Exploring the Experiences of First-Time Health Care Leaders in Critical Leadership Roles: A Phenomenological Study

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Abstract

Exploring the Experiences of First-Time Heath Care Leaders in Critical Leadership Roles: A Phenomenological Study

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In health care, there is a shortage of experienced and skilled senior and executive health care leaders. Health care organizations are promoting and hiring individuals who may lack some of the requisite knowledge and senior-level leadership experience. Little is known about the lived experiences of these first-time senior and executive health care leaders during their entry into these roles.

The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who have worked 6 months to 4 years in their first senior-level role in a health care organization. The following research questions guided this phenomenological qualitative study:

1. What is the lived experience of a novice health care leader in a critical leadership role for the first time?
2. How do these participants describe the challenges they faced and the leadership lessons they learned that influenced current actions in their roles?
3. What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?

The sample included nine novice senior health care leaders. Data were collected using an interview, observation field notes, and artifacts. From these methods, four findings emerged: (a) first-time senior level health care leaders experienced daily personal feelings of inadequacy in their new roles; (b) multiple operations and requirements of multiple departments make up one system requiring multilevel leadership accountability; (c) organizational challenges for senior-level leaders in non-profit bureaucratic health care organizations are particularly discouraging and problematic; (d) individuals in middle-management positions who aspire to or are promoted to senior-level leader roles in health care organizations would benefit from mentoring programs and succession planning approaches.

Major conclusions were that hospital boards and chief executive officers (CEOs) need to reduce the anxiety, fear, and uncertainty experienced in the initial novice leaders’ transitions by providing structured orientations with assigned peer partners and assuring an on-going structured leader development program and structured mentoring and coaching programs to provide stability.
This Ed.D. Dissertation Committee from The School of Education at Drexel University certifies that this is the approved version of the following dissertation:

Exploring the Experiences of First-Time Heath Care Leaders in Critical Leadership Roles: A Phenomenological Study

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Dedication

It is with great gratitude that I give thanks to God for giving me the mental and physical endurance to take this academic journey and the courage and determination to complete the journey. “The Lord is my strength and my might” (Exodus 15:2), without his guidance I am lost. I dedicate this dissertation to my wonderful and loving husband, Gerald, who has shown patience and impatience, support and threats, and encouragement in the good times and in the bad throughout the course of this journey. I also dedicate this dissertation to my sisters (Deloris and Ethel), brothers (Don Roy, Ricky, and Maurice), and to the memories of my mother (Katie), my dad (Benjamin), and my grandmother (Anna) who all believed in me as I grew up and inspired me to keep moving forward in spite of life challenges.
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No achievement is done alone. I would like to say how grateful and thankful I am to the following people.

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Chapter 1: Introduction to the Research

**Introduction to the Problem**

Rising costs of health care and a changing health care environment have created a perfect storm placing tremendous demands on the economy, the nation’s leaders, and health care leaders. Health care spending today is 17% of our gross domestic product (GDP) and is predicted to rise to 20% by 2020 (The Henry J. Kaiser Family Foundation, 2012). Health care spending, as described by Leigh and Wheatley (2010), causes “stresses at the macro level…[and] the micro level—for employers and individuals” (p. 193). According to The Henry J. Kaiser Family Foundation (2012), along with spending, many health care changes have occurred. Such changes have been driven by innovation and new technologies; patient demand for quality; and new regulations at the federal, state, and local levels. In the midst of such changes, the industry is experiencing an aging and retiring workforce, creating a shortage of experienced health care workers in all specialties and at all levels of the organization (Meister & Willyerd, 2010). Meister and Willyerd (2010) suggested that by 2020 organizational leaders will be pressed to adapt their workplace policies to further accommodate a multigenerational workforce of five generations and to incorporate gender and ethnic changes.

Is one of the solutions to the health care dilemma well-trained health care leaders? Schyve (2009) pointed out that only leaders of health care organizations have the responsibility, resources, and control to establish and promulgate the mission, vision, and goals; to head strategic planning; and to encourage and promote a high quality and patient safety-oriented culture. Health care leaders stand in the midst of this perfect storm and
may be best positioned to lead during this critical time period if they are capable and experienced. According to recent research, this highly critical position of leadership calls for leading with increasing transparency, communicating effectively with and engaging employees, and partnering with the community to encourage patient participation (Garman & Lemak, 2011; Herman, 2012). With the baby boomer generation aging and retiring within the next 10 years, a leader shortage is inevitable. Because the stakes are high and the challenges many, some seasoned health care leaders may decide to retire early or “look for a new place because it’s time for a change” (Gamble, 2012, p. 1). Often, these personal decisions leave critical senior positions open. Organizations cannot leave these positions vacant because of the high cost involved nor can these organizations afford to make a hiring mistake. According to Besheer and Ricci (2010), “The loss of a CEO can cost a healthcare organization $1.5 million in severance, recruitment expenses, and the new CEO’s salary” (p. 1). Besheer and Ricci further suggested that the loss of the CEO may also cause other senior executive leaders on the team to leave. These organizations are frequently looking inward to fill key leadership positions with first-time (novice) leaders who are inexperienced and must acquire the additional skills and competencies demanded to effectively lead in this tumultuous environment (Besheer & Ricci, 2010).

With the aforementioned information in mind, one can imagine the demands and stresses on newly promoted first-time senior health care leaders. First-time senior level leaders have been placed in powerful and critical positions during uncertain times and in the rapidly changing context of health care. Often these first-time leaders may be experts
in their area of specialization within the organization but not at leading complex health care organizations and systems (Porter-O’Grady & Malloch, 2011).

The aim of this study was to listen to the voices of emerging first-time senior health care leaders and allow them to share their thoughts, experiences, and lessons learned while leading a health care organization for the first time. The remainder of this chapter includes the statement of the problem, purpose and significance of the problem, research questions, conceptual framework (research stance and experiential base), conceptual framework diagram, Streams of Research, and summary.

**Statement of the Problem to Be Researched**

Because health care organizations are experiencing a shortage of experienced and skilled health care leaders, they are promoting and hiring individuals who lack some of the requisite knowledge and senior-level leadership experience into senior leadership positions. Such positions come with responsibilities for leading complex organizations. What is known about the lived experiences of these leaders during their first years in these roles has yet to be documented.

**Purpose and Significance of the Problem**

**Purpose Statement**

The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who worked 6 months to 4 years in their first senior-level health care leader role in a health care organization or system.
Significance of the Problem

The study of their journey provided knowledge and insight into their inner motivations and skills as leaders. The challenges they faced in their initial time in the role as they managed internal and external issues, as well as their expressed leadership-development needs, provided new insight and understanding toward development of future health care leaders. Finally, this study contributes to the current body of knowledge by describing the lived experiences of first-time senior-level health care leaders. Presently, there is a gap in the literature. The findings, conclusions, and recommendations from this study will assist organizational leaders in managing the development of internal emerging leaders more systematically.

Research Questions

This was a phenomenological qualitative study designed to answer the following research questions:

1. What are the lived experiences of novice health care leaders promoted or hired into a critical leadership role for the first time?

2. How do these participants describe the challenges they faced and the leadership lessons they learned that influence their current actions in these roles?

3. What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?

Setting a strong foundation for this study, the researcher reviewed the literature regarding health care system definition and current health care challenges such as workforce regulations and technology impacting senior level leaders and their
organizations. Leader/leadership development and training was also reviewed. Such areas provided a foundation for the current research.

Literature focused on novice senior-level health care leaders (especially CEOs) is limited. Not much is known about those novice leaders who take on jobs presenting challenges even an experienced leader would find difficult. This research explored the challenges of health care leader positions and how these newly promoted leaders develop expertise in guiding and directing the operations of a health care organization or department. Clarifying the personal challenges, concerns, and motivations offered insights to the leadership development and training that may enhance their skill set and support them in the transition. Exploring how these health care leaders fare at cultivating and preparing their workforce for the digital future and how they succeed at identifying and managing their organizations’ changing needs contributed valuable information addressing the gap in the preparation of novice health care leaders.

The Conceptual Framework

Researcher Stance and Experiential Base

In my professional career, I have had the opportunity to work in health care leadership in both military and civilian public hospital settings. My civilian job as a nurse manager for 30 years afforded me learning experiences that allowed me to build trust and rapport while simultaneously gaining knowledge and skills in working with people at all levels of the organization. On the journey to becoming a Military Reserve Commander of a small hospital squadron (lowest element of command in a wing), I valued the leadership development training and various job experiences provided. The
timely and intensive leadership development offered a foundation not received in the community hospital settings.

For last three years, I have worked in a C-suite of a public hospital organization as a change agent and organizational consultant where I had the opportunity to observe the behaviors and interactions of seven first-time health care leaders who held positions as chief officers and directors of various hospital services and departments. Based on my tacit observations, I came to believe researching the experiences and career journeys of recently promoted first-time health care leaders may provide the opportunity to acquire knowledge and insight about their inner motivations, skills as leaders, leadership development needs, and strategies for managing the challenges they face. Recognizing that each person draws from his or her personal experiences as they enter a senior-leadership role, I chose a phenomenological research design to understand the essence of their lived experiences.

Qualitative research can mean different things to different people. For me, it means exploring my assumptions about a particular lived phenomenon (in this case, leading a health care organization in a senior-leadership role for the first time) experienced by a special group of individuals (novice health care leaders) and gaining an in-depth understanding of their physical strength, endurance, beliefs, feelings, and views. My research was influenced by my adoption of a social constructivist viewpoint. Bloomberg and Volpe (2008) suggested the focus of a social constructivist researcher is on the world in which people live and the researcher simply plays the role of a facilitator for many voices. Creswell (2007) suggested the following:
Individuals seek understanding of the world in which they live and work. They develop subjective meaning...these meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrow the meaning into a few categories or ideas. (p. 20)

In the analysis of the interviews and artifacts, I sought to portray the complexity faced by these first-time novice leaders. Drawing from Moustakas’s (1994) representation of a phenomenological design, I collected data from nine individuals who experienced the phenomenon in order to gain information allowing for an analysis leading to understanding the true essences of the experience.

Since beginning my research journey, my thirst and curiosity to know more about the world in which I live and work has grown. My mental models are guided both consciously and unconsciously by my interactions and my perceptions of what I read, hear, see, and experience; these are my realities. By taking an ontological perspective (Creswell, 2007) focusing on the nature of social reality, I sought to embrace the different realities represented by this study’s participants, thus learning and understanding the participants’ experiences of their environments through their own voices.

As a researcher, I was aware I needed to identify and suspend (bracket) my mental models (beliefs and assumptions) to listen and understand the dynamics of the phenomenon as experienced by my research participants. I bracketed my experiences by identifying them and recognizing how they could influence the questions I asked and the analysis I conducted (Moustakas, 1994). While bias cannot be eliminated through bracketing, it can be acknowledged and minimized. Through this research, I gained valuable knowledge that will provide health care leaders—potential and current—with a
first-hand account of the realities of being a first-time senior-level (novice) health care leader.

**Conceptual Framework of Research Themes**

This study was built on a foundation of different streams of academic literature exploring the theory, research, and practice of related topics. The purpose of the literature search was to identify previous related literature that would shed light on novice senior-level health care leaders’ experiences, their interactions with their environments, and other nuances affecting their actions and behavior. While Chapter 2 of this study includes an in-depth discussion on the related literature, the following paragraphs provide a brief overview of the following topics: (a) health care system defined, (b) health care challenges, and (c) health care leader development.
Stream One: Health care system defined. Stream 1 provides a brief overview of the meaning of a health care system and an understanding of the dynamics, complexity, and changes occurring in health care systems. The World Health Organization (WHO; 2007) defined health systems as consisting of people and organizations whose goal is to improve and promote the health of all people through various entities. The aim of this definition is to provide a common understanding that has common direction. In terms of complexity science, Zimmerman, Lindberg, and Plsek (2008) asserted that a health care leader’s understanding of complexity science will aid
them in leading the unpredictable and unstable characteristics of their organization. Zimmerman et al. further asserted that even though complexity science is in its infancy, it touches every discipline (such as biological, physical, psychological, and social sciences) and provides a common language for studying complex organizations. Stream 1 concludes with an explanation of complex adaptive systems and change. Health care organizations are described as complex adaptive systems (Begun, Zimmerman, & Dooley, 2003; Plsek, n.d.) with a link or interacting interconnected elements or agents operating from its own internal set of directions (Plsek & Greenhalgh, 2001). Change is a constant element of complex adaptive systems that requires understanding and management. In health care organizations and systems, change moves with different interacting parts adapting to the shifting realities (Porter-O’Grady & Malloch, 2011).

**Stream Two: Health care challenges.** Due to the uncertainty and turbulence of health care changes, health care leaders face a multitude of challenges. According to Melum (2002), “In the twenty-first century, the challenges facing organizations seem bigger and more complex, the pace of change gets faster and past strategies seem inadequate for the future” (p. 55). Drawing from the literature, there appears to be three major challenges topping the list for health care leaders: (a) workforce changes, (b) new health regulations, and (c) technology development.

The workforce in America is shifting, shrinking, and aging (Meister & Willyerd, 2010). Meister and Willyerd (2010) predicted five generations in the workplace—traditionalists (born prior to 1946), baby boomers (1946-1964), generation Xers (1965-1976), millennials (1977-1997), and generation 2020 (born after 1997)—will require changes in workplace policies. A second challenge to health care leaders is the new
policies and regulations related to health care reform and the Affordable Care Act (ACA). The ACA will add 30 million people to our health care system, creating a need for more workers, especially physicians and nurses (Congressional Budget Office, 2012). Regulations such as the Health Information Technology for Economic and Clinical Health Act (HITECH), Health Data Initiative, and ACA will ensure major changes in the delivery of health care, administrative operations, and even the practice boundaries of various health care professionals (Kocher, 2012).

Technology is said to be one of the major driving forces of change in the health care industry as well as one of the reasons for the rise in health care costs (Goyen & Debatin, 2009; Herndon, Hwang, & Bozic, 2007). Health care leaders play a vital role in financial decision making, equipment selection, procurement, training, implementation, and management of technology in their organizations (Hikmet, Banerjee, & Burns, 2012). Today’s health care leaders need an in-depth understanding and awareness of their organization’s technological needs as well as the wants and needs of their patient community relating to the demand for quality care.

**Stream Three: Health care leader competencies and development.** Stream 3 addresses health care leaders’ competencies and examines various competency and development models. There is a belief that the current chaotic health care environment may be creating increased turnover of health care leaders, especially chief executive officers (CEOs). The American College of Healthcare Executives (2012) reported a 16% turnover rate for CEOs in this country, predicting CEO turnover rates will continue to increase over the next 20 years due to baby boomers retiring out of the system.
Oliver (2006) noted that organizations today require different kinds of leaders than those of the past, suggesting the top-down approach or dictatorial management style is no longer effective. Porter-O’Grady and Malloch (2011) posited that today’s leaders must have the ability, skills, and behavior to effectively predict, adapt to change, and guide their organization to successful outcomes. They further suggested that health care leaders must not only have financial skills and intellectual abilities but emotional competence as well. Other scholars in health care leadership also subscribe to the importance of emotional intelligence (Dye, 2010; Dye & Garman, 2006; Goleman, 1995; Porter-O’Grady & Malloch, 2011; Staver, 2012). Goleman (1998) asserted that the skill of managing one’s feelings is a valuable component of effective leadership. Such skills enable health care leaders to identify and assess issues and create a roadmap to tackle the matters at hand. Further, Dye and Garman (2006) described 16 competencies associated with exceptional health care leaders, breaking them into four cornerstones and further discussing how each set is applicable to leaders in the C-suite. The literature review in Chapter 2 provides a more in-depth explanation of these competencies.

Chapter 2 also introduces a review of leadership-developmental models. A review of relevant research suggests the process of health care leadership development is limited and underfunded in most health care organizations (National Center for Healthcare Leadership [NCHL], 2010b). Dye (2010) explained, “Many senior executives express an interest in professional growth and development, [however] they devote little time and funds to this pursuit” (p. xi). Dye (2010) further suggested that leader development should offer leaders a process providing the educational balance of theory and hands-on experience needed to round out and advance their leadership knowledge.
According to the NCHL (2010b), “Well-constructed leadership development programs work well” (p. 2).

Stream 3 ends with Dreyfus and Dreyfus’ (1986) five stage model—novice to expert. Their development model outlines an individual’s progress to competency through the following stages: novice, advance beginner, competent, proficient, and expert. Dreyfus and Dreyfus are credited with creating a development model successfully applied in different fields such as dentistry, medicine, nursing, and in everyday life.

The overview of the three literature streams provided insight into and a mental picture of the constantly changing and intense work world of first-time (novice) senior-level health care leaders. Streams 1 and 2 established background and set the foundation for understanding the meaning of a health care system and identified key challenges that are the catalyst for workplace issues tending to evolve and change, requiring constant oversight and organizational adaptation. Stream 3 offered competency and developmental models that can be utilized to assess and guide novice leaders in their development process.

**Definition of Terms**

**Baby boomer**

A generation of individuals who were born between 1946 and 1964 (Meister & Willyerd, 2010)

**C-suite**

Executive officers, including the CEO, collectively described as the *C-suite* (Schyve, 2009). It also describes the office location of all the executive officers.
Chief executive officer (CEO)

A health care administrator responsible for the overall activities and administrative operations of the organization

Chief medical officer (CMO)

Executive officer responsible for physician practices and operations

Chief nursing officer (CNO)

Executive officer responsible for nursing operations

Chief operations officer (COO)

Executive responsible for hospital operations

Chief quality officer (CQO)

Executive officer responsible for quality improvement

Competencies

Stated expectations crucial to the employee’s and organization’s performance

Director-level leaders

Hospital department specialty directors/managers; clinic, health center, and ambulatory care directors; and small facility directors

First-time senior-level leaders

Novice health care leaders promoted or hired into senior leadership positions without past health care executive experience and formal leadership development

Health care organization

Any organization providing care and treatment to an individual or community
**Health care (or healthcare)**

The prevention, treatment, and management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health professions (Health care, 2014)

**Health care system**

A set of relationships in which the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends) (Hsiao, 2003)

**Leader development**

The focus is on the individual leader and the goal is to improve leader performance and effectiveness, keep the leader engaged, and enhance the leader’s promotion readiness (Garman & Dye, 2009).

