Laparoscopic techniques allowed for the large incision to be replaced by four much smaller incisions. The net effect was an increased level of safety in the procedure, faster OR turnover, and a decreased length of stay with better patient outcomes. Robotic surgery has further expanded on these benefits.[10]

The demand for these disruptive innovations is created by manufacturers, providers, and patients. However, if the learning curve associated with disruptive innovation is not managed, unintended consequences of rapid acceptance may lead to patient harm. When adapting disruptive innovations, it is important to consider all factors, including potential harm, benefit, and learning curve management. It has been suggested that one of the best ways to cope with rapid change and disruptive innovations is using the "manage, steer, and create" model. Under this model, healthcare leaders are encouraged to manage the present, steer to the next horizon, and create the future.[11] The health leader of the present, and surely into the future, will also see a myriad of data-driven and "big data-" driven tools, programs, and solutions that will either stand alone for utilization of the health organization or will embed or interface with existing clinical and enterprise resource planning information systems; these will be organic to the health organization's information system or

exist in an open-architecture or cloud environment. These disruptive innovation software systems will require leadership to evaluate their value and usefulness based on the health organization's strategic and operational plans, mission, values, and goals.

PUBLIC HEALTH

The American public health system is charged with providing assessment, policy development, and assurance functions. These three assigned functions are further subdivided into the 10 essential services, which include: (1) monitoring health; (2) diagnosing and investigating; (3) informing, educating, and empowering; (4) mobilizing community partners; (5) developing policies; (6) enforcing laws; (7) linking to provide care; (8) assuring a competent workforce; (9) evaluating systems; and (10) conducting research (**Figure 3–2**).

Public health powers operate at the national level, state level, and local level. Through the effective division of powers the public health system can carry out the 10 essential services by addressing public health–related concerns

at the local level. The primary functions of promoting and protecting the health of people and the communities in which they live is achieved through the effective coordination of all system-mandated activities. Public health is best defined as the collection of publicly available healthcare-related services that seek to address population-level health. These population-level pro-health services can be seen as complementary to the healthcare delivery systems that function to treat illness at the individual level. While a physician treats individuals with an illness, public health professionals seek to prevent people from getting sick or injured in the first place.[13] Typically, this is done through changing behavior patterns and promoting wellness. Notable activities of public health include vaccine development, health education, tracking of disease and environmental issues, and developing policy. Public health organizations are typically divided into five core areas: biostatistics, epidemiology, community health, environmental health, and health policy and management.

Biostatistics is the use of analytical tools to examine data relating to living organisms. The most visible use of biostatistics in health care is the development and analysis of clinical trials for pharmaceuticals. Epidemiology is the
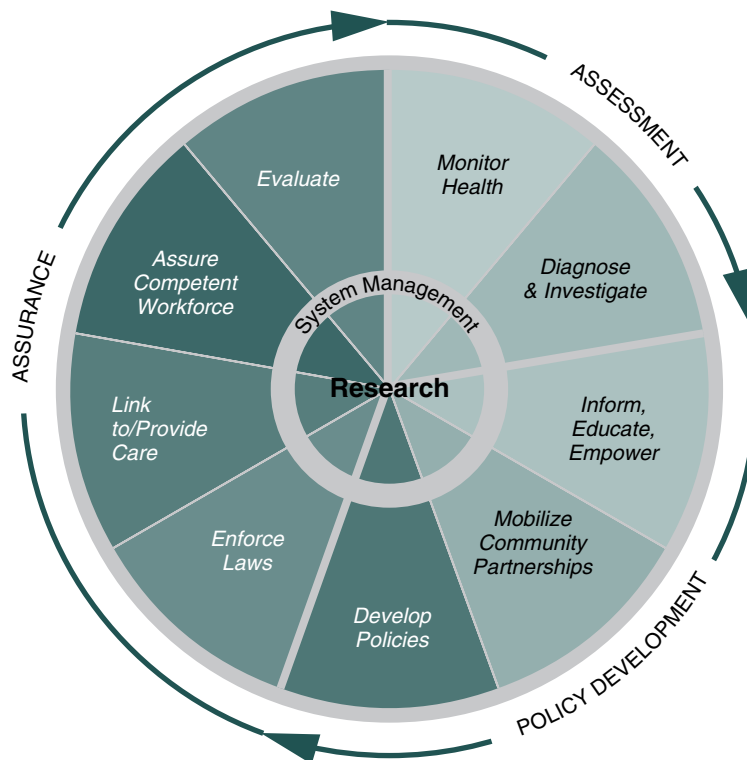

FIGURE 3-2 CDC training cycle.[12]
http://www.cdc.gov/healthliteracy/training/page1299.html.

branch of public health that deals with the incidence, distribution, and control of disease or other health-related factors. Community health is best known for health education and promotion resulting from the study and improvement of health characteristics in geographical areas. Environmental health includes monitoring and improving the environment outside as well as within facilities. Finally, health policy and management specializes in recommending and implementing policy as well as managing the programs that result from policy implementations.

The primary goal of the public health system is to improve the health status within communities through controlling activities or environmental variables that could lead to adverse health outcomes. Of course the efforts of public health are not able to prevent all morbidity, so the ability to deliver tertiary care is still necessary. A physician or other licensed medical professional usually provides hands-on healthcare delivery either in a stand-alone facility, such as a nonaffiliated physician's office, or through a healthcare organization.

HEALTHCARE DELIVERY

The healthcare delivery system in the United States is arguably the most complex system for delivering care in the world. This complexity results from the fragmented nature of services provided, the large number of organizations providing care, and the existence of both private and public insurance as well as self-pay.

Outside of the United States, most developed countries have a single-payer system that is controlled by the government or an agency controlled by the government. These national health plans are typically financed through taxes imposed on the population. These systems are often much less complex because there is either a single (government) payer or government with a self-pay option.

Whether in the United States or elsewhere, healthcare organizations are under increasing pressure to deliver increased efficiency and greater value and to simultaneously increase the quality of care. These policy and public opinion mandates are concurrent with the increasing complexity and needs of patients, which is forcing delivery of care model reform.[14]

RESOURCES, REIMBURSEMENT, AND FUNDING

In 2010, U.S. healthcare spending cost about $2.6 trillion. For decades the rate of healthcare spending in the United States has grown faster than the growth rate of the economy as a whole.

Per capita spending on health care in the United States is the highest in the world; however, the health outcomes of the citizens are not the best in the world. For example, the United States ranks comparatively low on measures such as infant mortality, life expectancy at birth, and healthy life expectancy. In 2011, the United States spent $8,508 on health care per person and received an overall ranking of 11. The United Kingdom, which ranks 1, spent $3,406 per person.[15] It was thought that the enactment of the ACA would lead to lower costs; however, this has yet to occur. In fact, costs continue to rise post ACA—although at a rate of about half that of previous years. Sources are conflicted about the cause of the declining rate, but evidence points to the aftereffects of the 2011 recession in the United States.[16]

REIMBURSEMENT

In the United States, when healthcare organizations provide care to insured patients, the healthcare organizations are reimbursed after the fact by insurance companies. Because private insurance reimbursement rates are determined through direct negotiations with the health system and the process can differ among insurers, we will focus on Medicare reimbursement to illustrate the process.

Hospitals are reimbursed for inpatient Medicare services provided through the Inpatient Prospective Payment System (IPPS). The payment comes in the form of a per discharge or per case basis for Medicare beneficiaries with inpatient stays. The claim filed by the hospital needs to include all outpatient diagnostic services as well as any admission-related outpatient services provided prior to admission to the healthcare organization. When patients are discharged they are assigned diagnosis related groups (DRGs), a classification system that groups similar clinical conditions and procedures provided during the patient's hospital stay. When assigning the DRG to the Medicare beneficiary, the hospital uses the principal diagnosis and up to 24 secondary diagnoses, which can be used to list comorbidities or complications. Based on these diagnosis codes and other factors, such as gender, age, and discharge disposition, the DRG is assigned.[17] Medicare reviews cases submitted for reimbursement and pays or rejects claims based on published criteria found on the CMS website. Rejected claims can be appealed by healthcare organizations in a series of formal appeals.

In addition, bundled pricing, such as that now required with total joint care (such as joint replacement) bundled pricing for Medicare (federal agency responsible is CMS), will change the reimbursement landscape.[18] Bundled pricing

will facilitate the establishment of narrow networks of providers—a few providers in a given geographical area who are most efficient and have quality patient outcomes—to be utilized for services by Medicare health insurance plans. Higher cost providers—those that have not reduced supply chain, labor, and other costs to perform procedures—will be left out of the network. This is important because the commercial market–that is, health plans that are not Medicare or Medicaid and are usually established with employee benefits–tends to follow the federal programs of Medicare and Medicaid for pricing and reimbursement. Understanding the "value proposition" in health care is increasingly part of the business of health care and healthcare services.

FUNDING

Health care in the United States is generally funded from three sources, self-pay, private insurance, and government insurance.

Individuals typically use self-pay methods for care not covered by other sources. Credit cards or other generic means of borrowing are sometimes used for this purpose, but there are two options available for individuals to save in advance for self-pay, flexible spending accounts (FSAs) and health savings accounts (HSAs).[19]

FSAs are typically offered by employers. They allow employees to have a certain amount of money deducted from their paychecks and deposited into the FSA. The money in an FSA can be used to pay for out-of-pocket healthcare expenses. As an incentive to employees the money deposited into the FSA is not subject to federal income tax. However, the money in the FSA is usually forfeited at the end of the year, so careful planning is required on the part of the employee.[20]

HSAs are also used to pay out-of-pocket expenses. Unlike an FSA, HSAs earn interest and the unused balance is not forfeited at the end of the year. Typically, people who have health insurance plans that limit their reimbursements enough to be classified as high deductible are eligible for an HSA.[21]

Currently, about 17% of healthcare costs across the United States are funded out-of-pocket. As you may expect, charges for individuals are typically higher than for insurance companies, because insurance companies are able to negotiate rates based on volume. This can lead to individuals who pay out-of-pocket receiving extremely large bills for health services. In fact, many personal bankruptcies are related to medical expenses. To avoid this the ACA requires almost everyone to have some form of health insurance.[22]

Private insurance is purchased from insurance companies, which must be accredited in each state were they sell their product. Most private insurance is purchased by businesses as a benefit for employees; premiums are typically shared by the business and the employee. Because the cost of employer-provided health insurance is not considered taxable income, it is essentially government-subsidized. Individuals may purchase private insurance on their own, but these applications are typically evaluated closely to identify risks to the insurance company.[23]

In 2010, the private insurance market in the United States was fundamentally changed by the passage of the ACA. The purpose of the ACA is to increase availability, affordability, and use of health insurance in the United States. One of the primary methods by which the ACA seeks to accomplish this is through the expansion of the private insurance market, creating incentives for employers to provide insurance and penalties for individuals who choose not to purchase insurance. For the purposes of risk pooling and reducing program overhead, the ACA created insurance marketplaces within each state. These insurance marketplaces impose minimum standards for the insurance plans sold within them, and there are separate marketplaces for individuals and small businesses.[24]

Government insurance programs include Medicare and Medicaid as well as programs for active military and Native Americans. The Medicare program is designed to provide health insurance to the elderly, disabled, and individuals requiring dialysis. Medicaid covers individuals living below a certain level of income and those with certain disabilities. Approximately 30% of the population is covered by government insurance or government-provided care. The ACA increased federal funding for state Medicaid programs in the short term and expanded eligibility criteria. However, states are not penalized for not complying with the new criteria, so the total number of individuals who will enroll in the program is uncertain.[25]

SOCIODEMOGRAPHIC FACTORS

Sociodemographic factors are things such as age, race, ethnicity, languages, as well as income and education.[26] There is a growing body of research suggesting that these factors affect health outcomes, in addition to influencing how people are viewed by others and how people view the world. For the health leader sociodemographic factors come down to two questions: Do you know who your high-risk patients and high utilizers are? Do you know precisely where they live?

According to Dr. David Nash, in a presentation at the 2015 ACHE Congress on Healthcare Leadership, the number one health predictor in 2015 is your ZIP code. This stems from the observation that large disparities in health can be found among pockets of population that live short distances from each other. A commonly cited example is the Washington, D.C., area. Babies born in Montgomery, Arlington, or Fairfax counties can expect to live 6 to 7 years longer than babies born in Washington, D.C. These counties are one ZIP code apart—just a few stops on the subway. Observations like this can be used to predict the percentage of patients who share that risk factor and determine strategies to improve care coordination and delivery.[27]

Basic electronic health record (EHR) systems, however, are not equipped for this kind of data analysis; more advanced systems using predictive analytics are needed. In order to elevate a health system from basic EHR usage to predictive analytics there are numerous paths and options with regard to software. In order to facilitate decision making by the healthcare organization, a model such as the 4Ps of Health Analytics can be used to structure the discussion and formulate a plan of action.