**Leadership development**

The focus is on leaders collectively and the goal is to improve the effectiveness of the organization, engage and develop leaders, and enhance the future leader pipeline (Garman & Dye, 2009).

**Senior executive-level leaders**

The top organizational leadership who collectively guide and direct health care delivery in health care organizations

**System**

A combination of processes, people, and resources forming an integrated whole interacting to perform functions that achieve an end (Schyve, 2009; Skyttnner, 1996)
Assumptions and Limitations

Assumptions

My assumptions for this study were based on observations and interactions with seven first-time senior-level leaders with whom I worked in the C-Suite of a health care organization. Such leaders appeared to struggle with the in-depth skills and knowledge needed to make the requisite high-level management decisions. At times, their actions seemed to produce chaos and confusion for those reporting to them. The first assumption was that if prior to accepting their positions, these novice leaders were provided with leader development including formal (classroom) and hands-on training, coaching, and mentoring their struggles to make the appropriate decisions might be less of a problem. Such assumptions were validated by Groves (2006, 2007), who suggested leadership-development methods including “360 degree feedback, executive coaching, mentoring, networks, job assignments and action learning” (p. 5) provide broader and more effective learning.

My second assumption was that with time, practice, and when provided with a variety of experiences, novice leaders would move from novice to expert. Such an assumption was validated by Benner (1984) and Dreyfus and Dreyfus (1986), who described the behaviors of a novice leader as one who does not have a range of real-life experiences enabling informed decision making and has little or no understanding of the complexity of the situation. According to the Dreyfus model (as cited in Eraut, 1994), an expert is one who has deep tacit knowledge and skills that evolved over time from a variety of real-life experiences.
My third assumption was there are financial and staff benefits for an organization to assess the needs of their current in-house junior staff and begin a leadership program. A logical projection based on these three assumptions implies that without the development and implementation of structured training programs for future health care executives, many health care organizations will find themselves in survival mode, under pressure to find qualified health care leaders. Due to the significant challenges in the delivery of health care services and the retiring baby boomers, health care positions will become available in critically important leadership levels of the organization. Organizations will struggle without a plan and a pipeline. Finally, the fourth assumption was that the study’s participants would be forthcoming and open about their motivations, fears, and the lessons learned during their journey.

Limitations

This research pulled information from the shared lived experiences of the study’s participants who were first-time senior-level leaders. The leaders had varying degrees of leadership background in various health care specialties and worked in health care organizations of different sizes. The study participants included nine leaders. Because the sample size was small, it precludes generalizations but may offer useful insights.

Summary

The traditional operational processes and structures of health care organizations are becoming antiquated and will not meet the future needs of these organizations moving forward. Is it safe to say the health care industry as it has been known in the past is slowly fading? There are tremendous changes in all aspects of health care driven by forces such as technology, cost, mergers, new health care laws, retiring and changing
workforce, and inexperienced health care leaders. Such changes will radically impact health care organizations. This study focused on the first-time (novice) senior-level health care leaders’ lived experiences during their transitions to their new senior-leader roles; their feelings, fears, and lessons learned; and their motivation for taking on critically complex positions in health care organizations and systems. The literature reveals minimal documentation on the lived experiences of novice health care leaders but does offer solutions such as succession planning, leadership-development programs, and mentoring and coaching for health care organizations interested in having individuals available and prepared for future health care senior-level leadership roles. Even though generalizations cannot be drawn from this study, knowledge was gained from documenting the experiences of these individuals as they transitioned to the role of senior leaders. Light was shed on possible changes needed to prepare future health care leaders. In addition, this information is also valuable for an individual’s personal development as well as the development of training programs for health care organizations. The results of these first-time senior-level leaders’ experiences, captured through in-depth interviews, verified and added new insight to the current body of knowledge.
Chapter 2: Review of the Literature

Introduction

The U. S. health care industry is in a state of flux (change), creating an environment of instability and uncertainty. Health care leaders are squarely in the midst of this environmental change. The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who have worked 6 months to 4 years in health care leader roles in a health care organization. To provide an overview of the health care environment, this literature review discusses various challenges—internal, external, and personal— influencing the experiences and actions of this group of leaders. The following review is divided into three streams: (a) health care systems defined, (b) health care challenges, and (c) health care leader competencies and development.

Literature Review

Stream One: Health Care System Defined

To understand the experiences of first-time senior-level leaders in health care organizations, one must understand the internal and external factors influencing their work environments. Stream 1 reviews theory, research, and practice related to a broad definition of health care organizations or systems, complex systems, complex adaptive systems, and change.

What is a system? Many definitions are found in the health care literature. For this study, Skyttner’s (1996) definition of a system was utilized: “A system is a set of interacting units or elements that form an integrated whole intended to perform some
function” (p. 35). In addition, the literature offers many definitions and conceptual frameworks of health systems (also known as health care systems). Hsiao (2003), recognizing there was no clear-cut definition for the term health care system, examined research (over a decade) on health care systems from various researchers. Hsiao concluded that a health care system “is a set of relationships in which the structural components (means) and their interactions are associated and connected to the goals the system desires to achieve (ends)” (p. 4). Hsiao further described five means (he used the term control knobs)—(a) financing, (b) the macro-organization provision, (c) payment incentive, (d) regulations, and (e) persuasion of the public (both private and governmental)—used to achieve three common goals: (a) health status, (b) financial risk protection, and (c) consumer satisfaction. The WHO (2007) initially defined a health system as “the sum total of all organizations, institutions, and resources whose primary purpose is to improve health” (p. 2); building on Hsiao’s definition of a health system, the WHO expanded their definition to a newer version stating, “A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health” (p. 2). To achieve their goals of improved health (levels and equity) and responsiveness, social and financial risk protection, and efficiency, the WHO added a health-system framework consisting of six building blocks: (a) good services delivered, (b) health workforce, (c) information systems, (d) medical product vaccines and technologies, (e) health financing, and (f) leadership that has “important linkages between them” (p. 48). Hsiao’s and WHO’s concepts and frameworks are similar in content. Their aim was to provide common understanding of a health care system and a
roadmap with common directional standards and strategies that might help organizations navigate similar system challenges.

Porter-O’Grady and Malloch (2011) proposed that there are some differences between an *institution* and a *system*: “In institutions, most of the work is compartmentalized and organized vertically, which, together with the focus on process, creates a clear separation between various loci of the work” (p. 47). A system involves seeing the whole: the activities of each unit and how they work together, the “multifocal interest/goal, strong alignment of stakeholders, [being] focused on relatedness, outcome driven, centered on thriving, and horizontal/vertical linkage” (Porter-O’Grady & Malloch, 2011, p. 48). As proposed by Porter-O’Grady and Malloch, a system (such as in the health care industry) is not mechanical but is more biological, allowing for fluidity and flexibility between boundaries or integration between services. The work of a system (the services within the system) is for the purpose of advancing the health of the local community, and the role of the leader is to ensure the system and the needs of the community are congruent.

**Complex system.** Dye (2010) explained that health care organizations have been described as health care systems only within the last 40 years. Dye further noted that health care organizations were once just structures including freestanding hospitals, private doctors’ offices, nursing homes, mental asylums, and local pharmacies. Mergers were rare and most physicians were not employed by health care organizations, unlike today, but in their own private offices. Today, health care organizations have combined and grown into large, complex systems resembling businesses, creating complex and unpredictable environments.
As articulated in the literature, various authors and researchers described the health care industry as complex (Dye, 2010; Ginter, Swayne, & Duncan, 2002; Plsek & Greenhalgh, 2001) and different from other industries (Dye & Garman, 2006; Langabeer & Yao, 2012; Rona, 2005). *Complex* denotes diversity, which implies many disparate connecting elements (Zimmerman et al., 1998) and *different from other industries* suggests the human factor is the end product. The words *complex* and *complexity* are commonly utilized in health care literature to explain the unpredictable nature of behaviors and interactions occurring in the health care systems. The study of complexity is a fairly new approach to understanding health care organizations and systems. Although the study of complexity was not the focus of this stream or study, it did help clarify and lay the foundation for understanding the operating environment of health care organizations and systems.

Kannampallil, Schauer, Cohen, and Patel (2011) defined complexity in health care as “the interrelatedness of components of a system…[the] influence of system components on each other…complexity is relative; it increases with number of components in a system, number of relations between them, and uniqueness of those relations” (p. 944). Kannampallil et al. asserted that an approach providing degrees of complexity makes more sense in a health care setting. Their approach included four degrees defining the range of system complexity that may manifest in a system: (a) few components, low interrelatedness (near-linear behavior); (b) many components, low interrelatedness (described, predicted, and managed); (c) few components, high interrelatedness (relatively complex and more difficult to predict or manage); and (d) many components, high interrelatedness (challenging to describe, predict, or manage).
Kannampallil et al. concluded that these components offer a structured approach for health care workers to study various relationships in their system to manage them appropriately.

Zimmerman et al. (1998) further explained that because the health care industry (made up of human behaviors) does not seem to comply with either a traditional cause-and-effect concept, a reductionistic paradigm or the linear concept (input is proportional to output), health care leaders and researchers have to sort out other approaches, sciences, or theories allowing them to study and understand the dynamics and interactions of the system in which they work. Complexity science seems to best articulate the health care environment; it identifies and addresses the daily behaviors and interactions taking place within the health care environment. Zimmerman et al. proposed that complexity science provides a conceptual framework helping researchers and leaders examine and understand the key dimensions and realities of organizational life. It combines theories and concepts from disciplines such as biology, physics, and sociology that allow for exploration of adaptive living systems. Zimmerman et al. further stated that complexity science “is the study of complex adaptive systems—the patterns of relationships within them, how they are sustained, how they self-organize and how outcomes emerge” (p. 5).

**Complex adaptive system (CAS).** McDaniel, Lanham, and Anderson (2009) suggested in their study that health care organizations are complex adaptive systems (CAS). McDaniel et al. reviewed four studies (Beinhocker, 2006; Cillier, 1998; Maguire, Mckelvay, Mirabeau, & Oztas, 2006; Waldrop, 1992) that captured five major characteristics defining a CAS: (a) diverse agents who learn (physicians, nurses, patients, and other stakeholders); (b) nonlinear interdependencies (relationships among all
stakeholders); (c) self-organization (pattern development produced by agent interactions); (d) emergence (various unexplainable properties found at different levels of the organization); and (e) coevolution (response to environment alters the organization and environment). McDaniel et al. recommended that to study the dynamics of a health care organization, the researcher should treat research design as a verb (an active state throughout the study) versus the traditional noun (which is an end product of guidelines) and learn from small samples. Because health care organizations are in a constant state of unpredictable change, a researcher must be open to and understanding of the organizational dynamics. McDaniel et al. warned researchers to be cautious of studies comparing health care organizations to machines and suggested that when studying health care organizations, researchers should use guiding process strategies: anticipate changes, build tension, capitalize on serendipity, and finally act-then-look.

The CAS approach has been employed in various studies of health care settings. In one recent research study, Tsasis, Evans, and Owen (2012) utilized the CAS approach to examine health care professionals’ perceived views and experiences about moving toward an integrated care system and identified factors that might impact integrated care partnerships. Their study revealed that integrated care is difficult to attain when challenged by poor alignment or siloed behaviors between the organization and the semi-autonomous professional workers. Tsasis et al. concluded that to have coordinated patient care there must be an environment allowing for relationship building and information sharing.

**Change.** Previous research described health care as a complex system adapting to both planned and unplanned internal and external environmental forces by constantly
changing in order to thrive (Porter-O’Grady & Malloch, 2011). Constant change is one of the critical driving forces in the complexity of health care. There is a critical need for health care leaders to invest in learning about and understanding the dynamics of change. Porter-O’Grady and Malloch (2011) suggested that understanding the dynamics of change means recognizing the need for change; confronting and resolving resistance; finding the most appropriate change-process model or approach for the organization and issue at hand; and understanding the importance of strategies, implementation processes, and sustainment of change.

Changes in health care have been studied in various aspects of the health care system—the organization, specialties services, and departments as well as the mechanisms for delivering health care. Understanding the research in the area of organizational change may broaden a health care leader’s view and expand his or her understanding of how people influence the dynamics and difficulties involved in creating change. Implementing change in organizations and systems can be particularly difficult, as noted by Chreim, Williams, and Coller (2012). Chreim et al.’s case study examined the processes of radical change (during a 4-year period) that occurred when moving an embedded physician system to a new integrated system that would eliminate duplication of care and enable a more cohesive continuum of care for all patients.

In Chreim et al.’s (2012) case study, the participants were an active and strong physician-stakeholder group who maintained control and directed change with no resistance from other professional groups. The case findings identified leadership as being extremely important in the change process; the case study called for agreement among the stakeholders, the gaining of new knowledge by all, and the elimination of
boundaries. Chreim et al. concluded that research done over a period of time can produce tremendous insight and, in this case, successful change.

In a similar study of organizational change in health care, Caldwell, Chatman, O’Reilly, Ormiston, and Lapiz (2008) explored how team dynamics, leadership, and change readiness influence the outcome of implementing new strategic change. The study involved a large medical group of 4,000 physicians who practiced in 20 large medical centers. One of the reasons for the change was the acknowledgment of patients expressing dissatisfaction with the organization’s impersonal and bureaucratic interactions. The goal of the change was to increase patient satisfaction by establishing new customer initiatives: increased staffing, new scheduling systems, call centers, and changing the patient-physician relationship. Caldwell et al. found that when a group has a positive orientation toward change, leadership has the greatest impact on the success of that change.

The workforce studies continue to grow as workers age and leave their profession to become the 75 million retirees who will utilize the system and place high demands for quality and services on those remaining workers. Clinical studies continue to occur and the inclusion of patients as partners in studies is increasing (Barello, Graffigna, & Vegni, 2012; Crawford et al., 2002). There has been an acute awakening and awareness of health care researchers that patients have much to say and contribute to clinical and administrative studies, especially regarding safety and care delivery. In addition, health care leaders are utilizing various methodologies, processes, designs, and interventions (Grol, Baker, & Moss, 2002) to help study and promote change in health care. Importantly, new senior-level leaders need to personally study the dynamics of change
and its potential through whatever means possible. Research studies are an important mechanism for informing first-time health care leaders.

Stream 1 provided a foundation for understanding the working environment of first-time senior-level health care leaders by discussing the key elements of a health care system and emphasizing definitions of health care systems, complexity theory, and change. The expectation was that the interview questions regarding the participants’ lived experiences, as indicated in Research Question 1, would produce evidence of the complexity of the day-to-day activities occurring in a health care organization or system in addition to offering descriptions of change. The following research stream, Stream 2, examines health care challenges impacting health care leaders in their efforts to lead and guide their organizations. Stream 2 focuses on three selected challenges to provide specific examples of the complex and difficult activities occurring in health care organizations at the executive level.

**Stream Two: Health Care Challenges**

Health care literature describes many challenges for leaders in health care organizations and systems as well as multiple reasons and causes for these challenges. Many of these challenges tend to be financial, clinical, and administrative in nature. For the purpose of this study, this literature stream addresses three selected health care challenges: (a) workforce, (b) technology, and (c) regulatory issues. The challenges were selected because they are powerful dictators of organizational direction. Understanding the positive and negative impact of these challenges further provides an understanding of the world in which first-time senior-level health care leaders reside.
Workforce. One of the most critical elements of any organization is the workers. In general, both the workforce and the workplace are changing in this country and around the world. Researchers Karoly and Panis (2004) and Derkensen and Whelan (2009) noted that in the next 10 to 15 years, the U.S. workforce will be shaped by demographic trends, technological advances, and economic globalization. In addition, Karoly and Panis concluded that a large composition of the shifting workforce would be the aging baby-boomer generation. The researchers argued that, at present, keeping the older generation of workers in place brings strength, experience, and tacit knowledge to the workforce and concluded that the U.S. education and training systems must evolve to better meet the needs of the 21st-century workforce.

Focusing on the future general workforce and workplace, Meister and Willyerd (2010) were interested in how to prepare for the 2020 workplace. They surveyed 2,200 working professionals from around the world to understand what was needed from employers now and in the future. Meister and Willyerd also surveyed 300 employers on their current and future practices in the workplace. In addition, Meister and Willyerd further studied workers of four generations and the aging workforce. The results of the surveys and interviews produced 10 potential driving forces that may influence the workplace in 2020. Meister and Willyerd (2010) listed the following driving forces:

1. Shifting workforce demographics—changes in the U.S. workforce involving generations, gender, and ethnicity changes;
2. the knowledge economy—jobs requiring complex interdisciplinary skills;
3. globalization—working in virtual teams producing instant knowledge sharing;
4. the digital workplace;
5. the ubiquity of mobile technology;
6. culture of connectivity—blurred lines between work and fun [“weisure time” (p. 28) as coined by the authors];
7. the participation society;
Meister and Willyerd (2010) predicted that the “workforce of 2020 will place new demands on employers as they manage a workforce with greater diversity in age, gender, and ethnicity” (p. 20). They further speculated that the two disciplines of leadership and management would eventually merge to develop the leaders of the future. Meister and Willyerd introduced the 2020 leader model, which includes five required leadership behaviors: (a) collaborative mind-set, (b) development of people, (c) digitally confident, (d) global citizen, and (e) anticipates and builds for the future. Meister and Willyerd further suggested that to build a workforce for the future, the leaders must see the “development of people as one of their most important goals including providing honest feedback, career guidance, and learning opportunities” (p. 188).

Meister and Willyerd (2010) also offered a workforce-engagement model composed of a set of principles and practice areas that can guide any organization to engage employees and keep them interested in the organization. The principles included collaboration, authenticity, personalization, innovation, and social connection. The practice areas included social recruiting, uber-connection, social learning, and accelerated leadership. Finally, according to these researchers, the key to a successful organization is the understanding and engagement of the various generations in the workplace.