THE 4 PS OF HEALTH ANALYTICS

To effectively guide and direct their organizations, health leaders need information. Starting with raw data gathered from various operational, governmental, and other systems, how do health leaders create an organizational culture based on knowledge utilization? How do health leaders take data, place them in context, integrate information from multiple domains, take action based on the information, promote organizational learning from those actions, and improve strategies and operations of the healthcare organization? With the changes in the healthcare industry that require closer connections to the community's health care, organizations serve those communities with more assumption of risk for the health status of those communities. What model can health leaders use to achieve a knowledge-based organization? Complicated ideas are often shown as a model. A *model* is a simplified substitute for an event or situation that is being studied or predicted. Models can be used in multiple ways. The most common is to describe a situation or prescribe a course of action. A *descriptive* model describes *how a system should function* according to the model. A *prescriptive* model shows *how to make a system function* according to the model. The most useful type of model is a combination of the two concepts, a model that is both prescriptive and descriptive. Models of this type describe how something works and show how to make it work as described.

Due to the complex nature of the health industry there are many models regarding the operation of health organizations. This is true of health analytics—health information for analysis and decision making—because it is an exciting, rapidly evolving field, even by health industry standards. The implication of change is relevant—the health industry is a dynamic industry. Recent changes from healthcare reform, policy changes, and the need to demonstrate value in health services delivery have created an environment where new models of health analytics, health information utilization, and health technology are required.

The 4 Ps of Health Analytics describes the interconnections between the four major categories of data found in health organizations: patients, populations, processes, and profitability (called "net margin" for not-for-profit [NFP] organizations). Traditionally, these four types of information have been used separately. When data are not easily accessed or integrated with other data from complementary domains, they are referred to as being in an *information silo.* As computer systems evolved, it became possible to store data in an electronic database which, when properly implemented, allows for information that, previously in a silo, can be used with other data sources. Another term for these electronic databases is *data warehouse* or *enterprise data warehouse.* A data warehouse is a system that creates a central repository of data and makes that data available for reporting and data analysis.

Patient data are data pertaining directly to the demographic information, history, diagnostics, treatment, care plans, and outcomes of care of the patient; these data are contained in the electronic medical record (EMR) system. *Population data* refer to the communities where health organizations are located. The data in this category are related to improving community health status and to the health and well-being of the community as a whole. *Process data* include information on the way business is conducted within the healthcare organization; these data (or elements of the data) can be found in enterprise resource planning (ERP) systems and organizational documents. *Profitability data* ("net margin" for NFP health organizations) include data on the ability of a health organization to generate income, such as cost of services, amount billed, and expected reimbursement along with expenses; these data can be found in ERP systems and organizational documents. The goal for a healthcare organization is this: How can data be turned into actionable operations that maximize efficiency, effectiveness, and efficacy?

TECHNOLOGY AND ADVANCEMENTS

Improvements in technology have created the era of "big data," a term used to describe the exponential growth and availability of data.[28]

The growth of big data has provided researchers and business professionals with access to unprecedented amounts of data. Combined with the ever-increasing power of computers, the newly available big data can be used to examine the effectiveness of existing processes and improvement efforts.

In health care, the mandated use of EMR is fueling big data throughout the industry. When coupled with a business intelligence or enterprise resource planning system, nearly all of the clinical, as well as business processes, will generate data that can be used to track process effectiveness.

EFFICACY AND VALUE OF THE SYSTEM

The efficacy and value of the health system can be traced back to the improvement in health status for the communities that it serves. Because the ultimate goal of healthcare organizations is to improve the health status of the communities they serve, all metrics used to track efficacy and value should support this outcome.

The trend in the U.S. health industry is for leaders to become more efficient, effective, and efficacious in leading people and managing resources, while simultaneously achieving high performance and quality outcomes within their organization. To keep up with this trend, measurement and assessment have become necessary competencies for leaders. However, before any leader can become skilled in these areas, he or she must understand the differences between the constructs of efficiency, effectiveness, efficacy, performance, and quality. Today's leader must also identify how the operationalization of salient variables for these constructs can assist in leading highly successful organizations.[29]

Terms such as *efficiency* and *effectiveness* are called constructs. Constructs are those things that lack identification through one of the five senses. As a result, to maximize opportunities for achieving highly effective, efficient, efficacious, performing, and quality organizations, it is incumbent on the health leader to recognize the differences between these constructs (as they are generally understood in the healthcare arena) and be able to use common indicators (e.g., variables) that are also understood by internal and external stakeholders. Failing to use appropriate terminology (e.g., constructs and variables) that is universally understood and applied consistently within and outside the organization may result in conflicting messages. For this reason, it is incumbent upon the leader to "stay on message," adhere to industry standards in terms of the definition and use of commonly accepted and widely employed health terminology, and measure these variables consistently.

Efficacy and value of the health system are determined through the aggregate data collected from the five major areas we just discussed: public health; healthcare delivery; sociodemographic factors; resources, reimbursement, and funding; and technology and advancements.

The efficacy and value of the health system will also be redefined by population demographics. As the millennial generation takes over a larger percentage of the workforce, the cultural changes that they have brought to other areas will also occur in the workplace. Examples of these changes include pervasive usage of mobile technology, the Internet, and innovative services such as ride-sharing mobile applications. As the first generation that has had access to personal computers for their entire lives, millennials have a different perspective on these technologies; technology is not the "new" way to get things done but the "easiest" way to get things done. This complete embracing of technology has been disastrous for industries that have failed to adapt (think of newspapers and record companies); it has been a great boost to industries that embrace change.[30]

According to some sources, millennials are one of the unhealthiest generations. This is leading to an increased utilization of health services by millennials at an earlier age.[31] While this is not necessarily good for the health of their generation, it could prove good for health care—an industry that typically adopts business process innovations more slowly than other sectors. As millennials interact with the health system they could potentially drive systematic changes to the healthcare industry.

SYSTEM FEEDBACK

System feedback in the healthcare delivery system is the end result of the efficacy and value provided by the system. Based on the magnitude and nature of the feedback, existing policies are either supported or modified. In some cases, feedback with regard to the efficacy and value of the system indicates the need for new policy, to create a shift in the trajectory of the system.
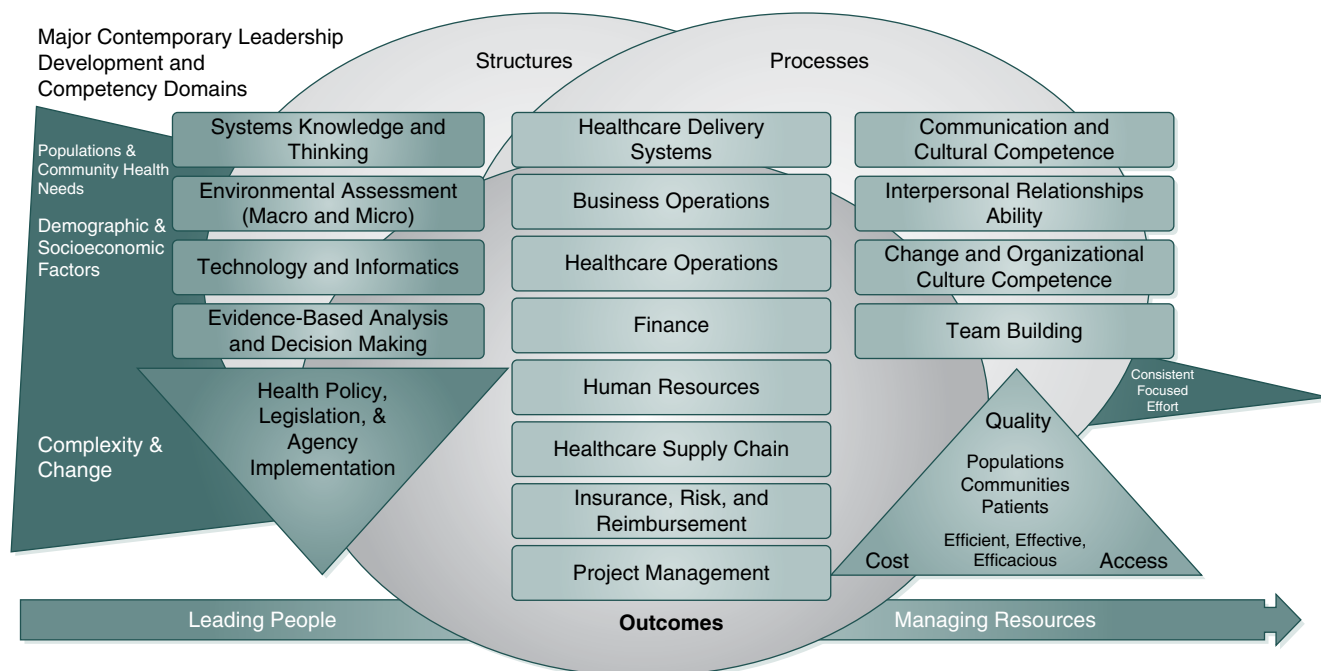
FIGURE 3-3 Major contemporary leadership development and competency domains.

STRUCTURES, PROCESS, AND OUTCOMES

The structures, processes, and outcomes of the Donabedian model encompass the majority of competency domains required of today's health leaders. As discussed in the first half of the chapter, the Donabedian model was designed as a tool to improve the outcomes of health services by modifying the structures and processes that create those outcomes. Outside of these competency domains we find the population health needs, including demographic and socioeconomic factors that increase the complexity and change facing the organization. In order to manage these external influences, a constant focused effort must exist within the processes of the organization. This relationship is represented by the red triangle behind the Donabedian model. William Kissick's Iron Triangle can be found at the juncture of outcomes and processes. Based on its position within the competency

domain map we can see that quality is directly influenced by the processes of the organization, with cost as an outcome; both of these modify the access to care in the community. The yellow constructs above the Iron Triangle are process changes, or leadership competencies that improve healthcare quality. Opposite the Iron Triangle, the triad of health policy, legislation, and agency implementation is represented.

COMPLEXITY AND CHANGE

Healthcare executives must be able to lead and manage change within their organizations. The ACA, new payment models, and a changing market are driving healthcare executives to launch new strategies within their organizations. But how can healthcare executives ensure that they are truly leading change? The key is to understand the difference between managing change and leading change. It has been suggested that ineffective leadership in times of change has caused much of the fatigue and frustration in the healthcare industry.[32] According to a recent ACHE seminar, this is because burnout of clinicians and staff of their organizations is associated with leaders making changes without considering the greater context or how their decision relates to the vision of the organization.[33]

The assertion that today's challenges require healthcare leadership is supported by several development and competency domains developed by Drs. Ledlow and Stephens (**Figure 3–3**).

POPULATION AND COMMUNITY HEALTH NEEDS

Population health is a growing topic in health care, which, if you think about it, is long overdue. With the move to value-based care, healthcare organizations have an increasing focus on population health and the needs of the community, because it is the measure by which they will be evaluated for reimbursement of service provision. Healthcare services that are high in value for the patient result in improved health status for the individual. On a community scale, this results in decreased morbidity and mortality rates, improving the health status of the community. In 2015, the number one factor to predict health status was not blood pressure, age, or cholesterol level; it was your ZIP code.[34] In many population centers, the average health status of residents can vary widely, even among relatively close areas. As classic example of this is Washington, D.C.

Figure 3–4 illustrates different life expectancies at birth in the metropolitan Washington, D.C., area.[35] These differences in life expectancy are reflected in the health status of those communities and driven by demographic and socioeconomic factors.

Examples of these demographic and socioeconomic factors include, race, age, education level, and proximity to environmental hazards. These factors will affect the payer and case mix index at healthcare facilities within the community. Advanced analytics are being used in some parts of the country by healthcare organizations to map out the community in terms of health status. Utilizing analytic tools such as community mapping will help to identify trends so that the healthcare organization is able to manage health-related trends within the communities they serve.

Even utilizing advanced techniques, consistent focused effort will be required for health systems to improve the health of their communities while managing expenses and covering their costs.

SYSTEMS KNOWLEDGE AND THINKING

Systems knowledge and thinking is a way of investigating and communicating complex issues. The core of systems thinking is seeking to understand how things are connected to each other in the total system.[36] In health care,
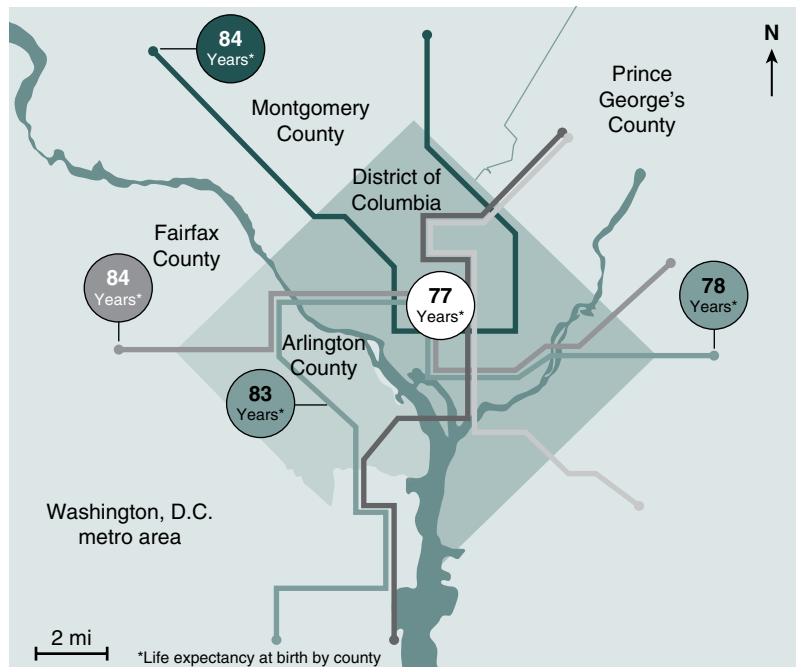

FIGURE 3-4 Your ZIP code may be more important to your health than your genetic code.