Derkensen and Whelan (2009) asserted that in a complex workforce like health care, various professions in the workforce directly influence cost and quality of health care. Derkensen and Whelan found that by 2020 there will be a shortage of over 200,000
Physicians and one million nurses. Additionally, according to Derkensen and Whelan, the shortage is expected to worsen as 78 million baby boomers retire and require more health care, thus creating a workforce shortage of health care professionals. The vast majority of the retiring health care workforce will be those in the nursing profession. Finally, Derkensen and Whelan concluded that a balanced health delivery ecosystem can be created if more funding is provided for health care training programs.

Matthews, Collins, Collins, and McKinnies (2013) added to this discussion by reminding readers there is a looming shortage of chief executive officers, again due to baby-boomer retirements and few younger workers interested in replacing them. Matthews et al. suggested there should be a focus of research studies on health care leaders. Two studies were conducted in 2007 and 2012 on various levels of administrative health care positions to ascertain educational and demographic information to determine trends in the preparation of health care leaders. In the results of the 2007 study, one indicator predicted “a quarter of chief executives plan on retiring within the next five years, nearly 90% will retire by 2030” (Matthews et al., 2013, p. 73). The study was repeated in 2012, and findings indicated a slight decline in those who planned to retire in 0-5 years: 33.3% down to 29.2%. Matthews et al. concluded that this evidence of a potential shortage of health care leaders should not be taken lightly by health care organizations but should be utilized to prepare for the future by assessing current talent needs and developing appropriate plans.

In addition to a shortage of professional health care workers, first-time senior-level health care leaders are tasked with managing and leading an increasingly complex multigenerational workforce. A significant amount of literature indicated that our society
is aging, which means our workforce is aging. Research further suggests that our workforce is shifting and changing demographically; the workforce is becoming more diverse with women and people of color (Charles, 2003; Pitts & Wise, 2010; Thun, Grobler & Miczka, 2007) and at least four generations currently in the workforce (Keepnews, Brewer, Kovner, & Shin, 2010; Meister & Willyerd, 2010). Increasing diversity is leading to tremendous challenges for leaders, especially first-time senior leaders. Understanding and managing an aging, racially diverse, and multigenerational workforce requires cultural awareness, sensitivity, people, effective and political communication skills, and a clear understanding of generational characteristics.

As we look into the future, Meister and Willyerd (2010) suggested there will be five generations in the workforce: Veterans (Traditionalists), Baby Boomers, Generation X, Millennials, and Generation 2020. Keepnews et al.’s (2010) study of newly licensed (6-18 months) nurses (2,369 surveyed) from three different generations—Baby Boomers, Generation X, and Millennials—in the workplace determined 11 differences in the generations in various areas such as job satisfaction, organization commitment, work motivation, supervisor and mentor support, and promotional opportunities. Meister and Willyerd concluded that health care leaders at all levels of the organization should anticipate and recognize these differences and provide support.

Continuous education and training of all health care workers—professional and non-professional—in health care organization such as hospitals is another challenge for the first-time senior-level health care leader who must ensure their workforce is skilled and competent. The challenges health care leaders face include knowledge management (Guptill, 2005; Riege, 2005), training for and implementation of new technology, general
organizational health care leader required training and education, and capturing knowledge from those retiring or moving to other organizations. Studies suggest that aging workers have tacit knowledge and intellectual capital highly valuable to an organization (Matthews et al., 2013). Matthews et al. (2013) suggested that health care organizations have become more conscious of the loss of this knowledge and the impact on the organization’s knowledge base. To avoid knowledge gaps in staff skills and maintain patient safety, health care leaders are challenged with finding ways to capture knowledge and experience.

Regulations and accreditation. The challenges of laws and regulations in health care organizations are many. Health care organizations and leaders are held accountable for compliance with these regulations, which often requires leaders with navigational skills. Regulations in health care provide standards and guidelines for operations in various specialties of care, organizations, and professional licensures. In addition, non-compliance with these regulations could mean loss of licensure, revenue, and funds.

Field (2007) referred to regulations in health care as a regulation maze and described health care regulations as fragmented and bewilderingly complex. Field further asserted that health care organizations are regulated by local, state, federal, and private agencies such as the Centers for Medicare and Medicaid Services (CMS) (federal) and The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (private). Such agencies generate hundreds of standards and requirements that often conflict and compete with each another. In addition, the Institute of Medicine (IOM; 2001), an advisory group that advises the federal government and acts on behalf of the National Academy of Science, described health care regulations as a dense patchwork. The IOM
further suggested that this dense forest of laws, regulations, and accreditation processes are a patchwork of systems at the state level that is frequently duplicative, inconsistent, and contradictory. IOM explained that the regulating processes are unable to keep up with the pace of change, leaving health care leaders and organizations caught in the middle of this regulation war and struggling for survival.

For background purposes, The Joint Commission on Accreditation of Healthcare Organizations (JCAHO; 2013) is a private organization composed of multiple accreditation programs such as long-term care, hospitals, clinics, lab services, etc. The commission’s responsibilities are to set and administer quality standards to ensure continuous improvement in quality and safety of the public through the evaluation of services of health care organizations (JCAHO, 2013). The CMS is a federal agency that links with state agencies to administer regulation oversight for Medicare programs (SearchHealthIT, 2010) such as the Health Insurance Portability and Accountability Act (HIPAA).

Recently, Kumar, Henseler, and Haukaas (2009) utilized a qualitative approach to study the effects of HIPAA on U.S. health care. Kumar et al. explained HIPAA was signed into federal law in 1996 with the goals of (a) regulating how confidential health care information can be used and disclosed; (b) allowing more patient access to their own records; (c) limiting the use of information; (d) ensuring storage and transactions are secure; and (e) establishing the legal context for compliance. Study findings, based on research reports and interviews of health care providers, indicated HIPAA implementations caused (a) changes in organizations’ infrastructures, (b) fear of penalties if non-compliant, (c) an increase in paperwork, (d) increased caution when releasing
information due to uncertainty about privacy responsibilities, and (e) restrictions on those who conduct medical research. Finally, the HIPAA enactment had very little effect on patients, partly because patients were not familiar with the content of the regulation. Kumar et al. concluded that the HIPAA regulation language was confusing, and the confusion impeded information flow and diverted resources to ensure compliance with guidelines.

In another study regarding accreditation standards and reducing medical errors in health care organizations, Hosford (2008) examined whether (over a period of 5 years) the implementation of the new JCAHO patient-safety accreditation standards had a positive impact on error reduction through the chosen medical error management model. Hosford received survey responses from 145 hospital administrators at JCAHO accredited and non-JCAHO-accredited hospitals in 48 states. Results indicated JCAHO-accredited hospitals were much more successful at implementing an effective medical-error management program than non-JCAHO-accredited hospitals and that public awareness of patient safety at all hospitals increased. However, the study also found that with all the progression of hospitals in medical-error management there seems to be inconclusive evidence that the JCAHO initiative is reducing errors.

The issues in the Kumar et al. (2009) and Hosford (2008) studies point out the current challenges occurring in everyday operations in health care organizations. HIPAA regulations involving privacy and security of health care information currently impact every aspect of health care. However, as information technology advances, health care organizations may encounter more challenges in complying with the requirements of the regulations. Technology could cause a need for changes in the content of various
regulations. Patient safety (a JCAHO standard) is paramount in health care organizations. Therefore, reducing medical errors is a perpetual goal. To achieve sustainable superior health care delivery, health care leaders must continue to search for best practices.

Technology. Since there are many aspects of technology, it is important to have an understanding of the meaning of technology in health care. The World Health Organization (WHO; 2014) described health care technology as a means to capture and organize knowledge to solve problems of health. The WHO further explained there are broad categories of technologies such as pharmaceuticals, medical devices, procedures or surgical techniques, management, and communication systems. Mandy and Dopoulos (2012) described health care technology as including software, imaging equipment (such as digital mammography), pharmacy equipment and point-of-care solutions, and informational technology infrastructure. Health care information technology is defined as a support for decision making and the management and delivery of care (WHO, 2014). Technology is a means to collect, store, and transfer information electronically (Medicare Payment Advisory Commission, 2004).

The cost of health care remains a challenge for the American people, especially for senior-level health care leaders in charge of organizations. New medical technology is acknowledged as one of the driving forces of health care growth and spending (Congressional Budget Office, 2008). Technology accounts for at least half of annual and long-term spending growth (Goyen & Debatin, 2009; Keenan & Kennedy, 2004), making technology a critical operational factor for health care leaders.
First-time senior-level health care leaders need to understand the long-term impact of technology on their organization as well as why it is important to explore the various options before making a technology selection. Thielst (2007) asserted that for health care leaders to be successful with planning and implementing technology, leaders need to have a deep understanding of the technology’s capabilities and limitations. Thielst provided suggestions for leaders to consider when planning for implementations of health care technology. Thielst recommended leaders (a) note that technology is rapidly and constantly changing; (b) know the organization’s stakeholders’ needs and benefits; (c) review information regarding new technology with their implementation committee, executive team, and technology experts; (d) understand the organizational impact of related public (federal and state regulations of specific technology) and organizational policies including mission and vision statements; (e) direct the process and utilize process-improvement techniques; and (f) include appropriate staff in planning from the beginning, keeping all staff updated on processes and changes while educating users. Thacker (2011) added one more important suggestion: create a future state living technology vision document to serve as a roadmap and revisit the document every three to five years to update. Updating the document would allow the leader to have conversations with all stakeholders, allow assessment of the current state of operation, and allow for modification to the future state if necessary.

With any implementation process for new technology or continuous educational training in organizations, there is a need for educators or trainers to direct and guide learning, especially in health care. Health care leaders ought to be conscious of the importance of trainers and educators in their strategy plans for the future. Due to the
looming nurse shortage, there is a demand for educators and continuous education (Ray & Berger, 2010). Health care research addresses shortages of educators in nursing schools (National Advisory Council on Nurse Education and Practice, 2010) but not in health care organizations. A number of organizations seem to be moving to online education. Electronic courses are best suited for content on theory, memorization, and sequencing processes but not necessarily for hands-on skills requiring face-to-face interaction with an instructor, such as demonstration of basic life-support technique. Pullen’s (2006) study of 300 health care professionals using web-based learning suggested online learning containing a clinical tool was effective in increasing and improving continuing professional education knowledge and self-reported practice performance. Pullen (2006) concluded that online learning offered convenience and flexibility by allowing one to learn relevant practice topics at one’s own pace, on one’s own time, and in an any-where learning setting.

Stream 2 introduced three challenges currently experienced by first-time senior-level health care leaders. The challenges—workforce, laws/regulations, and technology—influence the operations of the work environment of leaders in health care organization on a daily basis. To gain an understanding of their workplace environments, participants were asked to share experiences of their most difficult organizational challenges. Probing questions provided further discussions on workforce, technology, and regulatory compliance issues if not mentioned in the initial response.

To understand the backgrounds of participants in this study, it was important to first have a basic understanding of the necessary career credentials of most senior-level health care leaders. Stream 3 describes the general composition of health care senior-
level leader groups and the general requirements for accessing these roles. The final focus of the third stream is on health care leaders’ competencies and development in health care organizations.

**Stream Three: Health Care Leader Competencies and Development**

Kouzes and Posner (2007) defined leadership as “the study of how men and women guide others through adversity, uncertainty, hardships, disruption, transformation, transition, recovery, new beginnings, and other significant challenges” (p. 164). For this study, Kouzes and Posner’s definition of leadership seemed to accurately describe the current environment of the health care industry. The need for effective and astute leaders in the rapidly changing environment of health care is critical to the overall transformation of health care delivery systems and to the adaption and sustainability of the organization’s new direction. A leader in the current health care environment needs to be able to “read the signposts of change” (Porter-O’Grady & Malloch, 2011, p. 46), navigate and map the political terrain, and plant the seeds that create the environmental conditions necessary for change (Bolman & Deal, 2008). Interestingly, early predictions by Chapman (1993), President and Chief Executive Officer of a Washington, D. C. health care system, indicated those executives who would be successful in the coming decade would be those who are able to recognize levels of risk, uncertainty, and rapid changes occurring in the new era of health care and react appropriately. Chapman further explained that health care leaders should nurture their intangible leadership qualities, such as understanding one’s self, commitment to serve, and increasing one’s depth and breadth of vision. In addition, Chapman also predicted health care reform would impose new leadership accountabilities and risk. He encouraged leaders to develop an art for
manipulating change for the advantage of their organization and community, balance long-term vision and short-term realities, initiate conversations with external and internal stakeholders to garner a common purpose, keep communication open, educate when necessary, and update often on current undertakings. Chapman’s words and thoughts endure as clear message for today’s health care leaders.

**Description of a health care group.** According to Schyve (2009), a member of the JCAHO accreditation body, most health care organizations are composed of two groups of leaders: (a) the governing body (the board members) and (b) executive officers including the CEO, which is collectively described as the C-Suite. Schyve also acknowledged a third group: the physicians group. However, for the purpose of this study, the focus was the executive-level leaders and the directors of specialty departments who report to them. As explained by Fried and Fottler (2011) and Perry and Bokar (2007), the composition of executive leadership in health care organizations depends on the size of the organization. In large organizations, such as health and medical centers, there are multi-layers of health care administrators who provide leader direction for various sections of the organization. The C-suite may include titles such as chief nursing officer, chief medical officer, chief operation officer, chief information officer, chief finance officer, and chief technology officer (Compdatasurveys, 2014; Fried & Fottler, 2011; Schyve, 2009). Even though there are varying responsibilities for these positions, the general leadership responsibilities include (a) providing strategic direction; (b) organizing and managing the delivery of care; and (c) providing leadership, guidance, and support to members of the organization (Fried & Fottler, 2011). For the purpose of this study, it was important to have an understanding of the suggested general educational
and experience requirements these individuals should possess to hold critical leader positions in health care administration.

**Executive-level leaders and director-level leaders.** The general education background requirements for executive-level health care positions is a minimum requirement of a bachelor’s degree while a master’s degree (health administration, public health, public administration, or business) is preferred, plus 10 to 15 years of experience serving in various levels of leadership positions such as at the chief (CEO, CFO, COO) and director (department or division) level (Fried & Fottler, 2011; Gamble, 2012; McLaughlin, 2013). Fried and Fottler (2011) suggested that although a majority of health care administrators have degrees and experiences in health care administration, a growing number have clinical backgrounds in nursing and physician cores. Such individuals may have followed traditional career paths by serving as director of nursing (DON), CNO, or clinical practice to CMO. Directors or managers of specialty departments, divisions, or facilities (small clinics or ambulatory-care centers) generally tend to have bachelor’s degrees along with licensure in their specialty or chosen profession in addition to past experience gained at the frontline of the manager/supervisor level. Regardless of the career pathway, understanding the competencies needed to be an effective and successful leader in these positions is most important to developing future leaders.

**Health care leader competencies and models.** Researchers (Berger & Berger, 2011; Cook & Bernthal, 1998; Guo, 2009) asserted there are various types of competencies in organizations such as organizational or core competencies, job family or job/role competencies, personal competencies, and special competencies for managers and senior-level leaders. Berger and Berger (2011) suggested competencies are stated
expectations crucial to the employee’s and organization’s performance. Such competencies are associated with a set of personal and professional skills, behaviors, attitudes, and knowledge and they provide a common language for measuring performance in an organization as a whole as well as the individual performance of an employee. Competencies, as described by Garman and Dye (2009), are associated with a higher level of performance requiring more than the basic competency level, i.e., above the minimum skills and knowledge required to do the job. Identified competencies and competency models may offer leaders a framework or understanding of themselves and insight into what is needed to expand or improve their leader capabilities and effectiveness as a leader. The focus of this study was leader and leadership competencies in health care.

Health care leaders need additional skills and competencies to meet the new challenges caused by the changes in technology, population, and various current and pending regulations (Liang, Short, & Brown, 2006). Since health care leader and leadership competencies vary depending on the organization, Freshman and Rubino (2002) suggested emotional intelligence is one of the most valuable and necessary competencies for health care leaders and needs to be used in combination with other competencies. In 1990, Mayer and Salovey coined the phrase *emotional intelligence* and introduced hierarchical abilities involving (a) accurately identifying emotional expressions, (b) generating feelings to understand self or others, (c) deriving knowledge from understanding emotions, and (d) self-regulation of one’s own emotions. Building on the work of Mayer and Salovey (1990), Goleman (1998) introduced an emotional intelligence model composed of five dimensions: (a) self-awareness, (b) self-regulation,
(c) motivation, (d) empathy, and (e) social skill. Dye and Garman (2006)—experts in competency modeling, health care C-Suite leadership development, and in-depth familiarity with the health care leadership world—developed the exceptional leadership competency model for health care executives, which included 16 competencies contained in four cornerstones or clusters.

Adapted from Dye and Garman (2006)

Figure 2. Exceptional leadership competency model.

Dye and Garman (2006) developed this list of competencies though interviews and surveys of eight seasoned health care search consultants, health care CEOs, and executive
coaches. Dye and Garman compared and contrasted their list with the academic leadership literature and other well-respected consulting firms to ensure the list of competencies was credible.

The Healthcare Leadership Alliance (HLA), which is composed of over 100,000 members from across major health care professional associations, collaborated to create a shared language and understanding of competencies (Stefl, 2008). Drawing from diverse credentialing processes, the HLA posited five competency domains composed of 300 competencies statements common to all practicing health care managers: (a) communication and relationship management, (b) leadership, (c) professionalism, (d) knowledge of the health care environment, and (e) business skills and knowledge. The HLA competencies were defined differently for each of the three skill levels: entry level, mid-career, and senior level. Stefl (2008) reported that “the identification of these five domains [allows] healthcare managers in a wide range of positions and settings [to] share a common lexicon” (p. 364). The HLA model provides a tool that can also be used by a range of organizations (e.g., universities, health care organizations) to assess an individual’s competencies and skills for leader roles. The HLA model may also be used by individuals to identify future roles and build a career plan around the required competencies (both general and specific).