Reproduced from Robert Wood Johnson Foundation.

there are many interconnected systems and processes that contribute to providing care for patients. It may be hard to realize how simple actions such as proper facility maintenance or proper receiving of items via three-way matching can contribute to patient care, but everyone who works in health care must be aware of the interconnected nature of the various systems within a healthcare organization.

In order to determine the possible effects of an action, healthcare leaders can perform an environmental scan. Environmental scanning is a process of systematically surveying and interpreting relevant data to determine opportunities and threats.[37] All healthcare leaders must be able to assess the overall situation currently facing their organization, and this requires an assessment of both internal and external environments. A situational assessment must be an objective and honest look at the multiplicity of factors that could affect the health organization's success in achieving its vision, mission, strategies, and goals. One tool commonly used for the internal assessment is SWOT analysis, which investigates internal strengths and weaknesses and external opportunities and threats.[38]

Situational assessment and continuous environmental scanning are crucial if organizations hope to survive in the dynamic health industry. It is the responsibility of a leader and a leadership team to remain current about and relevant to situational and environmental change that can or will affect the organization. Forces that contribute to the health industry's rapid and dynamic environment are varied but cumulative; as a consequence, they have a additive impact on the industry. "Technology, demography, economics, and politics drive change, not only as individual factors but interacting to make the rate of change faster."[39] With regard to technological changes and the evolution of informatics, models such as the earlier mentioned 4 Ps can be used to guide the adoption process.

Healthcare delivery systems are made up of several subsystems that affect each other and are affected by the environment. It is for these reasons that systems knowledge and environmental scanning are essential tools for healthcare leaders, as discussed. Business operations are activities that support provision of care to patients but may not be directly related. Examples of business operations include supply chain, finance, and human resources. Healthcare operations, also called clinical operations, include activities directly related to providing patient care. Healthcare operations are typically led by physicians or advanced practice nurses. Examples include emergency room care, radiographic services, and surgical services.

FINANCE

Under the control of the Chief Financial Officer, the finance department is responsible for the financial accounting of an organization and assisting in making strategic decisions. The exact activities overseen by the finance department will vary among organizations, but it will always include day-to-day transactional accounting and related activities.[40] With the financial accounting covered, other activities such as securing external funding or providing financial reporting for strategic planning can take place. In the typical healthcare organization, some business functions such as supply chain management report up through finance.

HUMAN RESOURCES

Human resources (HR) within the healthcare organization is seen as potential source for innovation in the transition to value-based care. According to a survey by the American Society for Healthcare Human Resources Association (ASHHRA), HR can play a key role in managing healthcare reform goals through screening, shadowing programs, and continuing education.[41] The survey was referring to the role HR departments play in organizational culture. If individuals are hired who are not the right fit for the organization, replacing them is often extremely costly to the organization. To insure that hired individuals are a right fit for the organization, some health systems are using behavioral assessments, pre-hiring shadowing, and keeping communication channels open between HR and other departments within the facility.

HEALTHCARE SUPPLY CHAIN

The supply chain integrates with the healthcare provider to diagnose, treat, and care for a patient; if you remove either the supply chain or the provider of care from the equation, health care is significantly less effective, less efficient, and less efficacious. Patient safety, cost of care, quality of care, and access to care are intimately connected to the healthcare supply chain.

Supply chain management is the purposeful direction of the flow of goods. This includes the transport and storage of raw materials, work in progress, and finished goods from the point of production to the point of usage. A supply chain is an interconnected network of people and organizations that are involved in the production of products and services.

If they produce a product, every organization has some sort of a supply chain. Here, we will focus on the supply chain and logistics of healthcare organizations; the material presented also generally applies to other types of businesses. Supply chain management is an important area of growth for healthcare organizations for several reasons; the most obvious is the cost associated with mismanagement of the supply chain. It is estimated that in the United States supply chain costs in health care are typically around 40 to 45% of the operating cost of the organization,[42] and the associated costs are likely to continue to increase. Other estimates suggest that the healthcare supply chain is attributed to 30 to 35% of the annual operating costs of healthcare organizations; with a low of 30% or high of 45%, healthcare organizations must effectively manage their supply chain. Recent estimates suggest that there may be as much as $20 billion in efficiencies that could be gained by improving healthcare supply chain operations and management across the health industry.[43]

As healthcare treatments increase in complexity, the associated costs tend to increase. An example of this is stents used in percutaneous coronary intervention (PCI), a procedure used to treat narrowing of the coronary arteries in patients with coronary heart disease. The first stent was implanted during a PCI procedure in the mid–1980s.[44] Because of the success of the procedure, the use of stents became more commonplace. After a few years, certain complications began to appear. These complications were attributed to the material used to make the stents. Eventually, in 2001, a new stent was introduced to improve the outcomes of PCI procedures. The new stents are drug eluting, which means that they are coated in and secrete medication that reduces the risk of complications that were associated with the older type of stent. The increased level of safety associated with drug-eluting stents (DES) comes at a price. PCI procedures done with DES cost about $2500 more per procedure than they would have if basic, older version, stents were used.[45] However, the improvement in quality of care, now accepted as a standard of care (the level and type of care expected in the industry that produces higher quality outcomes), is required to perform this procedure in the healthcare organization. **(Figure 3–5)**

As the cost of medical supplies and devices continues to increase, the total expense associated with the supply chain increases as well. Currently, supply chain management is second only to labor in terms of expense for the average health system. If the cost of supply chain management continues to increase at the current rate, it is estimated that costs associated with the supply chain could exceed those associated with labor by 2022.[46] Technological advances are
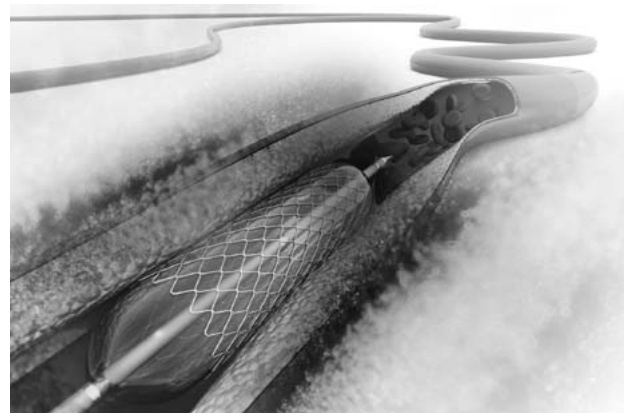
(a)
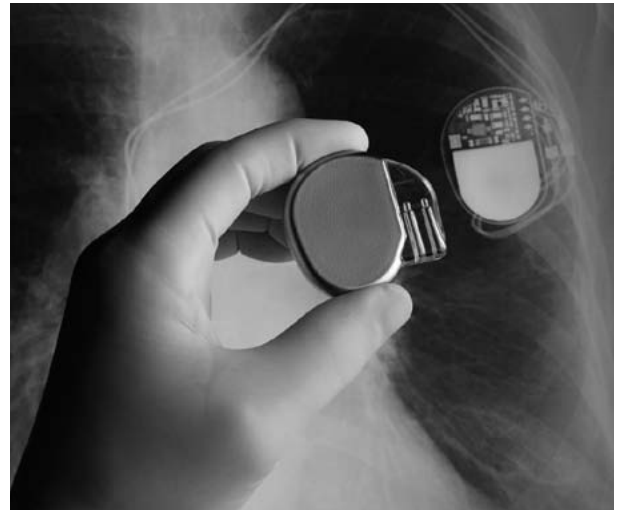
(b)

(c)

FIGURE 3-5 Technologies supported by the supply chain. a) Stent; b) Pacemaker; c) Pharmaceuticals.

enabling organizations to more efficiently and consistently manage supply chain operations, billing practices, and compliance while providing flexibility for different processes within the system of care. "In all industries, not just health care, three out of four chief executive officers consider their supply chains to be essential to gaining a competitive advantage within their markets."[47] According to Vance Moore, CEO of ROi (the supply chain entity within the Sisters of Mercy Health System based in St. Louis, Missouri), in a 2008 presentation in Chicago, the trend in the cost of the healthcare supply chain continues to grow where, if the trend continues, supply chain could equal labor cost for annual operating expenses for hospitals and health systems between the years 2020 and 2025.[48] Clearly, maximizing efficiency of the healthcare supply chain is an increasing concern amid increasing costs but with increasing quality.

Increased cost is partly due to a concept called *total cost economics*. Total cost economics, sometimes called *total cost of ownership*, is the complete cost of an item or procedure, including direct and indirect costs. An example of direct cost is the list price of the item. However, there are usually additional "hidden" costs associated, which are called *indirect costs*. An example of an indirect cost is additional training for physicians or specialized storage needs for new medical devices or supply items.

Healthcare organizations have to remain diligent when it comes to managing their supply chain, especially through times of rapid technological advancement. The consequences of supply chain disruptions in healthcare organizations can prove deadly for patients. Due to the consequences associated with running out of items necessary for patient care, all hospitals seek to maintain a reserve level of essential items in stock. However, there is room to streamline the supply chain in almost all facilities. A streamlined supply chain can create a competitive advantage for an organization through the elimination of unnecessary purchasing and storage of items. A *competitive advantage* is an attribute or process that outperforms competitors in a specific area. An example of a business that maintains a competitive advantage due to its supply chain is WalMart. Can the healthcare supply chain provide competitive advantage for healthcare organizations? Can the healthcare supply chain increase value to the delivery of care? The answer to both questions is "Yes." However, the healthcare industry needs to focus on improving its supply chain.

Healthcare organizations, individually and as an industry, are behind other industries when considering supply chain structure, coordination, management, and value. Other industry leaders understand a simple reality, and this simple reality is important to think about and understand when working to improve the supply chain. That reality is: Funds, information, and products are closely linked together. It is imperative for health care, using a team approach, to make improvements to supply chain operations, management, and information systems that drive their care delivery processes by providing the "technology of care" to providers of care. In the healthcare supply chain, these statements are generally true:

- Supplies are traditionally the second largest expense category for providers.
- Providers are getting supplies today.
- Providers are paying for every part of the supply chain.
- Providers control a very small portion of the cost of products used in their facilities.
- Providers have very little control or impact on the quality of supply service.
- Providers believe that the supply chain is a necessary evil and that it does not play a significant role in the quality of patient care.[49]

An excerpt from a healthcare supply chain book written for senior healthcare executives follows; the situational assessment today reveals similar findings.

Today's healthcare supply chain characteristics:

- *Multiple systems, multiple processes that lack cohesiveness and uniformity*—Many health systems, if not stand-alone facilities, use different materials, management information systems, and processes across facilities and departments.
- *High distributor fees*—Most healthcare organizations spend hundreds of thousands of dollars, if not millions each year on outside parties for supply (medical/surgical and pharmaceutical) distribution.
- *Service quality failures and service frequency did not match need*—Distributors commonly fill between 80% to 90% of the order. This causes a tremendous number of product shortages for clinicians each day. At times, distributors overfill orders causing excessive stock on shelves and higher costs for the overage and cost of storing the items. As for frequency, many healthcare organizations receive supplies based on distributors' schedules not based on clinical needs.
- *Wholesalers lead pharmacy processes*—The medications obtained, primarily from outside distributors/wholesalers, control the systems and processes for medication sourcing, ordering, receiving, and distribution.
- *Inconsistent management processes*—Many healthcare organizations manage the supply chain operation in different ways within the same facility. In some

cases,[49] each department seems to be a unique entity with regard to supply chain operations.

- *Limited usable data*—In many healthcare organizations, identical products are named differently depending on facility and/or department. This reality limits the ability to aggregate data for decision making, volume purchasing, and bulk ordering, thus impacting the bottom line.
- *Many intermediaries*—The majority of distributors service many customers and stock what sells for *them* best, not necessarily what is needed or wanted. This means that most healthcare organizations get supplies, or are sourced, from many different distribution facilities to meet their needs or are directed to use what the distributor stocks in that particular service region.[50]

Opportunities clearly exist in the healthcare supply chain for improvement, higher value, better patient care, and enhanced integration of information for quality decision making. This chapter intends to assist in that industry effort.