Although the HLA was intended to be a shared model for leadership competency assessment and development, a range of other competency models have been created in recent years. Building on the initial HLA approach, the NCHL (2010b) interviewed top futurists and thinkers and developed the NCHL’s healthcare leadership competency model. Recognizing realities in the industry, their competency model specifically
captured the health care leader’s role. HLA’s global model included three domains of focus: (a) transformation, (b) execution, and (c) people possessing 26 competencies (eight technical and 18 behaviors) constantly revalidated by users, researchers, and experts. Garman and Scribner’s (2011) quality leadership developmental competency model identified competencies for leader quality improvement. The interprofessional competency model (Calhoun et al., 2008) evaluated “leadership skills across all health care professions and career stages” (p. 375). Although first-time executive-level health care leaders have a wealth of health care leadership competencies to guide them in their transition, health organizations need to be aware of these models and their potential value, making conscious efforts to assist and support first-time health care leaders in mastering and sustaining these acquired skills. With understanding about which model will serve as the best guide, competencies specific to the individual’s needs and organizational needs and strategies become the foundation of any effective leader or leadership-development program (McCauley, 2008).

Health care leadership development.} {McAlearney (2008a) conducted a study surveying 104 health systems regarding executive leadership development in U. S. health systems: 52% reported having an executive leadership-development program, 88% linked their program to the organization’s strategic goals, 73% customized their program to the needs of the participants, 86% utilized executive coaches, and the majority indicated the program was worth the investment. Just as there are a variety of definitions for leadership and leadership competencies, leadership development literature reveals a wide variety of developmental models for developing health care leaders. When a health care organization becomes involved in the development of their current and future leaders,
they open up their organization for employee engagement and satisfaction, increase both productivity and profitability, and create a highly positive and inviting culture for learning. In terms of leadership development, Garman and Dye (2009) offered important insights regarding the value of leadership development:

1. Leadership development is a long-term investment that requires short-term sacrifices.
2. Leadership development is a relatively safe investment that yields a return in the form of improved performance across the leadership team.
3. Returns on these leadership investments tend to compound over time. (p. xviii)

Another important component emphasized in the development of leaders is the differences between leader development and leadership development (Day, 2001; Garman & Dye, 2009; McCauley, Van Veslor, & Ruderman, 2010). Day (2001) and Garman and Dye (2009) presented several dimensions differentiating between leader and leadership development. Leader development focuses on the individual, while leadership development focuses on leaders as a group; leader development is about the development of self, whereas leadership development emphasizes developing and building through social capital (networking relationships and understanding people).

Hesselbein, Goldsmith, and Beckhard (1996) offered an early model of leadership that resonates across its 50 year history. Their model calls for personal, business, and leader development of the individual. Hesselbein et al. suggested that each element was equally important for an executive to be well balanced. The business dimension means having the sense and skills to identify and address global business challenges. The leadership dimension requires the executive to have fully developed skills to lead an organization with confidence. To achieve the personal dimension, the executive leader
must identify his or her personal purpose, vision, values, and talents and must be able to integrate these elements into their personal life. In addition, Hessselbein et al. suggested organizations must assess their existing internal education program, select external programs using their three-dimensional model, create a succession-planning component (to select and prepare future leaders), use this model as a template for their human resources system, and utilize a self-assessment instrument. Finally, Hessselbein et al. argued “leadership is a factor that will ultimately determine [one’s] success or failure. The three-dimensional framework recognizes that…strengths are derived from the strength of individuals” (pp. 172-173).

Melum (2002) and McAlearney (2008b) defined leadership development as an intervention supporting the expansion of an individual’s capability. Such a definition is in contrast to the above description of leadership development. Melum further suggested high-performance models for leadership development tend to be composed of three dimensions: (a) target—assessing the entire organization for leaders to develop and then targeting the individual with the most potential; (b) approach—the workings of leadership development through assessment, challenge, and support; and (c) scope—inclusion of various organizational programs to expand the growth and development of a potential leader is important.

Melum (2002) reviewed a study of two companies that practiced leadership development and produced high performers. For both companies—HealthPartners and the 3M Company—leadership development was a priority. Even though the two companies had different approaches to leadership development, their focus was the same: Develop leadership in their people at all levels, do not delegate leadership development,
and embed it deeply into the organizational fiber. Responses from staff in both these organizations were extremely positive. Redman (2006) further argued that hands-on learning opportunities, coaching, and mentoring are strong essentials for leadership development even if there are no formalized training programs. Redman also strongly suggested targeting individuals early in their careers and working with them to provide exposure to leadership and development processes.

In the nursing profession, the research literature on leadership development reveals a slightly different approach. Swearingen (2009) presented a nursing leadership-development model that began at a grassroots level. The leadership program was built around Benner’s (1984) novice-to-expert framework. Benner defined five development levels: (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and (e) expert. Each level has a set curriculum and an identified audience. All newly hired nurses in an organization (experienced or not) begin at the novice level and continue through to expert level. In this model, leaders of the organization are responsible for developing new leaders and for teaching courses in the program. The impact of this model includes increased awareness of leadership by staff at all levels, increased staff retention, availability of a large pool of nursing staff for promotion to higher level positions, delivery of higher quality patient care, and furthering the organization’s financial stability.

Benner (1984) built a model on the Dreyfus and Dreyfus (1986) five-stage model of skill acquisition. Dreyfus and Dreyfus introduced their model in 1980 as part of a private report to the U.S. Air Force. The Dreyfus and Dreyfus development model outlined a student’s progress to competence through stages: novice, advance beginner,
With the growing support and utilization of leadership development programs in health care organizations, researchers have begun to examine practices, modes, and mechanisms for developing leaders at all levels of the organization in the health care industry. McAlearney (2006) pointed out that although there is now more support for leadership development in health care organizations and systems, there is still little known about the practice of leadership development in these organizations. Between 2003 and 2007, McAlearney (2008b) conducted three exploratory studies on various aspects of leadership-development programs, interviewing over 200 key managers, executives, and academic expert informants from various hospital and health systems in the United States. The first study investigated the content and process of leadership-development programs, the second study (an extension of the first study) investigated topics such as succession and leadership-program planning, and study three was an ongoing study designed to capture information on executive leadership training and development programs over an extended period of time. Data analysis from all three studies indicated leadership-development programs (a) increased the workforce
leadership skills (especially for new leaders), (b) focused employee training, (c) increased employee satisfaction and reduced turn over, and (d) linked education/training to the organization’s strategic plan. McAlearney (2008b) concluded that health care leadership-development programs offer a vehicle for focusing the organization’s direction and for providing opportunities for improving quality issues.

While the previous studies were being conducted, McAlearney (2008b) continued to broaden the health care leadership body of knowledge by conducting other studies on leadership development for physicians. According to McAlearney, Fisher, Heiser, Robbins, and Kelleher (2005), because physicians are essential and critical to the success of a health care organization, health care leaders and organizations must be able to leverage the unique perspectives of physician leaders. Recognizing that physicians are trained to be autonomous decision makers and not administrative managers, McAlearney et al. found—after conducting a case study at a children’s hospital—leadership-development training was necessary to bridge the gap of understanding between the clinical and administrative sides of the organization. Leadership-development training was implemented with much success for this organization, thereby producing the first physician CEO. Such studies demonstrate the importance and value of leadership-development programs.

Garman and Lemak (2011) provided a summary of lessons learned regarding the development of health care leaders since the founding of the NCHL in 2001. They explained that in the past leadership development was only a passing thought in most health care organizations and health systems, but the Commission on Healthcare Management Education now requires graduate programs to incorporate the competency-
Based on components into their curriculum. They further asserted that there are five key lessons learned from research over the last 10 years: (a) acquiring excellence is a lengthy journey—current career paths to senior-level health care leader require an early start and mastery of new competencies along with a three-year (or more) working plan that allows a first-time health care administrator to gain experience to be considered effective; (b) leadership development is just as important as leader development—sending an intact leadership team to learn together is more valuable than sending just one leader; (c) leadership-development investment is not about how much but how—today leadership development is strategic and identifying high-potential leaders is critical; (d) organizational elements of culture, practice, and HR’s talent management coming together as a synergistic team to select the best people for the organization—health care organizations are beginning to understand the importance of leadership development as it relates to creating and sustaining a positive organizational culture; and (e) leadership experiences provide greater learning—practical experience is essential to adult learning, as is preparation, feedback, and receptivity to the feedback.

Finally, Garman and Lemak (2011) suggested the future of health care leadership development will bring more opportunities, new/innovative approaches to competency modeling that can be tailored to local needs as the industry evolves, and more studies related to leadership practices in various dimensions of health care organization will be needed (measuring patient experiences). In addition, Garman and Lemak noted technology including simulation and other advanced learning tools will play an extremely important part in developing executive-level health care leaders.
It is evident from this review of the literature that leadership development is critical to the success of health care organizations, especially in these times of increasing instability and confusion. This literature stream revealed that health care organizations appear to have been slow to recognize the importance and value of early identification of leaders and to embrace the structured process of development. According to Redman (2006), some health care organizations—those recognizing the impending nursing shortage—have initiated leadership-development programs. Several studies suggested utilization of these processes may create a pipeline for future health care leaders with the essential leadership skills needed for executive positions. The information in this stream provided insight about why an organization and first-time senior-level health care leaders would likely benefit from knowing and understanding the position competencies and the formal learning experiences offered by leadership development programs. To capture data on this element of the study, the participants were asked to discuss the concepts of leader/leadership development in their organizations. Probing questions were utilized to clarify incomplete or unclear responses as deemed necessary by this researcher.

**Summary**

Based on the literature described above, it appears necessary for health care leaders (especially executives) in public and private health care organizations to understand the complex nature of their role. Such leaders play a critical and crucial role in developing and guiding the current and future workforce. They must be able to anticipate the future and provide capabilities to address it. The three streams of literature introduced provide important insights into the challenges facing health care executive leaders. It is also evident from this review that health care organizations would likely
fare better with leadership development programs focusing on competency
development at all levels of the organization and moving the staff member from novice to
expert. Organizations that begin succession planning to select future leaders will increase
the pipeline of experienced individuals ready to move into executive positions.

Research suggests change is inevitable and that it presents itself at a rapid pace.
The literature posits that the health care industry is complex and different from other
industries because of its various interacting autonomous professions and human
involvement. The challenges of complying with laws and regulations, technology
advancements, and workforce issues require a consistent and constant internal and
external collaborative approach with all stakeholders to create and maintain a viable and
progressive strategic plan. Health care organization boards of directors will have to
ensure their executives are trained to manage change. How these executives lead their
people through change is critical to the wellbeing of the organization. Research suggests
the role of executive leaders is complex and that the health care industry is going through
significant change and therefore requires leaders with vision and strategic ability to move
people and processes in response. Health care organizations appear to have paid
insufficient attention to succession planning and the development of a strong leader
pipeline. There is a shortage of health care leaders due to factors such as frequent leader
turnover and retirements. Because of this, executive are entering leader roles without
sufficient preparation.

The purpose of this study was to explore and describe the lived experiences,
challenges, concerns, and perceptions of first-time senior-level and director-level health
care leaders who have worked 6 months to 4 years in their first executive health care
leader role in health care organizations and systems. The study of their journey may provide knowledge and insight into their inner motivations and skills as leaders. The challenges they faced during their initial time in the role as they managed internal and external issues, as well as their expressed leader development needs, may offer new insights and understanding toward the development of future health care leaders.

The first goal of this study was to enable these first-time health care leaders to record their experiences regarding their transition into their new role and their reactions to it. The second goal was to understand and gain a better perspective and appreciation for their personal motivations, stresses, frustrations, concerns, and challenges. Finally, the third goal was to apply the lessons learned in a professional-development setting to clarify what skills, knowledge, and professional development might be needed as a senior-level leader.
Chapter 3: Research Methodology

**Introduction**

The literature review in Chapter 2 described current and future factors critically impacting the role of leaders in health care organizations and systems of today. The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who have worked 6 months to 4 years in their first senior-level health care leader role in a health care organization. This study utilized the following three research questions to provide direction for this study:

1. What are the lived experiences of first-time senior-level health care leaders promoted or hired into a critical leadership role for the first time?
2. How do these first-time senior-level health care leaders describe the challenges they faced and the leadership lessons they learned that influence their current actions in these roles?
3. What professional development efforts might offer a needed foundation for the initial success of novices promoted into similar positions?

Chapter 3 is organized into the following major areas: (a) research design and rationale, (b) site and population description, (c) research methods, and (d) ethical consideration.

**Research Design and Rationale**

**Research Design**

A qualitative research approach guided this study using a phenomenological design. Merriam (2009) suggested qualitative research is an inquiry approach used to
“achieve an understanding of how people make sense out of their lives…and describes how people interpret what they experienced” (p. 14). Creswell (2008) explained qualitative research “as an inquiry approach useful for exploring and understanding a central phenomenon” (p. 645). Merriam further asserted that qualitative research is complex and is best explained by four characteristics: (a) focus on process, understanding, and meaning; (b) the researcher is the primary instrument of data collection and analysis; (c) the process is inductive; and (d) the product is richly descriptive.

For this study, the phenomenological methodology provided insight into the world of first-time health care leaders during the first 4 years after promotion to a new leadership role. The phenomenon may be best explained by those individuals who have lived the experience. Burns and Grove (2003) defined a phenomenon as “an occurrence or a circumstance that is observed, something that impresses the observer as extraordinary, or a thing that appears to and is constructed by the mind” (p. 491). Schram (as cited in Merriam, 2009) described phenomenology as the “study of people’s conscious experience of their life-world, that is, everyday life and social action” (p. 25). Creswell (2007) and Van Manen (1990) referred to phenomenological research as a means of describing the lived experiences of a common concept or phenomenon of several individuals.

Merriam (2009) and Van Manen (1990) further asserted that bracketing is a critical component of phenomenological research. Van Manen explained that in order to bracket, the researcher must be able to suspend his or her assumptions, biases, and personal viewpoints and focus on describing the essence of the phenomenon as
experienced by the participants. Moustakas (1994) used the term *epoche* instead of bracketing. He argued that *epoche* is a necessary first step and requires refraining from judgment and suspending one’s “every day, ordinary way of perceiving things” (p. 33). After examining one’s own fears and assumptions, listening to the participant’s experience can begin (Merriam, 2009). Rich, thick data are collected through interview, observation, and artifacts and are analyzed through a process of coding, theme development, and interpretation.

Moustakas (1994) presented a 4-step approach to conducting transcendental phenomenological research: (a) *epoche*, (b) phenomenological reduction, (c) imaginative variation, and (d) synthesis. He defined transcendental phenomenology as a “scientific study of appearance of things, of phenomena just as we see them and as they appear to us in consciousness” (p. 49). In the first step (*epoche*), the researcher prepares for the participants interviews by “setting aside pre-judgments” (p. 180) and bracketing out the researcher’s own assumptions and experiences (Creswell, 2007) to conduct the interviews without bias.

During the second step (phenomenological reduction), the researcher continues to bracket and suspend personal beliefs and perceptions while listening to and focusing on the voices of the study’s participants to capture new knowledge and understanding of the essence of the participants’ lived experiences. The researcher collects data through an in-depth interview process (using open-ended semi-structured questions), observation, and artifact review by recording a textural description of the phenomena from each of the study’s participants and then combining them.
The third step in the process is imaginative variation, in which a list of individual structural qualities of experiences is combined and clustered into themes. Moustakas (1994) explained that in this step “a structural description of the essences of the experience is derived, presenting a picture of the conditions that precipitated an experience and connected with it” (p. 35). The final step in the process is synthesis, in which the data previously transcribed, coded, and categorized into themes are interpreted to convey a summation and outcome of the experience.

**Rationale**

Because the health care industry is increasingly complex, complicated, and constantly changing, there is a need for leaders who are experienced and skilled in leading and building health care organizations that are patient centered, quality driven, and cost aware (National Center for Healthcare Leadership [NCHL], 2010a). As baby boomers retire from the system and severe budget constraints are necessary, there is an increasing reliance on promoting individuals with no previous senior-level work experience from within the system to take key leadership roles. Information regarding these newly promoted individuals is limited or simply not documented.

Phenomenological methodology allows for exploration and analysis of these individuals’ backgrounds, personal motivations for accepting promotions into these roles, and levels of leadership skills and defining experiences. A sample size of nine participants was utilized. The information shared by participants confirmed the requisite skills and competencies identified as critical to successful role implementation but are deemed best acquired before entering the health care senior-level leadership role.
Additionally, it would be helpful to identify what supports and resources are needed for leadership-role transitions.

**Site and Population**

**Population**

The population chosen for this phenomenological study was health care leaders located in health care organizations and systems throughout California. The nine participants were first-time health care leaders who accepted senior-level positions such as chief executive officer (CEO); chief medical officer (CMO); chief nursing officer (CNO); chief operations officer (COO); chief quality officer (CQO); and directors of various departments, ambulatory care centers, and outpatient clinics. This study did not focus on gender, age, and ethnicity but on health care leaders who had been in their position for at least 6 months but no more than 4 years and had no previous executive leadership experience or formal leader or leadership development or coaching prior to accepting their positions. A snowball-sampling strategy was used as a means of selecting participants who held rich information about the phenomenon being studied. Bloomberg and Volpe (2008) and Burns and Grove (2003) described snowball sampling, or network sampling, as a process of utilizing identified subjects to identify other potential subjects who have similar or same characteristics. Keeping with Dukes’s (1984) recommendation of 3-10 subjects in a phenomenological study, this study’s sample size included nine participants.

**Site Description**

Due to the snowball sampling strategy, participants came from health care organizations and systems located in the state of California that required no single-site
utilization. Individual interviews were conducted at various off-site locations—homes and offices—convenient to each participant. Since individual interviews were conducted at various locations convenient to each participant, site access was not an issue for this study.