PROJECT MANAGEMENT

Traditionally, physicians have been individual thinkers and actors. Successful methods and technologies from other sectors have been slow to be adopted. This is, perhaps, because medical school and graduate medical education has been traditionally focused on the individual.[51] As the focus on quality continues to increase in health care, it is becoming clear that lessons learned in other industries must be adopted by healthcare organizations.[52] Some key lessons that can be learned from project management include the importance of collaboration and sharing vision, proper execution of a plan, the role of technology, and being mindful of costs.[53] These key project management lessons focus around open and honest communication with team members while driving results toward the mission and vision of the organization.

Managing risk is another important aspect of project management, especially in health care. With the proliferation of patient-centered medical homes, accountable care models, episode of care payments, and global payment, healthcare organizations face increasing levels of competition and decreasing levels of payment.[54] For years, the U.S. healthcare system has been working to combat issues of increasing costs and disparities in the quality of care provided. This situation prompted the government to create and pass the ACA in 2010.

One of the changes brought by the ACA was the accountable care organization (ACO). An ACO is a re-envisioned payment and care delivery system that is designed to help address the issues of cost and health disparities in health care. ACOs do this by being a provider-led organization that is responsible for the overall cost and quality of care provided. ACOs are incentivized based on treatment cost savings achieved while meeting quality of care standards.[55]

One side effect of the regulatory pressures brought about by the ACA is healthcare organization consolidation. New payment systems, as well as requirements to use new technologies, have given many small healthcare organizations a choice: join forces with another organization or close the doors. Recent studies have shown that as healthcare organizations consolidate, health insurance companies increase their premiums. This holds true for insurance plans on and off the ACA-created health insurance marketplaces.[56]

When planning and managing projects within the healthcare organization, these external forces and cost drivers must be accounted for if the healthcare organization is to adapt to market conditions and successfully complete its planned projects.

GOAL-SETTING THEORY

Goal-Setting Theory was developed by Edwin Locke in 1968. According to the theory, goals are the aim of an action or behavior. Setting a specific outcome, or goal setting, can be done for any verifiable or measurable outcome. In short, goals are the aim of an action or behavior. Between 1968 and 1980, studies showed that specific, well-defined goals led to a greater improvement in performance than an easy goal or a goal that was vague. This performance is further enhanced through feedback mechanisms and availability of required resources to perform the tasks required.

According to Locke, there are seven steps to optimize goal setting:

1. Specify objectives or tasks to be done.
2. Specify how performance will be measured.
3. Specify the standard to be reached.
4. Specify the time frame involved.
5. Prioritize goals.
6. Rate goals for difficulty and importance.
7. Determine the coordination requirements.[57]

When working through the process, it is important for leaders to ensure that new goals do not conflict with other organization goals. Some other risks associated with using this theory are creating an environment where excessive

risk is acceptable, adding unwanted stress, or eroding employee confidence.

Since the theory was originally published, goal-setting theory has been applied in various industries and management situations, most notably in the logging industry. As a result of the work done since the 1968 publication of the theory, Locke began to explore the relationship between goal-setting theory and expectancy theory in the early 1990s. Expectancy theory says that low goals may be easier to obtain but that they do not provide as much satisfaction as more difficult goals.[58]

COMMUNICATION AND CULTURAL COMPETENCE

Health leaders need to have exceptional communication skills. They must learn techniques for clarifying what some-one else is saying and for being clear in their own communication. Mintzberg's study on managerial work revealed that managers' activity was characterized by "brevity, variety, and fragmentation"; managers were continually seeking information, preferring oral communications to written reports.[59,60] This finding applies to leaders as well. The preference for oral communication may be difficult for health leaders to enact but nonetheless is important. As an example of personal preference for oral communication, it has been noted that within the first 7 months of President Barack Obama's administration, he had more White House press conferences than George W. Bush did in his 8 years as president.[61] Although verbal communication may be time consuming, given the of employees and the public for such communication, it is a very valuable tool that is essential to achieve success and increase understanding across diverse constituent groups.

Simply put, communication is the process of *acting on information*.[62] Communication contributes tremendously to the culture and climate of the healthcare organization. A response—feedback—is an essential aspect of the communication process. Obstacles to communication, called noise, either in the channel or in the mind of the receiver, may contribute to an inaccurate understanding of the intended message. Communication is the main catalyst behind the motivation efforts and strategies utilized by leaders.[63] "Various management [leadership] practices, including goal setting, reinforcement, feedback, and evaluation, require communication."[64] There are three goals of communication:

- Assuring understanding
- Achieving intended results
- Acting ethically and morally

Communication is a process of active transaction (transactive), which means messages are sent and received simultaneously. Everything you do or do not do, say or do not say, communicates something. You cannot not communicate.

As globalization increases, healthcare leaders need to be culturally aware, understand, and lead people from diverse backgrounds, diverse educational portfolios, and diverse outlooks. In today's global economy, it is commonplace for subordinates, peers, and superiors to be from different geographic, national, and cultural backgrounds. Likewise, patients, customers, and their families are more diverse. This trend requires a culturally competent and adaptive perspective for both the health leader and the health organizational culture the leader maintains. It adds complexity to the health leader's landscape from both internal and external environmental perspectives. In turn, this complexity lends credence to demands for a dynamic culture leadership mentality and process to create a robust organizational culture amid an environment of change, the speed of which is increasing.

Globalization causes concern when discussing differing perceptions across cultures:

- Individualist (self-oriented) and collectivist (team-oriented) cultures will have significantly different perceptions of work and performance.
- Power distance (higher power means more physical space): High-power cultures tend to be authoritarian, whereas power is more equally distributed in low-power cultures.
- Uncertainty avoidance (risk taking and plan imple-mentation without all information and organiza-tional coupling) is thick with rules and guidelines.
- Gender equality: Assertive, material, and competi-tive cultures tend to be masculine, whereas collab-orative, harmonious, and nurturing cultures take on a feminine persona.
- High-context communication cultures transfer mean-ing with more emphasis on the situation, whereas low-context communication cultures emphasize the sender's responsibility to transfer meaning more than the situation.[65]

Situational leadership applications fit nicely in the paradigm of a culturally competent leader, considering the complexity of globalization. Leadership expectations differ depending on the culture, society, nation, or ethnic group to which leaders belong (and reside and practice). It is difficult to find much in the literature on leadership outside the Western perspective, for example. The Western perspective in the literature is predominantly based on

research conducted in the United States, the United Kingdom, Australia, or Europe. "To date [as of 2004] more than 90% of the organizational behavior [including leadership] literature reflects U.S.-based research and theory."[66]

INTERPERSONAL RELATIONSHIP ABILITY

The Purpose-Assemble & Charter-Align-Resource—Perform, or PAARP, model (**Figure 3-6**), when followed throughout the lifecycle of a team, can result in improved morale of team members, improved outcomes, and greater value to the organization. Throughout the team lifecycle, identifying purpose and continual communication are keys. Proposed by Stephens, Ledlow, and Schott, the PAARP model postulates that the actions of interprofessional teams occur in five distinct phases that repeat as necessary depending on the type of team.