**Research Methods**

The data were collected from three different data sources, creating triangulation that established the trustworthiness and credibility of the study. Triangulation means using data gathered from multiple data collection methods—artifacts, interviews, and observation (Creswell, 2008; Merriam, 2009)—and corroborating the findings across the data sets. The data collection tools in this study included the interview, observation and researcher field notes, artifacts, and recording devices.

**Description of Each Method Used**

**Interviews.** Participants were contacted by phone or email requesting their participation. After an email request, a Letter of Invitation (see Appendix A) was sent and when a response was received, a phone call was made to each participant to review the study’s intent and confirm his or her agreement. After verbal confirmation of an agreement, an initial meeting was scheduled at a location selected by the participant. A copy of the Interview Protocol (see Appendix B), including the demographic sheet and semi-structured interview questions, were hand carried to the participant or sent by email. At the beginning of the meeting, the researcher chatted with the participant to allow for rapport building. Next, the purpose of the study was introduced, the participant demographics sheet was reviewed for clarity, and a brief explanation of how the interview would be conducted was provided along with an explanation of the
participant’s rights. Finally, before starting the interview, the participant was informed the interview could be stopped at any time if he or she became uncomfortable. In addition, the participant was assured that his or her real name and organization would be kept confidential. At this point, questions from the participant were encouraged and, if there were no questions, the interview began.

An in-depth, 45-90 minute, face-to-face recorded interview was conducted with each participant utilizing the 14 semi-structured, open-ended interview questions and follow-up probing questions for clarity and deeper understanding. At the end of each interview, the participants were thanked for their time and participation. Two recording devices were used to capture the interviews. Recordings and transcriptions for this study were maintained in a secure cabinet at Drexel University, assuring participant confidentiality. Data stored on a computer were password protected along with unique identifications for all transcripts and data.

Observation. Observation was the next element of data collection for triangulation. To capture the natural environment or setting where the interview took place, handwritten observation notes (field notes) were utilized. “Field notes can come in many forms, but at the least they include descriptions, direct quotations, and observer comments” (Merriam, 2009, p. 137). For the purpose of this study, this researcher adopted the observer’s role in the situation and began observations before the interview started by noting time and date and by describing such things as the physical setting, who was in the scene, and various occurring activities. Because the researcher was considered an instrument of the study and part of the scene, this researcher recorded personal
thoughts and feelings regarding the current scene and activities after completion of the interview.

**Artifacts.** The third data collection element for triangulation was artifacts that added verification to each participant’s experience. Artifacts are various objects, photos, visuals, and communications materials such as newspaper articles, personal documents, and books. Artifacts were described by Merriam (2009) as things or objects found in the environment of the participant, while documents represent a form of communication. Since documents and artifacts are valuable sources of information, this researcher requested the participant provide documents, objects, and other information related to various aspects of the participant’s experience. An explanation was given to the participant regarding what an artifact was and why artifacts were important. Although requests for artifacts were made before and after the interviews, no artifacts were received from eight of the participants. Participants stated they did not provide artifacts because “they forgot” or “time didn’t allow me to search.” Only one participant allowed pictures to be taken of the various ribbons, plaques, and photos in his office. Questions were asked about the history and value of the items to the participant. Photos were taken of the written documents, objects, and photographs and were coded with unique identification (Merriam, 2009).

**Data-Analysis Procedures**

Recognizing that the data-analysis process answered this study’s research questions (Merriam, 2009) and involved working with large amounts of raw data, organizing, storing, and securing data became extremely important to the end result of the study. According to Creswell (2007), data analysis begins with preparing and organizing
the data. The following is an overview of what should take place in a
phenomenological process and the actual description of how it was done is captured in
paragraphs below. As recommended by Moustakas (1994), upon completion of each
interview and transcription (verbatim) of the raw verbal data of the interview recordings,
the researcher again bracketed (suspended assumptions) before reviewing the data. The
researcher listened to recordings and reviewed field notes of each interviewee for
accuracy. The textural data (transcribed) described the “what” of the phenomenon as
experienced by each participant. In the second step of the process, the researcher created
the “how” of the participant’s experience (the structural description), which was achieved
by coding and categorizing the textural descriptions into themes. The process continued
with analyzing, interpreting, summarizing, and validating the findings and writing up and
reporting the essence of the collective experiences of the participants. A visual outline of
the steps in the phenomenological research process is found in Appendix C.
Stages of Data Collection

The data collection timeline is displayed in Table 1. The timeline begins with the development of the proposal and proceeds to review and approval of the proposal by the doctoral committee.

Table 1

Timeline for Collection

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>PROPOSED DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee Review/Approval of Proposal</td>
<td>August, 2013</td>
</tr>
<tr>
<td>Submission of proposal to Drexel IRB (2 weeks)</td>
<td>September, 2013</td>
</tr>
<tr>
<td>Identify participants</td>
<td>September, 2013</td>
</tr>
<tr>
<td>Participant Interviews/Artifact Collection</td>
<td>October-November, 2013</td>
</tr>
<tr>
<td>Transcription and Coding of Data</td>
<td>November-December, 2013</td>
</tr>
<tr>
<td>Analyze and Interpret Data</td>
<td>January-April, 2014</td>
</tr>
<tr>
<td>Draft Chapters 4-5 from Findings</td>
<td>April-May, 2014</td>
</tr>
<tr>
<td>Complete Full Dissertation</td>
<td>May, 2014</td>
</tr>
<tr>
<td>Committee Review</td>
<td>May, 2014</td>
</tr>
<tr>
<td>Editor Review Dissertation</td>
<td>May, 2014</td>
</tr>
<tr>
<td>Defense/Celebration</td>
<td>June, 2014</td>
</tr>
<tr>
<td>Graduation</td>
<td>June, 2014</td>
</tr>
</tbody>
</table>

The research proposal was submitted along with other required documents to Drexel Institution Review Board (IRB) for review and approval. Upon receiving the IRB approval, the data collection process began.

1. After identification of the participants in September, 2013, stage one of data collection began with this researcher beginning to mentally prepare to release any
prejudgments and perceptions regarding the phenomenon to be studied. Such a process is called *epoche* (Moustakas, 1994).

2. Stage two included the one-on-one interviews with each of the selected participants. Nine participants who had the same or similar common characteristics were selected through a snowball-sampling strategy. The individuals were contacted by email or phone and invited to participate in an interview. Dates, times, and places were scheduled. The interviews were conducted in locations selected by each participant. Eight of the interviews were conducted in the participants’ offices, and one was conducted in the researcher’s home. Before the interviews began, the researcher began the *epoche* process. Once the introduction of the study was over and the recorders were turned on, the participants became relaxed and answered all the questions related to their experiences. Interviews lasted from 40-90 minutes with an average time of 60 minutes.

3. In stage three, after all interviews were completed and artifacts collected, data were transcribed. The transcriptions were reviewed with verbal recordings for accuracy. This researcher began the coding process by reading the participants’ transcripts several times and extracting themes. The many themes were categorized into primary themes and supporting sub-themes.

4. Stage four in the timeline was analyzing and interpreting the data. The primary themes and sub-themes were analyzed for deeper understanding of the meaning and findings were identified. Quotes were sorted and organized to support the findings.
5. Stage five, the last data collection stage, involved recording the findings and results for Chapter 4 and the conclusions, recommendations, and summary for Chapter 5, written in a document form according to Drexel University’s requirements and guidelines.

**Ethical Considerations**

The intent of this study was to explore the challenges, motivations, lessons learned, and backgrounds of a unique group of individuals in their first senior-level roles. Before this research began, the researcher gained approval through the Institution Review Board (IRB). In preparation for the review, the researcher provided the IRB committee a clear and concise research proposal including information on all aspects of the research study, which allowed the board to thoroughly examine whether this researcher had met all the ethical standards and guidelines for the safe and respectful treatment of the research participants.

The snowball sample included nine research participants who had been newly promoted or hired into senior-level positions for the first time. Each had been in their roles for at least 6 months but not more than 4 years. Participants may have worked in similar roles but in different organizations. Before beginning the study, each participant was provided an explanation of the research purpose, problem, design, method, and data collection process. Because personal information was shared with this researcher, extra time was allotted for each participant to discuss his or her concerns about confidentiality, privacy, and the IRB process. Special emphasis was placed on the participant’s understanding of the interview and observation process along with data security and confidentiality of the results. Participants were informed that fictitious names would be
used. After the above information was thoroughly shared, reviewed, and understood, each participant was asked to provide verbal informed consent. Finally, the participants were advised on their right to withdraw from the study at any time during the course of the study. Each participant was encouraged to request clarity on anything at any time during the course of the study. All data, including recordings from the study, were kept in a locked drawer to maintain confidentiality and computer information was maintained under password protection at Drexel University.
Chapter 4: Findings, Results, and Interpretations

Chapter 4 highlights the findings, results, and interpretations that emerged from interviews with nine first-time senior-level health care leaders. Data from interviews, researcher observation, and artifacts provided rich, in-depth descriptions of journeys to initial (and current) senior-leader roles. Four major themes emerged from the analysis of the data. The descriptive themes emerged from the nine participants’ responses regarding motivations, perceptions, intentions, challenges, and social interactions. Chapter 4 begins with a restatement of the research’s purpose and research questions; continues with an explanation of the findings, results, and their interpretation; and concludes with a summary.

The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who worked 6 months to 4 years in their first senior-level health care leader role in a health care organization or system. This phenomenological qualitative study design was guided by the following research questions:

1. What are the lived experiences of novice health care leaders promoted or hired into a critical leadership role for the first time?
2. How do these participants describe the challenges they faced and the leadership lessons they learned that influenced their current actions in these roles?
3. What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?
Demographics of the nine first-time senior-level leaders offered information on participant gender, initial (and current) senior-leader role, tenure in this role, education, and organizational setting. Summary information on years in health care, age, and ethnicity was also provided. The nine participating leaders—five women and four men—were first-time health care senior-level leaders with tenure of four years or less in their initial senior-leader role. Seven participants were 30-50 years old, and two participants were older than 50. Participants had 15 or more years in health care with a range of 15-40 years. The nine participants averaged more than 10 years at the same health care organization. Eight of these nine first-time health care leaders were internally promoted and one was hired from outside the organization. Ethnicity of the group was self-reported: six were Caucasian, one was Hispanic, one was African American, and one was East Indian.
Table 2

Demographics of Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Current Position</th>
<th>Years in Initial Senior Leadership Role</th>
<th>Highest Educational Credential</th>
<th>Organizational Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Female</td>
<td>Clinic Director</td>
<td>2</td>
<td>M.S.</td>
</tr>
<tr>
<td>P2</td>
<td>Female</td>
<td>Chief Executive Officer (CEO)</td>
<td>4</td>
<td>M.S.</td>
</tr>
<tr>
<td>P3</td>
<td>Male</td>
<td>Med Director, MD</td>
<td>3</td>
<td>M.D.</td>
</tr>
<tr>
<td>P4</td>
<td>Female</td>
<td>Quality Director</td>
<td>1</td>
<td>M.S.</td>
</tr>
<tr>
<td>P5</td>
<td>Female</td>
<td>Chief Nursing Officer (CNO)</td>
<td>3</td>
<td>M.S.</td>
</tr>
<tr>
<td>P6</td>
<td>Male</td>
<td>Chief Medical Officer</td>
<td>3</td>
<td>M.D.</td>
</tr>
<tr>
<td>P7</td>
<td>Male</td>
<td>Assistant Director, Health Promotion</td>
<td>4</td>
<td>M.D.</td>
</tr>
<tr>
<td>P8</td>
<td>Male</td>
<td>Nursing Director, Ambulatory Care</td>
<td>4</td>
<td>B.S.</td>
</tr>
<tr>
<td>P9</td>
<td>Female</td>
<td>Disease Program Chief</td>
<td>2</td>
<td>M.S.</td>
</tr>
</tbody>
</table>

Findings

In this study, each of the nine participants’ transcripts was read and reviewed several times and then coded by theming (using one or two words and word phrases). The multiple themes were categorized into primary themes, producing four primary
themes and sub-themes. The four emerging primary themes were (a) career path, (b) first-time leader perception, (c) health care system structures, and (d) leader/leadership development. Sub-themes under each primary theme allowed for in-depth supportive descriptions of each theme.

Figure 3. Four primary themes emerged from the data.

Theme One: Career Path

The group of participants had diverse family and health career backgrounds. The study participants shared their journeys to their current senior-level leader roles by
describing segments of their personal lives. The segments are revealed through the
following sub-themes: personal influences, motivation, education, and work experience.

**Parental influences and family values.** Participants described their families and
communities as influences on their lives. Five participants identified their fathers as
being most influential in their lives, two participants indicated their mothers had the most
influence on their lives, and the remaining two participants always referred to both
parents. P2 described her father’s dedication to his work as an influence on her:

My father was the bigger influencer for me: his dedication to his civil service, his
public service. My dad was not a transient person; he’s gotten a job and stayed
there. He worked really hard and he liked to be part of something….He worked
for the city of San Francisco and he was, you know, he would go to the city
functions, and then when he retired from that he came to work for [the] county,
um, and he worked for the city of Paris, you know, he just, he was much more
likely to be part of something.

P1 described the value she derived from her father’s career in the military:

My father was military, so I’ve had the honor and privilege of being able to
travel….My father had a very strong work ethic, which was instilled into each one
of his children. My father believed that when you worked hard you were
rewarded by obtaining a job. My mother worked also. My father worked two
jobs to provide for the five kids that he had to ensure each of us were able to have
the things that we did.

P4 stated, “I was a daddy’s girl….I model after my dad. His opinion was respected. He
finished his career as [a] full-time teacher…he had influence. He influenced just about
everything.”

P5 described her father’s influence on education and care, “My dad
always…encouraged us and influenced us to, to go to school, get higher education and
become a professional.” P7 described the “profound effects” that his father’s drinking
had on his life choices, describing his father’s ability to be successful in his career while being a “functional drunk.”

Six of the participants noted their family values were centered on education, community volunteerism, sharing with others, and respect for others. Although three of the participants did not mention education or volunteerism as family values, it was clear from their responses they had been exposed to education; in particular, some participants mentioned that their mothers or fathers went back to school to become a lawyer or teacher. In terms of respect for others and educations, P8 often repeated these words throughout the interview, “My values were very much influenced by my parents. They taught us to be respectful of others and the importance of education and hard work.”

Another participant explained it as follows:

I think my father also was in the Vietnam [war] and worked in legal aid. So he always had sort of a community outlook to his law practice….Mom always did community work, so I think working [and] serving the community was…definitely a value of our family and certainly affected where I was, what career path I had chosen. (P9)

Another important detail stood out regarding family influence: six of the participants stated both parents were college graduates and one stated her father was a college graduate. Instead of college backgrounds, the last two participants indicated only that their fathers were military or came up through the ranks to be a police chief.

According to the participants’ responses regarding parental influences, early in their lives their parents began to lay the foundation of going to school, getting an education, and a getting job. In addition, a majority of the parents seemed to emphasize working hard to get rewarded in life and career. The participants indicated their parents were highly educated professionals who were aware of the privileges education could
provide. There was also emphasis on giving back to the community by volunteering, sharing of knowledge, or supporting community projects and programs that would benefit the less fortunate and the community as a whole.

*Motivation to make a difference.* The second sub-theme that emerged from the participants’ descriptions of their career paths related to personal motivations. An overwhelming majority of participants mentioned their initial motivations were “working with people.” P1 described the “servant leader” nature of the profession:

> I always chose a profession that cared about others in society, and it was more of a servant-heart type of profession where you’d always be helping someone else and empowering them. My dream down the road was always to be a director down at a nursing unit like med/surg or critical care or something like that. But I wanted to do more. I really wanted to make a difference, and I felt as though I had done everything I [could do] at the level of the charge nurse and [needed to] step up my game. And stepping my game up was, I thought, going to a manager position. I never thought I’d go from charge nurse to director and that’s what happened to me. So the opportunity came before me to apply for a position at an outpatient clinic with another health care organization and I chose to interview for that.

P2 described the goal for a position that had meaning and impact:

> I also went into a field that I really enjoyed. I enjoyed, uh, working with people…a lot of really what healthcare is…around just connecting with people during their life experience….I mean, I know a lot of people focus on the technical piece of that, but that can be learned by anybody, but I think that I really found, you know, I naturally liked people….I have always aimed to, I have always had this sort of belief that I could, I wanted to do something that, you know, had meaning or impact….I would have been happy and would still be happy to do that from a variety of positions….it’s just so happened that the CEO position…was the pathway, that…became available to me at the time, but I think that…[the] more important decision that I made was to work on things that mattered to me and to work on things where…it was genuine….I love the challenge. The challenge of it and, um, because I had a lot of ideas and things…I wanted to do. And I could act on the ideas more readily, you know, in a, a senior leadership role….I mean, I was respectful of the level [of] the position….sort of respected how hard it would be, but I didn’t even have to think twice…it seemed like such an honor to be offered a senior-leader position in such a great system.
Other participants shared that their motivations to take the senior-level leader roles were about “making change”:

[I] thought a lot about [it] before accepting the position…the things that drew me to this were several things, uh. One is…I saw that there was…going to be opportunities for a lot of change in the next few years…improvement with putting in an electronic, uh, health record, with really expanding primary care access and redesigning primary care. And so I wanted to help on those projects, and I thought I could make a real contribution on those projects…and then the other thing was…the people I’d be working with closely I respected and admired, and I thought I could work really well with them. (P3)

P5 wanted the opportunity to make changes in nursing that would make a difference:

I think one of the things that motivated me was the ability to make changes…the things to improve, the things that I used to talk about, “Why can't we do this? How come we can’t support our nurses…to deliver patient-centered care?” And I thought that in my current role, if I were to get that position, I would have much more…opportunity to influence the nursing staff and other staff members too. And so I think, just for that fact, that it would give me the opportunity [and] the ability to do that…plus, you know…I like challenges and I like to lead…and all this was an opportunity for me to do all of that.