According to PAARP, the actions of leadership give purpose to a group. There are several theories that can assist the leader in providing this purpose: the great groups approach, goal-setting theory, and the theory of planned behavior. Great groups are a common subject when it comes to planning teams, but so many of the associated principles are quickly glanced over for the sake of expediency. It is important to remember that not only does a leader create a great group; it is the group that makes the leader great. For the group to succeed, the right people need to be in the right jobs. With the right people in place, the great group is focused on results and achieving their goal.[67] Team members must align, resource, and perform tasks as laid out by leadership through the defined purpose and assembly of the group. Once tasks are complete, the standing group is repurposed for its next task or, for single-purpose groups, adjourned.

CHANGE AND ORGANIZATIONAL CULTURE COMPETENCE

There is a growing trend to incorporate organizational culture into leadership theories and models. This is a rather new emphasis but a critically important one. Leaders build culture in everything they do—from role modeling, to assigning responsibilities, to communicating with others—including how they communicate and what they do not do or do not say. Models with an organizational culture emphasis require leaders to determine, develop, and maintain an organizational culture that can best meet the expectations, if not thrive, in the external environment. This perspective envisions a more important and dramatic role for organizational culture as a construct—a leadership role—compared to that assigned under the situational leadership philosophy. *Leaders must now create culture!* The Dynamic Culture Leadership model enables leaders to create the culture of excellence that is required in healthcare organizations.
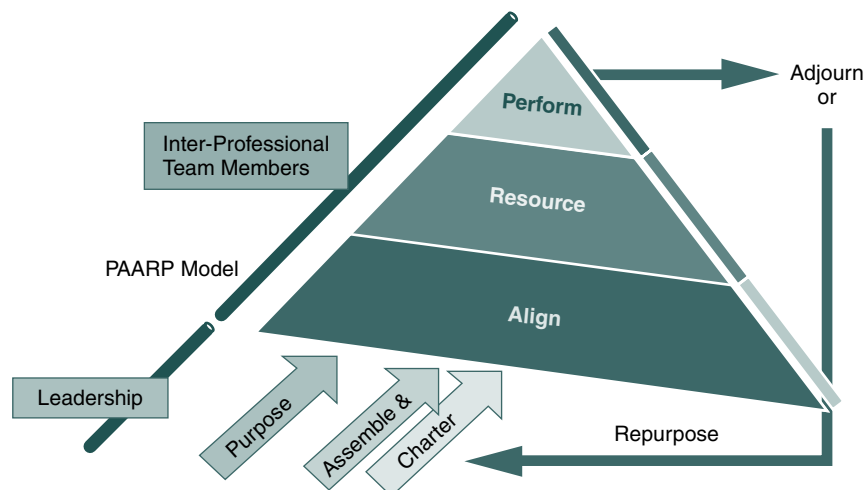

FIGURE 3-6 The PAARP model.

THE DYNAMIC CULTURE LEADERSHIP MODEL[68]

Due to the increasingly dynamic nature of the healthcare environment, superb leadership is required at all levels of the healthcare organization. This reality is the catalyst for the development of the dynamic culture leadership (DCL) model. Leadership in this model is recognized at three levels as the critical ingredient in the recipe for overall success: at the personal level, at the team level, and at the organizational level. The challenge is to focus the knowledge, skills, and abilities of organizational leaders appropriately and to empower the total organization to complete its mission, reach its vision, and compete successfully in an environment that constantly changes.

TEAM BUILDING

Surprisingly, many healthcare organizational leaders are unfamiliar with the process of team building. This may be due to the fact that they moved into organizations with relatively large and stable groups of employees who are comfortable in their positions. It may also be because the leader has become a prominent figure in his or her field of study through excellence in the execution of skills (as might be the case with a surgeon, for example). This level of leader acknowledgment is different for a middle-level health leader and especially for a CEO of a large healthcare organization who maintains responsibility for many elements of the enterprise. Without the experience of leading increasingly larger groups, the leader may not be fully aware of the life cycle and evolution associated with standing, ad hoc, and process action teams.

SUMMARY

There are a multitude of challenges facing the health organization leader today. This chapter served as an introduction for concepts that will be revisited in more detail. Because the healthcare industry is integrating public health and healthcare delivery, along with shared financial and service risk, it is prudent to attend to the aspects of integration between these two vital segments of the industry. This chapter provided a small yet vital foreshadowing of what health leaders need to understand, be aware of, and strategically and operationally plan for in order to successfully lead people and manage resources amid dynamic and turbulent times. Leadership competence is crucial across multiple and complex domains. Understanding the competency domains needed for successful leadership in today's health industry sets the stage for mastery of necessary knowledge, skills, and abilities to lead. Healthcare organizations need competent leaders as much today as at any time in the industry's history.

DISCUSSION QUESTIONS

1. Outline why the dynamic forces in the industry are important to professionals in the health industry, and identify challenges requiring quality leadership intervention strategies.
2. Explain and give an example of one aspect of change in the industry today, and link leadership competencies necessary for successfully navigating the organizational changes required for dealing with the change.
3. Relate, discuss, and explain the importance of the application of a leadership competency model to contemporary health industry change.
4. Distinguish the different aspects or domains of change in the health industry and how those domains impact leadership capability. Explain how the synergy of those changes might impact leadership capability and organizational success.
5. Relate the health reform efforts of the past decade to leadership needs at the health organization level.
6. Evaluate the health industry's need for leadership today and into the next decade.

EXERCISES

1. Outline at least four dynamic forces in the health industry, and explain why they are important to health professionals. For one of the forces, identify challenges requiring quality leadership intervention strategies.
2. Explain and give a specific example of one aspect of change in the industry today. Link leadership competencies from the competency model in this chapter that might be necessary for successfully navigating

the organizational change required to deal with the change.

3. Relate, discuss, and explain the importance of the application of a leadership competency model to contemporary health industry change. Evaluate your own ability in each competency domain from the model.

4. Distinguish the different aspects or domains of change in the health industry and how those

domains impact leadership capability. Explain how the synergy of those changes might impact leadership capability and organizational success.

5. Relate the health reform efforts of the past decade to leadership needs at the health organization level in a one-to two-page narrative essay.

6. Evaluate the health industry's need for leadership today and into the next decade based on issues set forth in this chapter.

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