P9 discussed the importance of making a difference in her local community, “I felt like working at the local level…I could actually see the change happening. And affect change and serve people in the community where I live and grew up.”

Finally, a couple participants provided very matter-of-fact comments about their motivations. P6 said, “If I don’t do it someone else is going to do it.” P7 was sure of a senior-leader role in the future, “I always thought that I was going to take a senior-leadership role…I mean, I’ve been told by my chief that I was on, I was on line to look at leadership.”
Supporting, empowering, and making a difference for people along with making changes seemed to be the major motivations for an overwhelming majority of the participants.

**Prior work experience.** The third sub-theme that shed light on the participants’ career paths was their work experiences leading up to their current roles. The participants’ responses identified a wide variety of differences in their previously held jobs. Exposure to these responses offers additional clarity and insight into each participant’s unique work history, revealing what knowledge and skills they brought to senior-level roles. The following responses are from two of the participants—a nurse and physician.

P2 (a nurse) offered these comments about previous work experiences in terms of being mentored and orientation to the current role:

I had to get some work experience and life experience, you know, grow up a little…so I did a very incremental…very slow incremental rise actually. I mean, a lot of people might think, “Wow, she was a CEO at 42,” but, you know, I started as a nurse’s aide….And so it was a good…career for me. The other thing is that…I went into nursing, which was kind of nice because it’s so broad. That I was able to do a variety of things from, you know, direct floor nursing to eventually sort of administrative…you know…take on sort of junior administrative [jobs] and then eventually administrative roles and…I never aimed to be the CEO.

P3 (a physician) provided work experience from a physician’s point of view, which is important because three of the nine participants were medical doctors while five were originally from the nursing profession. Experiences from the physician side, or clinical side, of the health care system tend to be a different working career journey from others entering the senior-level ranks. P3 indicated the newly created position currently
held included parts of two different senior-level job descriptions. P3 made the following comments about his work path (fictitious names have replaced original names):

I actually worked for a group…it was called the [Little Beaver] Rural Health Coalition. And we helped run some free clinics in [Black Bear South Idaho]. So just some of the sort of experience…organizing experience and working on a team there was helpful….In medical school, I continued my work with that organization….And my senior year of residency I was one of the chief residents, so…leadership experience there. A few years after coming on staff, I took a leadership role in the Family Medicine Department as part of the medical staff as…[one of the] county division heads. And I did that for a few years, and then…I was part of the faculty leadership group, which [I] kinda helped run the residency program…supporting the residency director. And then I became assistant residency director. I did that for a couple of years and then became, let’s see, Family Medicine Department Chair, and I’ve served as Family Medicine Department Chair for seven years before taking my current position… So my current position is a first real true administrative management position. [Before taking the position], I was reluctant to give up the patient care and the teaching, resident teaching, that I was doing. I knew I’d have to…cut back on my patient-care hours and eliminate the teaching hours I was doing. So it was a tradeoff.

P9’s past work experience was totally achieved in a public health organization, and this participant described the experience with the following statement:

I had been in the immunization clinic for about five years….So I worked in the AIDS program, uh, as a student worker and then as an intern, and then I became a case manager there after I graduated [as] sort [of a] financial counselor….Then I started to work for the immunization program. I mean, I helped implementation registry, which is a database throughout Contra Costa health services. And then I became the health emergency coordinator after 9/11, after the anthrax attacks. The health department got a lot of money to prepare for some kind of bioterrorism attack or other health emergencies. So I implemented [and] sort of developed that program, health emergency response, here in public health. And then I became the immunization coordinator. And that was during H1N1. We had a lot of vaccine…issues and pandemic issues. And then I became what I am now, the Communicable Disease Chief.

Such responses provide a hint of the variation in the work experience of the study’s participants. Each of their work experiences shaped the course of their career paths.
Summary: Theme One

In this primary theme, three sub-themes were discussed:

1. Sub-theme regarding parental influences and family values: Five participants identified their fathers as most influential in their lives, two indicated their mothers had the most influence on their lives, and two always referred to both parents. Family values were focused on education, volunteerism, and respect for others. A majority of the participants’ parents were highly educated professionals with a focus on hard work and reward.

2. Sub-theme regarding motivation to make a difference: Participants choices to accept their current jobs were based on wanting to do more, making a difference, empowering others, the love for challenges, the connection to people, and being part of making change.

3. Sub-theme regarding prior work experiences: Participants had a wide variety of career work experiences.

Theme Two: First-Time Leader Perceptions

Theme 2 includes four sub-themes: (a) feelings of strength and inadequacy, (b) lessons learned, (c) meaning of being a leader, and (d) the challenges of the organization. All nine participants articulated their experiences using words such as “anxiety,” “fear,” “scary,” “stressfulness,” “uncertainty,” and “worry” as well as “excitement” and “rewarding.”

Feelings of strength and inadequacy. This sub-theme emerged as the first theme under first-time leader perception. When speaking about their past and current experiences with their new job, participants aired their fears, frustrations, and insights
without hesitation. The following very revealing quotes are the responses shared by the participants regarding their inner feelings about themselves.

P1 spoke about the range of emotions that came from “learning by fire,” stating:

I would say in that leadership role…it’s a day-to-day… One day I can be so happy and excited to another day where I can feel like, “Oh my gosh, what did I get myself in?” I have fears, I have stresses, I have accomplishments and achievements; I can be happy. It’s a continuum of different types of emotions and things that are going on and it’s because I’m really learning by fire [and flying] by the seat of my pants. Every day something new comes because there is no mentorship or someone saying to me…“This is how you do it”…It’s like, “Okay, you got this job, congratulations, it’s yours.” There wasn’t an operator manual like when you buy a new car—you get an operator’s manual and you can turn it on and figure out when this light comes on what’s going on. Well, when you become a manager or a director at the level I am, there’s no manual. You’re taking your experience, the skill that you have and you put it all together and figure out what’s happening. And if you can’t figure it out, then it’s important for you to bring those people into your arena that are able to help you to be able to solve whatever problem comes about.

P4 described her worry about “not doing…a good job,” noting how it felt to not meet others' expectations:

It feels scary. Many, many days it feels very scary…if I don’t stay at this job, it will be because I felt like I couldn’t do a good job…I don’t like not doing a good job. So I struggle with this almost every day. I don’t have a good sense of…if I’m fulfilling people expectations or not and…I would say…my biggest stressor…is that I worry that I’m not doing to do a good job. And that…I’m not meeting people’s expectations.

P4 further explained that currently, “as a new leader,” the feeling of being totally out of one’s element is always there. “I felt out of place…and like I was masquerading as this person [in charge].” P4 added the following comment:

After 11 months [since accepting this new role], I can still walk into a meeting and still feel a little bit like I’m the outsider, [like] I’m not for real. I’m just place holding. And I don't like that…It’s this feeling of being out of control. It’s the feeling of not having mastery….That I’m always seeking new experience, yet I seem to hate new experiences.
Similar to P4 who described “masquerading as a person,” P9 also described feeling like a fraud:

Oh, I felt very nervous….I also felt like a fraud sometimes. I didn't really know what I was doing…part of the time I felt very excited that I got to learn a bunch of new stuff and work with different people…so I think part of my nervousness was being able to interpret the clinical information and then make the appropriate sort of administrative decision based on that…so I think sometimes I feel like I’m a fish out of water….So I feel a great sense of responsibility to do things correctly and appropriately for our county.

P6 described the move from peer to management as being “no fun”:

It’s terrible. I mean, it’s no fun. I mean…you’re managing people who previously you experienced as co-workers. And not just co-workers but as professional peers…now you are the screen that they play their movies on…you know management roles…in that…you really just are…at least in part, you simply act as a focal point…for people to have their needs met one way or the other.

P6 further explained why leaders should not stay in these senior positions permanently:

Well I think that [this is]…one of the reasons why these jobs are not permanent long-term positions. I mean…because at a certain point you do the usual things that you think you can do…you make the mileage you think you can make, and then you know you [should] get out before you find yourself not being useful. I mean…I fully intend to leave on a good day, not on a bad day. And I have seen enough people in this organization leave on bad days…but I don’t remotely think that I will finish my career here in this role.

Two participants spoke about falling back on their strengths and past experiences.

P5 had fears and anxiety but decided to focus on the strengths of past experiences:

I had some fears…there was some anxiety because I was getting into an environment that I had not worked before….But then, I also thought about, ok…you know, the strengths that I have, I can always apply those no matter what the setting is….So that helped me to kind of…stay focused…one thing that I would constantly remind myself was to do the right thing. You know, if you’re doing the right thing, in the right way, there are few chances that I could go wrong.
P8 described being “nervous, more nervous than any other management position” and recognized that “if you have good human-relation skills and communication, you will learn more and people will want to teach you...if you have that in place.”

The study’s participants revealed the range of emotions and feelings they experienced during the initial transition periods of their current jobs. All nine participants articulated their experiences using words such as “anxiety,” “fear,” “scary,” “stressfulness,” “uncertainty,” and “worry” as well as “excitement” and “rewarding.” Two participants indicated feeling like a “fraud” or masquerading in their position, and others were concerned about whether they were meeting the expectations of others.

**Lessons learned.** Participants described a wide array of lessons learned. Among these were modeling the behavior one wants to see in their staff rather than backstabbing other leaders, understanding that breaking down silos by encouraging collaboration goes a long way, and the importance of transparent and objective decision-making processes. P5 described learning to “look at others as who they are, not what I want them to be...and to accept them with their strengths and weaknesses and work with them and their strengths and weaknesses.” P5 also made the following comment:

[It is] not so much as to how I want, but as to what they can do rather than what I want them to do...I can accomplish more if I choose that perspective rather than me asking them to do what I want them to do.

P6 discussed the need to bring people inside the circle rather than “drawing a line in the sand” and added the following statement:

You can’t get too far in front of people. If you really want to make successful change, instead of drawing a line in the sand, you have to draw a circle in the sand and get everybody in that circle, and then have them all decide that they want to move two steps to the right...Yeah, you know, I’ve learned that the hard way. And it’s been a valuable lesson. And so now what I have had to learn to do is
tolerate a state of kind of distance, long enough to be able to get other people to see the same distance state as I and have them be willing to move.

P7 spoke about the need to understand the big picture in his role and being a leader:

My honest truth of this position is it’s too broad to cover everything effectively…So it was interesting to realize that my, what I thought was my main thing is not the main thing for everybody else….And trying to figure out how you fit into that model…you know, [it’s] a little bit of an ego hit sometimes. [So] I have my own pity parties in this office.

So it’s basic functions, [as] I see it…I’ve been tasked with the job to stop [and] scan the entire horizon of what’s going on, at least within my leadership area. Instead of getting caught up in the to-do and the functions of the moment, to look at the totality of what we are doing and say…“Are we going in the right direction? What do we need to change, you know? What do we need to get rid of? What do we need to add?” And looking at those strategic movements…that can get lost when you’re buried in the day-to-day work, the operational work that can bog you down.

P1 (the new external hire) encountered an environment of negative behaviors from her peers in senior-level leadership:

Seek first to understand….Steve Covey speaks a lot about thinking first and understanding, and… I believe that… that is key…that trust is a big thing in leadership. Identifying those you can trust [is important]. I’ve had a couple of incidences that happened….I was really appalled because I have high respect for you [people] when you say you’re a leader and the level of your leadership [position]….I [have] seen a lot of…for a lack of terms…backstabbing…gossiping going on amongst higher level leaders which shouldn’t be happening. They should be setting the example for those that are following in their [footsteps in that] position…modeling the [good] behavior. It is so important for us as leaders to model the behavior that we expect of others and stand true to those [behaviors]. Don’t just talk about it and give it lip service…actually eat, drink, sleep, and breathe it and believe in it because that’s what it takes to make change in an organization to be successful.

P3 shared lessons learned regarding collaboration, silos, and decision making:

One thing that’s important is building some organizational depth for change improvement….So, you know, trying, working with multidisciplinary groups is much more effective than working within silos…the physician organizational structure is one silo, but very little can get accomplished just working within that silo….you know, with behavioral health integration work that I’ve done, we’ve
gotten much more progress by collaborating with the behavioral health division in building relationships and working collaboratively rather than trying to work solely within the ambulatory-care silo.

I have [also] learned to understand my reflex decision-making tendencies and to try and bounce questions off of other people before making decisions…and try to understand my biases….Also, understanding when certain decisions are not my call to make…that they would need to be a joint decision or better made as a joint decision….Yeah, and I think also making [decisions] more transparent [and] the decision-making process…you know, having an open discussion about how decisions will be made. And who will make them.

Finally, the study’s participants expressed the importance of not being afraid of asking questions, the need to learn new things, and not being afraid of not knowing everything. P5 explained in the following way:

And if I didn’t know anything, I did not assume. I went and actually looked and asked people who knew about it. I was not afraid to say I don’t know. I was not afraid to learn….I wasn’t threatened by not knowing everything. As people may expect that “Oh, you are the chief nursing officer, you should know everything,” And that was not the case. I didn’t know everything; I still don’t know everything. But I do know one thing….I do know who to go to, to look for answers. So, that’s very comforting, because in this work environment I think we have lot of support and tolerance for that kind of learning.

The theme just discussed highlighted a few of the lessons learned by the participants during the course of their transitions. They spoke about the following topics: the importance of asking questions, breaking down silos, institutional structures isolating groups of individuals, decision making, understanding the big picture, and drawing circles in the sand rather than a line in the sand when negotiating group decision making.

**Meaning of being a leader.** This sub-theme provides broad views of the participants’ thoughts on the “meaning of a leader.” The following excerpts are descriptive responses from five of the participants. P3 described the meaning of a leader
as being a role model, one who listens to the frontline as well as “empowering other leaders,” and made the following additional comment of the topic:

I mean, it’s several things; one is…definite leading by example and…setting an example for behavior…[for] respecting other employees, trying to follow the mission of the organization….Some of it is trying to enable and empower other leaders in the organization….Some of it’s listening to the frontline staff, trying to understand what their needs are, trying to help them get their work done….So as a leader I’m not so much doing the work, but I’m helping create the environment where the frontline staff can be successful and, you know, meet the mission and serve the patients. So part of my job is kind of removing obstacles.

Similarly, P1 described the meaning of being a leader as empowering one’s staff:

You know, being positive, being creative, being nurturing. You know, empowering others is what means being a leader to me. It’s not about me. It’s about those that I’m trying to lead and how I am going to bring them to the standards and empower them to be greater than what they are.

P4 explained, “I really do subscribe to being the kind of leader who is a coach and a mentor and participatory leadership….I want to develop people…I am not a top down leader. It isn’t my style…it never has been my style….I’m very much an influencer.” P5 saw a leader as one who can also “follow….Being a good listener was also very important as well as being humble.” P9 gained a new perspective on what it means to be a leader:

I guess I used to think that being a leader was getting stuff done and accomplishing things. And I think that’s still part of it, but…now I feel more like it’s incumbent upon me to set the tone and…put the structure in place, and then other people will get things done. So in some ways a vision, but also all the resources available for people to sort of implement that vision or make it concrete for them. That’s sort of how I see being a leader now.

Overall, this sub-theme revealed that the participants saw being a leader as taking care of the organization’s employees, listening to them, respecting their views and
knowledge, and empowering them by removing barriers and giving them the tools and skills to be successful.

**Challenges of the organization.** The final sub-theme that emerged from the first-time leader perception theme was the challenges of the organization. For the purpose of this theme, it is important to note that seven of the nine participants were employed in non-profit organizations and two were employed in for-profit organizations. The following paragraphs present the participants’ descriptions of the organizational challenges that impacted their abilities to lead their organizations.

Two participants who worked for for-profit health care systems had very little to say about their challenges in their organizations. P1 (a new outside hire) mentioned challenges in relation to knowing and learning the operation of the system, “Challenges become very strong because people put you to the test to see [if you are] really able to do the job.” P7 was not worried about a budget or schedules, because someone else did that job, but was worried about the challenge of ensuring the employees did not become burned out with constant pressures to maintain high quality performance and profit:

> We understand we need to adjust and that we have a costly structure, and to protect that we’re going to have to do things at incredible efficiency and quality…with every change there’s difficulty. And it, it can lead to, uh, worker burnout.

> What I see as my focal role right now…is working very hard; so, while my CEO would tell you we gotta be more efficient, we gotta be higher quality, we’ve got to continue to do these things, as he presses and presses and presses. In terms of getting those [things done], um, I see my role in that is, is really working on the wellbeing of the people within the system. What is their personal health, what is their personal wellness? Where’s their stress level? Where’s their burnout? So, if I understand my leadership role, I would say I gotta be focusing on that because my CEO is not. He knows it’s important, but it’s not a good area. He doesn’t have wellness. He’s a CEO.
The seven participants who worked for non-profit health care organizations presented a different picture of their systems and challenges. Here are a few of their responses. P2 described two major challenges—labor and a highly educated and articulate piece of the workforce—driving the agenda:

You know, just working in such a highly represented environment…it’s difficult…[because] labor itself is the challenge, it’s the challenge of working within labor while coupled to a government bureaucracy…getting things done in a timely manner…creates a huge challenge for us…because we can’t really be a responsive system…because…we just can’t get things done timely. I think for the most part our workforce is pretty incredible…. [However], we have a highly educated piece [of the workforce], small though, a small percentage…[that is a] very highly educated and skilled piece and [an] articulate piece of the workforce that tend to basically drive the entire agenda.

P3 expressed challenges in relation to hiring, lack of competitive pay, and budget control:

Definitely workforce challenges, the access issues, um, trying to get enough, you know, primary care capacity. So a lot of that involves hiring more staff and the challenges of hiring primary care physicians when our pay scales are not competitive. [There are] some challenges around, um, just organizational change….You know, the other…challenge is the lack of transparent budgeting and lack of local budget control.

A couple of the participants cited lack of control with the human resources processes and the inability to make necessary changes. P4 said, “It’s personnel…it’s the personnel system I think maybe the number one….And the number two is probably just the unpredictability of some of the aspects of my job. There’s…a lot of parts to this job that I cannot control.” P5 shared the difficulties of not “having the full authority or control to manage and…make changes…simple things like…make changes to a job description” without going through “several layers of complexity.” In addition, P5 made the following statement:
Our hiring is [also] very complex and time consuming. You know, we can’t hire at the time we need to hire and we can’t hire fast enough. It’s a long drawn process….And in that we lose a lot of good candidates because they don’t wait for us and our system to work for them for weeks and months. So they go elsewhere, so you end up losing really good candidates to other systems and that’s really frustrating.

There were others participants who spoke about “personnel issues [that] occupies no less than 30%” of their jobs and about the challenges of a public health non-profit system. P9 shared the challenges of a public health non-profit system by explaining that some of what they do is “intangible” and “hard to articulate…because we don’t bill for our services particularly,” and “we’re just losing people because we don’t pay enough….Our human resources system here at the county is very difficult and cumbersome and not helpful.” The overwhelming majority of the participants’ challenges focused on the hiring and the human resources processes that resulted in their inability to manage and lead their organizations.

**Summary: Theme Two.**

In Theme 2, four sub-themes emerged. In the first sub-theme—feelings of strengths and inadequacy—the participants revealed their inner feelings about themselves. Their descriptive responses, such as “I needed a mentor because there was no operator’s manual like when you buy a car,” were very telling.”

The second sub-theme—lessons learned—emerged because the participants realized discoveries and errors made while leading and managing their subordinates. Such events provided them with a deeper understanding of the people they led and the colleagues with whom they worked. The eye-opening issues ranged from backstabbing in the senior-level ranks, to transparency while making decisions, to the importance of
collaborating versus maintaining or creating silos, to the realization that it is okay to not know everything. The third sub-theme—meaning of being a leader—showed that participants saw being a leader as taking care of the organization’s employees, listening to them, respecting their views and knowledge, empowering them by removing barriers, and giving them the tools and skills they needed to be successful.

Finally, the last sub-theme that emerged from this theme was the challenges of the organizations. The two participants in the for-profit health care organizations revealed much less of a challenge than the non-profit health care organizations. The participants employed by non-profit organizations focused on issues pertaining to human resources’ lengthy, cumbersome processes for hiring new staff and the inability to compete with other large organizations due to low salaries.

**Theme Three: Health Care Systems Structures**

Theme 3 emerged because the participants offered clear descriptions of the various components of the health care systems, shedding light on their work environments. The four sub-themes offered insight into the working environments of these first-time senior-level leaders and insight into their organizational infrastructures clearly shaping the daily operational activities of the organization and staff interactions. The sub-themes are (a) description of systems, (b) hierarchy within systems, (c) revenue and delivery of care in complex systems, and (d) technology’s impact on systems.

**Description of systems.** This sub-theme emerged from the participants’ descriptive explanations of the various components of their systems and their operating activities. The descriptive explanations provided a mental picture of the different organizational structures found within health care organizations and systems. The
organizations described by the participants are part of two different systems—“for-profit” and “non-profit.” As stated earlier, seven of the nine participants in this study were employees of the same “non-profit” system: six were in the same organization and one was in another organization of the same system. The remaining two participants were in the same “for-profit” system but in different organizations.

P2, one of the six participants in the same organization, identified and described the multiple interacting operating entities within a non-profit organization:

The public hospital, consisting of one small…166-bed hospital, [also has] eight clinics; [the] hospital does 12,000 discharges a year….The clinics do about 450,000 outpatient visits a year. We also have five jails. The county-jail system we run health in…that’s about 26,000 inmates a year, go through there…we do sort of basic health in the jail…and our system is really kind of a community hospital: general medical, surgical, health system. We do not do transplants, we do not do complex chemotherapy, bariatric surgery…we don’t have a burn unit….We do common things uncommonly well. We do primary care, we have a residency program, um, and one of the top residency programs…family medicine program [for physicians] in the United States. We have lots of students…Teaching is part of our mission. We have, you know, student nurses and student therapists…different kinds, respiratory therapy and radiology…those sort of students….A primary piece of our work force is our medical staff…that regularly and pretty much universally moves between outpatient and inpatient care, and the support staff are pretty much stationed wherever they are. So if you are an inpatient [hospital] nurse…you don’t generally rotate to the clinics. And if you’re an outpatient registration clerk, you pretty much…are working in outpatient your whole career. But the physician staff move between both inpatient and outpatient. As does some of the other support staff like IT…so it…lends for a really rich, I think, work experience for the staff…and a complicated experience requires a complicated support structure, to support that kind of complex activity. Particularly within our physician staff but also within the other…ranks.

Three other participants employed by the same organization described by P2 added a little more to the description of the organization:

[It is a]…fairly complex organization. Though not huge, it’s big in the sense that we have both hospital and ambulatory care. And the ambulatory-care system is
very spread out. It is a teaching hospital but we only have residency for the physicians—family practice physicians—and not for nurses. (P4)

P9 worked in the same non-profit system but in another organization—a public health organization. The organization, however, touches every organization in the county—public or private. P9 made the following statement:

So the Communicable Disease Program Chief position that I’m in oversees, um, sort of core public health programs. So...I oversee the tuberculosis program [and] disease investigation, [which is] any sort of disease outbreak or ongoing disease investigation—that’s part of my...purview...the public health lab, which is part of, sort of getting diseases under control...the health emergency response programs...federal statistics...and some epidemiology programs. So, it’s some core public health functions. And we serve the whole county and all of those programs serve the whole county...and many of them have to respond to outbreaks or incidents that happen sort of on a regular or not regular basis. It depends...we have a call rotation schedule. So...the Health Officer is the legal person that’s supposed to respond or has the authority to make some decisions and respond. And we have delegated powers under the California law to make decisions about closing restaurants or closing schools or putting people in isolation or quarantine and so [on]. We have some delegated legal authority. So I think that’s actually a part of the reason why I wanted the public-health division to do some strategic planning, because we relate to our hospital and ambulatory care here at the county. But we also relate to all the other healthcare systems.

Finally, P1 and P7 were employed in a large for-profit system but in different organizations. These two participants described their organizations from different points of view. P1’s point of view was from a general administrative side, and P7’s description comes from only the physicians’ side of the organization. P1 spoke about management and union connection:

[My organization is]...very, very complex...[and] very unionized. It is labor and managed by partnerships and has several different entities in it, and when you have all these different entities working with the one another there are so many different things and knowledge levels you need to know in order to [function].
P7 described the physician side of a large for-profit system (the state/facility’s names have been changed):

Let me give you the break down. So I…technically work for a medical group. The Medical Group…is all of the physicians which work in Eastern Utah Facilities. There’s a Southern Utah medical group that’s all the Southern Utah doctors. There’s a Colorado group, there’s a North West group which is Oregon and Washington. There’s a Hawaii group. There’s also a group in the mid-Atlantic state which is really the Baltimore, Northern Virginia area around DC….So we have…these different groups and different leaders….I work for the medical group here. And then Northern Utah [is] broken down into, I believe, 18 service areas. So, in any service area there’s a physician in charge who oversees all the business of that service area. Yes, so currently what I would tell you is this: we feel like we’re on top of the healthcare world. In other words, if you look at our system and our model efficiency and being able to preventatively care for patients, we think it’s top notch. Most of the rankings say we’re at the top. And yet…if you want to go business wise in Eastern Utah, we own about 43% of all healthcare in Eastern Utah. And we [are] a gorilla in this area.

The study’s participants described their organizations within two different systems and provided insight through a sketch of the interworking aspects of their various work environments. Such descriptions indicate an integrated network of operating units, processes, interactions, and people.

**Hierarchy within the system.** This sub-theme emerged because it shed light on the organizational reporting and functional structures influencing personal and operational relationships, processes, and outcomes in their organizations and systems. Participants’ roles were integral parts of the organizational chart and very much influenced by a hierarchical structure within their various health care systems. This sub-theme provides data on the participants’ perceptions of the dynamics related to hierarchy in their systems. P2’s descriptive response of the activities in a hierarchical structure provided an interesting point of view:
Oh, well I think it’s one big power grab, you know; everybody’s grabbing for power. Everybody’s clambering to hold onto power and nobody, nobody’s willing to distribute, redistribute any power to the patients or the people we serve….But I think these power grabs cause a lot of complexity. We have, you know, some very formidable groups within our system that use a variety of tactics to basically own and drive the agenda. And…it’s a distraction from what really needs to get done, but that’s the way it’s been, you know…these [power grabs] are just…passed on generation to generation, and so I think it’s slowly changing, but it’s still, you know, there.

I also think that there’s a lot of…this sort of overarching sense of drama in the system because…you do deal with life and death things….The other thing is, in this culture, in this environment, is…a system that is built with highly educated, highly skilled people who are very, very articulate…in a variety of perspectives and all of which are right. And so I think it’s…very complicated because the whole thing is like a series…it’s just…more often than not…you are working in the gray zone. It isn’t clear cut…it’s a lot of very smart people working in many cases in a non-precise arena. You know some areas are very precise, and we have very solid…systems…but there’s a lot of gray zone in the system, which requires a lot of thinking and dialogue and it makes it quite complicated…because…perspectives vary…from person to person.

P3 described an unclear organizational chart that did not provide clear lines and directions regarding a reporting structure and functional activities:

The org structure was a little unclear. Who reported to whom? So…the first few months were a little bit challenging in trying to figure out exactly what my roles and expectations, job duties, were. You know, who reported to me, who reported to others?…It’s a very flat leadership organization, and by that I mean that there are many leaders who have great areas of responsibility and large numbers of people reporting to them.

I got about 300 direct reports, because every physician who works in primary care reports directly to me; now that’s not, you know, in some ways that’s not true, because they do have their department heads and their division heads to report to, but because they aren’t technically management, they really can’t do a lot of the personnel type of issues and things, so a lot of those things come directly to me…and other people in the organization are similar [and] have a lot of, kind of, direct reports.

Division heads and department heads are elected positions, so that makes it sort of challenging for them to evaluate people who are electing them, you know. So there’s sort of pressure if somebody really is invested in keeping that position to not necessarily give bad evaluations to their staff who are going to be voting for them…and there’s less accountability that way, to really…make sure these people are doing thorough evaluations, not just checking boxes.
P6 brought attention to the many reporting departments, the complex activities of the organization, and the influences of the unions:

Well, in this organization, the scope of the CMO’s job is broad but shallow….I’m theoretically responsible for managing the contracts and employed physicians. I have some role in overseeing quality, but it’s not explicit…my direct reports include pharmacy, cardiopulmonary, diagnostic imaging, the CMIO which is the Chief for Medical Informatics….The ambulatory medical director reports to me, psychiatric medical director, and the jail medical director. I’m sure there are things I’ve left out.

I think…[the system is] complex because we don’t have to compete. Which I think is wrong. So we survive…people have called it…we live on blood money and I think that there’s a truth to that….I think that makes it very complex. There’s no bottom line.

[In addition], the influence of the unions, I think, is unfortunate. In that they have too much influence at the level of the board. And the patients aren’t heard at all…people use the patients as proxy for whatever they want. So I wouldn’t say that I’ve become jaded. I would say that I’ve become more schooled in the reality of self-interest.

P7 spoke about the many role activities of a physician leader and the confusion of the roles:

You go inside the medical group and…we’ve got physicians and assistant physicians in charge of about six or seven different functions. Whether it be HR or quality or access, we got these different things that are work-a-rounds…and we may come together in a unified goal or we may not…basically…the role can get, particularly my role, gets much more confusing because I actually straddle both the medical group and then I work with my marketing component, which is…another part of this. So I’m straddling across; a lot of leaders in our positions are working only with the physicians in the physician groups….I’ve gotta kind of cross the lines a little bit which makes you get…into their leadership structure a little bit. Without having any say or leverage within it…that can add to it. The thing that makes…every piece…dance effectively with good top-end leadership.

The remaining participants were very broad in their explanations of their organizational hierarchy. One participant said there was a lot of “person-dependent” jobs “rather than system or process dependent….If that person happens to be on vacation, then you have to wait for that person to come back for…[work] to move forward.” Other
participants thought their system was a complex environment because of an elected board “who’s first and foremost business was elected politics.” It appears that the reporting infrastructure in health care organizations and systems can be somewhat confusing and unclear, leading some to not understand their roles and responsibilities or where they fit into the organization’s operating structure.

**Revenue and delivery of care in complex systems.** In this sub-theme, the participants presented their thoughts and perceptions regarding the realities of current health care delivery and revenue sources in their organizations and systems; this sub-theme emerged because it describes another piece of a health care system critical to its operations, budget, and patient care. Six of the seven participants employed in the non-profit hospital organizations gave similar descriptions and impressions of their delivery systems and revenue sources, while the one participant (P9) employed in a public health (non-profit) system provided a different view.

Only one (P7) of the two participants employed in a for-profit system provided a response describing their care delivery and revenue sources. The following excerpts provide the participants’ thoughts and insights about the two systems regarding the dilemmas of care delivery and revenue reimbursements. P2 described their delivery of care and revenue, speaking first about delivery of care:

The most difficult is…the variation, or lack of reliability in the actual service delivery. That’s the most challenging….Yes, so, for instance, if somebody arrives with chest pain in the Emergency Department, I don’t, you know… I can’t tell you with 100% [certainty] that they are going to get aspirin within 10 minutes…and it’s hard to do all…it’s hard to deliver evidence-based care. I mean, the biggest challenge to us is, I think, delivering safe, evidence-based care every time.

We serve a very small commercial population…we serve employees mostly…we have a health plan and then a large portion of Medicaid—or in California, Medical—population which is…[a] needs-based program…mostly for
underinsured folks….And then we have uninsured. We are a public hospital, so we are considered the safety net for the community in healthcare….We exist within the context of a very highly employed, highly bedded community in our county.

P2 continued with a description on revenue resources for this non-profit organization:

I think the payment system is perverse and complex and we pay really for volume and not…necessarily value. And I think that the whole rewards system, even in terms of reputation…breaks down to who can invest the most in…marketing. I don’t know how much performance actually matters….I think we’ve, you know, we are moving into a time where we’re going to reduce beds in the United States. Reduce inpatient beds and focus more on community health and healthcare and…we’re in the midst of insurance reform. But we still haven’t really done delivery-system reform.

P3 shared thoughts and views on the delivery of care services and its incentives as well as the revenue sources—current payment model of fee-services and the new model of value-based services:

Incentive, more care, and expensive care…uncoordinated care…it still emphasizes hospital care and procedural-based care and it still doesn’t prioritize preventative care and primary care. It is starting to change…but…you know, I think we still have a very expensive, poorly coordinated system, and there’s a lot of excessive care given…while some of the most important care isn’t delivered. Until we get away from this fee-for-service model, that’s going to continue, but we are starting to move away from that.

[Regarding revenue], you know, many hospitals are focused on filling up their beds, and that’s a clear organizational goal. Whereas the goal really should be [to] keep the patients out of the hospital…because we have a small hospital and because our overflow goes to the health plan [of] other hospitals we contract with and so the hospital is really a cost and not a revenue generator. Our incentives are aligned for keeping patients out of the hospital. But it’s still been a challenge…we should be able to make the business case and generate the resources to do things that keep people out of the hospital, that aren’t directly revenue generating. Hopefully…we’ll have more data to be able to actually support the cost savings of those types of efforts.

I think healthcare reform, in the short term, should help our bottom line by just having us have more reimbursements for the patients we’re already taking care of….It’s unclear, in the long term, whether we’ll have a big influx of new patients, whether we’ll be additional competition for our patients, which actually could be a good thing. It may help us be more responsive…if we’re facing a
more competitive market place…we don’t want to keep…sort of taking our patients for granted.

P9’s point of view about health care delivery and revenue sources came from the non-profit public-health side of the equation:

So we have relationships with all the healthcare partners in the county because we give guidance around vaccines or we manage TB patients, regardless of where they go. So we’ve been interested in how…public health fits into healthcare reform, in particular, when all these delivery system changes are happening…How does public health both support those changes to serve the community better and also to increase the health and better the health of the whole population? So that’s probably why we want to do some strategic planning from the public-health division. So…I don’t think we can do public health; no one can do public health without a lot of partners.

[Regarding revenue]…I think that just in terms of the budget, communicable-disease controls, there are some…funding from the state and some funding from the federal government. But a lot of it relies on county funding. And it’s a core, its people expect public health to respond if there’s an outbreak or to provide vaccines if there’s a pandemic. But our core daily operations, people don’t see very often. So some of it’s very intangible—what we do—and it’s hard to articulate….And people may not understand the services that we’re providing to the whole county….So I think there are some issues, or some challenges, in terms of articulating what our work is versus where the funding comes from because we don’t bill for our services particularly. So…I think those are some challenges.

P7 spoke about what “excellent service looks like,” how some care was currently being delivered, and their financial-revenue risk.

My CEOs talking about… this is gotta be excellent service and here’s what excellent service looks like…the patient can call and get the appointment on the phone the first time and they can get it in the time frame that they wanted it….Are we offering them a video visit, are we offering them a telephone visit? Are we doing these kinds of things?

[Regarding revenue]…actual insurance packages sell them and we have foundation health which provides the capital and the hospital and all….We just had to make the decision to give up our Medicare Advantage plan that was actually offered to about 8,000 members. Now it called Pre-paid Care, 65 plus. It is a place of revenue for us. We actually do very, very well in this market.

We all run big risks; for the first time, I think our group runs financial risk because reduced revenue coming in is going to be…we’ve already established
what our cost is. We know what we’re paying our people and we know how we operated in the past. If we want to maintain our same level of security in employment, income, and retirement, we’re going to have to become even more efficient than we already are. And we kind of built ourselves for 50 plus years on that model. So the question becomes, “How much can we…squeeze out of this system? Is there enough, inefficiency, even in our system that we can survive this?”

In this sub-theme, participants presented very different scenarios and explanations regarding health care delivery and revenue sources, but it is clear that reimbursement and delivery are phenomena experienced by all these first-time leaders in their various health care organizations and systems. The participants appeared to be very aware that the need for change in care-delivery services is here and the revenue-source reimbursements will depend on carefully thought-out strategies allowing for quality care at the best cost for the patient.

**Technology impact on systems.** In this sub-theme, the participants identified their various technologies and some of the problems they encountered in implementation. This sub-theme emerged because technology is an extremely important aspect of health care systems today in both providing care and in administrative decision making and operations. Technology, as expressed by these participants, plays an important role in health care delivery and daily operations. They acknowledged that technology is only a tool helping optimize care for patients. P6 said, “Ultimately it’s just a tool. You know, whether it’s the CT scanner or a way of organizing information…it doesn’t change the disease.” All the participants thought technology was a great addition to health care, even with some of the difficulties in implementation. P7 embraced the new technology in their organization and system and proudly described some of the basic technologies being utilized:
[Our] new technologies…[include] updated webpages for the physicians…[and] smartphone apps. I’m thinking of the most common things we’re doing now, online programs…you know…health programs that…[patients] can be involved with. Using the online.org system and video visits, twitter, I mean; so all sorts of new technologies.

P8 recognized the opportunities of technology while cautioning health care organizational leaders about the effects of not having a well thought-out plan for implementation of new equipment or processes:

[Examples of technology issues] are operational things and hardware issues like electronic medical-record data. I actually see those as opportunities. I actually like it and endorse it and want to have new equipment come in. Because I think it actually prepares us and it’ll be necessarily a good thing for us and it will be more state of the art. Everybody has learning curves but if I were to ask the same group of nurses if you would want to go back to paper and we’d been on this 18 months and they would say no. Although five, six months into it, they would say absolutely it was the wrong decision.

We had many problems, you know…any problems…You know, 20/20 if you had to look back and do things differently, it would probably behoove the institution…[to do it] incrementally, not go all out at once. And that was disrespectful for the patients as well as our staff. And so I think we could have put a little bit more thought into that. A lot more thought before we did that, and learn from others. I get the intention was good, again, to start. But it was, in many ways, we could have put people in harm’s way. And to this day, we’re still optimizing; we’re still not there yet. And, that I do know, I truly believe, I think it is better for healthcare then having to rely on paper charts and snail mail.

Like the previous two participants, P2 conveyed respect and an appreciation for technology and what it can do to help accommodate the needs of staff:

I love technology….Well, I mean, I think we’ve introduced technology into our system…and…I just think, you know, we have introduced it in terms of the product we deliver in the healthcare…part of it, but we are about to introduce…payroll technology and scheduling technology, and I think it’s causing a lot of anxiety but I think it’s…overdue. We haven’t had technology to support our infrastructure….We’ve relied on people and it’s been a big lift for people to do, and I think the technology is pretty promising. Though…I recognize how hard it is to implement the technology and particularly one that can mess with people’s time and money.
You know, I think that technology, medical advances in technology, is incredible....I think we are in a wait-and-see change right now, and I think it’s going to be very different 20 years from now. But I don’t think it’s going to change overnight like people think. I mean, I think it’s been changing for, like, the last 10 years, and I think it’s going to continue to change for another, like, 15 years, in big ways.

The participants in this study recognized the importance of technology and the impact it currently has and will have on services, patients, and health care professionals at all levels and all specialties in their organizations and systems. A very important point was made by one participant regarding “disrespect for patients and staff” when implementing new technology, suggesting that people are and will be the means for making the leap to a new reality of the health care industry; therefore, it is critical and essential that leaders of organizations strongly consider the stress and safety of patients when implementing technology.

**Summary: Theme Three**

In this primary theme, four sub-themes provided findings about the participants’ systems—non-profit and for-profit. The sub-themes were (a) description of systems, (b) hierarchy within systems, (c) revenue and delivery of care in complex systems, and (d) technology’s impact on systems. The participants provided descriptions of their systems, thus allowing insight into their operations and a broader understanding of the various components making up their systems. In terms of hierarchy within the system, participants explained the lack of clarity in their reporting structure, blurred lines in the functional roles, especially with physicians, and the influences of unions on organizational boards.
Regarding revenue source and delivery of care in complex systems, participants were very aware of revenue-source challenges in their systems, particularly the participants in the non-profit organization, as well as the need for changes in care delivery to patients. Technology, according to the participants, allows for opportunities to optimize patient care. One participant explained technology should be seen only as a tool, “Ultimately, it’s just a tool…it doesn’t change the disease.” Finally, new technology should be introduced to staff incrementally, not all at once.

**Theme Four: Leader and Leadership Development**

Theme 4 emerged because it revealed the participants’ experiences in relation to their past preparations for their new roles and their recommendations for others desiring to take the same career path. While no participant spoke of receiving orientation to their current job, they also indicated they had no formal structured executive training, coaching, or mentoring before accepting their current job. However, since accepting their current jobs, they acknowledged they have attended leadership conferences, some organizational leadership training, and one indicated a 12-month Executive-leader Fellowship. Three sub-themes emerged from Theme 4: (a) the need for mentoring, coaching, and structured orientation; (b) professional-development practices in health care organizations; and (c) preparing aspiring leaders in health care organizations.

**Need for mentoring and coaching.** This sub-theme emerged because the participants saw mentoring and coaching as integral components of leader and leadership development. Since none of the participants acknowledged receiving formal mentoring or coaching, an overwhelming majority of the participants supported the idea of formal
mentoring and coaching. However, some participants acknowledged receiving informal mentoring.

P5 said, “From my experience, it is very important to have someone mentor you...someone you relate with...someone who you trust...respect...and admire...it’s a two-way street.” P3’s response identified the benefits of mentoring and coaching in relation to succession planning and institutional memory loss:

Then, I think, doing more formal mentoring, you know, identifying, having people identify clear mentors...and then I think doing more succession planning that clearly, trying to talk about the succession, trying to identify people to take over roles and advance...somebody leaves a role and then their replacement is found months later after that person [is] totally in a different role or totally left the organization. You lose a lot of institutional memory, and it’s sort of a very haphazard transition that way.

P8 explained how mentoring could be accomplished:

I would really suggest...not only a formal educated, as best you can, training but also a mentor that you’re able to shadow or be with for...a minimum of a year...lot of it I think it needs to be determined on who may be the...best fit. Because you assess their personality, how they work well, and you pair them up with what I think...would be best for that person....I think that at least a one year mentorship for new leaders that come on, both formal and informal. And have established meetings, even if it’s for 15 minutes or 10 minutes every other week...or, at least in the beginning, every week.

P5 provided an example of how coaching was currently attained with nurse managers in their organization:

Um, you know, I meet with them from the coaching perspective. I spend time with them going over, you know, what the leaders [should] look like, act like, and, and, um, the role modeling of a leader. Um, I spend time...meeting [with them], not just, uh, about the work they do every day but also what would help them grow as leaders.
P6’s response was funny but serious:

Oh, I think it’s, I think…[mentoring and coaching are] really important. I think it’s something we lack. I would love to have a closet in my room where a coach hides and then popped out every time after I had a conversation and said, “Well you know this is what I heard, what was it that you were trying to communicate? Because this is what you actually communicated.” I mean, I really do think that we don’t have an infrastructure of management learning. I just don’t think we do. I think [my boss] would benefit from it; I think I would benefit from it. And I certainly think the people who will sit in these roles next would benefit from it.

Finally, P2 spoke first about the lack of orientation experience and then about how lucky she was to have received informal mentoring and how important it was to her:

I didn’t get…[orientation] at all…you know, I took over from a departing boss who basically left instantaneously. So [he] really didn’t tell me anything…I didn’t get an orientation…my [current] boss has tried really hard to…[be] very available and open to me, but unfortunately [he] didn’t run the operations…. [He] worked at a higher level than me…more [on] the policy level, but I didn’t really have anybody to orient me to operations, the budget, and finances….I had to find my own way.

I did get very lucky, um, in that I came across, you know, some people…that really mentored me and sort of took the time to be really, um, honest with me and kind of stuck with me through the years and have remained, you know, very honest….I think it’s essential you have, um, people…in your life, no matter… what your end aim was, that, that are very, very honest with you…and so I’ve been lucky to have that…luckily I was open to that, because I don’t think…during my whole life I have always been open to…receiving feedback, but I was.

All nine participants indicated they did not have formal mentoring or coaching as they grew in their careers but acknowledged there was some form of informal mentoring or coaching. The participants said they received little to no orientation or transition time to their new positions. The participants seemed to agree that mentoring, coaching, and even orientation were needed components in the transition to new senior-level health care leader roles.
Improving professional-development practices. This sub-theme captures the views of the participants regarding what development practices they would use to transition general skilled leaders in middle-management positions into first-time senior-level leaders roles. An overwhelming majority of the participants were in favor of formal structured programs. P4 was adamant about developing a fellowship:

A leadership fellowship…that’s what I’m seeking. That’s what I would like. I want something that couples real experience. I don’t think you can sit down and get this out of a book or out of a lecture or out of an exercise. You have to…it has to be lived…you have to do that trial and error thing. But to have a cohort of people going through the same thing together…who periodically come together and share experiences with someone very experienced who can offer experience, knowledge, advice, [and] so forth. That’s a great combination of a way to move through this novice period.

Instead of a fellowship, P7 wanted formal mentoring and coaching programs:

I think…I’m more of the mindset you have to set things formally. You have to do formal mentoring and coaching, coaching, thank you. I think you have to set it up formally because there’s also this mindset of, “Oh, you’re asking for mentoring and coaching” or, “You’re not a very effective leader…You should have naturally known this.” I mean, again, it goes back to this idea of…you should have just known how to suck it up and deal with it. And so I think being a little bit more formal on setting the time aside because I felt the more times I went to my, my compatriots who had been doing this a little longer, I was bothering them, taking them away. I was invading their need for that time. And yet, it’s critical.

P3 thought “Sending potential new leaders to formal training, conferences, and things about, you know, management and leadership skills and change” would be beneficial. P1 was interested in developing a professional plan. P1 said, “Develop a plan…maybe do a self-assessment, [find out] what are your strengths and weaknesses.”

[Do] communication…personality-trait analysis. And definitely having a mentorship program and debriefing. I think, whereas a debriefing, it’s a safe zone because trust is so important as a leader. When you’re coming into a new organization, I know when I came into this one I didn’t know who I could trust or talk to. (P1)
The responses in this sub-theme provided the participants’ thoughts on what they viewed as the best formal training options for those aspiring to be senior leaders and current new senior health care leaders. The participants in this study based their suggestions for training programs on their past experiences and what might have been beneficial to them during their initial transitions. The participants’ overall goals were to encourage structured transitional training more accommodating to first-time senior-level leaders’ needs.

**Preparing aspiring leaders in health care organizations.** The participants indicated that leader and leadership development was either “critically important” or “very important” to their organizations. P9 mentioned there was “a lack of leader training in public health” organizations and that there should be institutionalized training. P8 said that leader and leadership development should be “a marriage…they needed to go hand in hand with each other.” P5 explained the need for leader and leadership development in the following way:

Oh, it’s very important….I think it’s important that any organization should have [good] leaders because you do want people who are going to remove barriers and challenges, who are going to listen to…[employees], who are going to be their eyes and ears and, and take their…situations and help them problem solve. Leaders can really do a whole lot of harm and they can do a whole lot of …benefit. And…I think it’s important for any organization to know that…leaders are not leaders by title. You know, you could be a director or administrator, but that does not necessarily make you a leader. You know, you can be a leader working in another department, you know, under someone else, and that boss that you report to…that boss is not necessarily a leader but may be your boss. But I think it’s important to cultivate the culture in an organization where people see themselves and act like a leader.
P2 provided other important thoughts on developing future leaders:

I think it’s very important. It’s the future of the organization. I think developing future leaders from everywhere…within the organization is critical. The other thing I think is important is being open to inviting other leaders from the outside in because they have important knowledge that, you know, we may not have…because, you know, the experiences they bring. But I think…it’s very important, I think…as a leader it’s probably the most important thing that I do. You know…developing tomorrow’s leaders and the succession plan for the organization is something [that] kind of has to…be happening all the time. And there has to be kind of a pipeline with a variety of levels going on all the time. And so I don’t think it’s something you should sort of leave to chance…You have to actually do it.

P3 also thought having leader and leadership development programs at all levels was important because it would allow interested staff to receive leader training, which would help empower and encourage staff to become leaders.

Well, I think if there was a more formal structure for leadership training…I think it would empower employees because people would see they’ve got more options for career paths…that leadership, that could be a potential career path for them…and [they] may feel less sort of stuck in their current role.

Finally, the participants offered many personal suggestions for first-time senior-level health care leaders. P7 suggested, “Get a formal introduction to your team…instead of flying by the seat of your pants.” P2 said, “Create a panel of friends [outside of your organization] in similar positions…bounce things off of them.” Four of the participants spoke of the importance of having a mentor, which was well expressed in P5’s statement, “[It is] very important to have someone mentor you…someone you can trust.” P6 advised, “Learn how to make business decisions…be politically astute.” P1’s final message to first-time senior-level health care leader was expressed in the following comment:
I would get involved in an [outside] organization where there are new leaders...keep people [friends] in your inner circle...that help empower you but also are able to tell you when, you know, you could have done [something] a little bit better....[They might say], “Let me share with you how you could have done that.” [And finally], always look for opportunities to do better but also be kind to yourself. When you do a good job, say, you know, “I did a good job.” Don’t look for the immediate feedback from others but give that feedback to yourself.

In this sub-theme, the participants focused on organization-wide leader training and the importance and benefits of developing leaders on all levels of the organization.

**Summary: Theme Four**

Theme 4 had three sub-themes offering reflections from the nine participants. The sub-theme emerged because the participants’ past experiences regarding the lack of senior-level experiences before entering their new roles afforded them the awareness to see and know the value of being prepared with the necessary skills upon accepting a senior-leader role.

The *need for mentoring and coaching* was positively supported by the participants. The participants indicated having a mentor, somebody you could trust and talk to off the record, was important to achieving success in your job and career. Having a coach to help you around speed bumps and to help you understand operations and the organization’s politics was just as valuable.

In *improving professional development practices*, the participants agreed there should be formal structured programs in health care organizations offering various approaches for transitioning middle managers into senior-level positions.

In *preparing aspiring senior level leaders in health care organization*, the participants indicated it was critical to have leader and leadership development. In addition, the participants thought having leader and leadership development programs for
all staff and at all levels of the organization was a way to empower employees and also a way to provide leader opportunities. Finally, in this theme the participants provided suggestions to aspiring first-time senior-level leaders on how to survive their transition period. They recommended the following: get an outside panel of friends in similar positions to bounce things off of, get a mentor and coach, look for opportunities to do better, and be kind to yourself.

**Results and Interpretations**

This section of Chapter 4 presents the findings that emerged from the themes in the study and an interpretation of each finding. The 16 sub-themes brought forth the rich descriptions that held the essence of the lived experiences of the nine participants who identified themselves as first-time senior-level health care leaders. Four major findings emerged from the 16 sub-themes:

1. First-time senior-level health care leaders experienced daily personal feelings of inadequacy in their new roles.

2. Multiple departments operations and requirements within one system required leadership accountability.

3. Organizational challenges for senior-level leaders in non-profit bureaucratic health care organizations are particularly discouraging and problematic.

4. Individuals in middle-management positions who aspire to or are promoted to senior-level leader roles in health care organizations would benefit from a mentoring and succession planning approach.

See Figure 4 for a visual representation of the four findings. The significance and interpretations of these findings are described with reference to the literature reviewed in
Chapter 2. Such interpretations formed the foundation of the recommendations presented in Chapter 5.

Figure 4. Visual representation of major findings.

**Finding One:** First-time senior-level health care leaders experienced daily personal feelings of inadequacy in their new roles.

Participants described their new experiences in their current roles as scary, terrible, stressful, and unpredictable and described their feelings of nervousness, anxiety, uncertainty, and being out of control. The 21st-century health care industry is in a state of transformation. Health care leaders are faced with a multitude of changes within their organizations and from the outside. To meet patients’ expectations and federal, state, and local requirements, these leaders must be able to “respond appropriately to the demand for change” (Porter-O’Grady & Malloch, 2011, p. 11). As stated in Chapter 1, one can
imagine the demands and stresses on newly promoted first-time senior-level health care leaders. First-time senior-level leaders have been placed in powerful and critical positions during uncertain times and in the rapidly changing context of health care.

Knowing this information, it is not difficult to envision and understand the participants’ fears and worries. However, one wonders why these individuals accepted these jobs knowing the stress and demands. This research is in line with Dye’s (2010) thoughts on value-driven leadership. Dye suggested values play a major role in behaviors or thoughts of leaders. Dye further explained that “values are ingrained” (p. 19), “formed early in life” (p. 19), and are what helps individuals deal with difficult and unexpected situations. Dye also added that the values acquired in early childhood usually develop and deepen with life experiences over the years, creating small change. Goleman, Boyatzis, and McKee (2002) suggested leaders with strong self-awareness have a brain makeup of a “hierarchy of emotionally toned thoughts” (p. 41) including “guiding values” (p. 41). Guiding values provide strength and direction, allowing leaders to decide whether or not a goal is appealing. Although values could be good or bad, they play a part in motivation (Dye, 2010). As identified in this study, the participants’ parental values played a major role in influencing and shaping their lives and careers; therefore, it can be assumed that these parental values also played a part in their motivations. Such a finding aligns with the explanations of Dye (2010) and Goleman et al. (2002) regarding values.

The participants in this study described their motivations as a strong desire to help people, connect with and empower people, and help facilitate needed positive changes. Even though these first-time senior-level health care leaders were passionately motivated,
their experiences in these senior administrative roles have been more challenging than they could have assumed. As revealed in their responses, these first-time senior-level leaders’ experiences have been a daily series of unpredictable events occurring out of the blue and often without warning. These unpredictable job events have created various degrees of chaos, confusion, and uncertainty in the lives of each participant. They described their experiences in their new roles as “scary,” “terrible,” “stressful,” and “unpredictable,” and their feelings as “nervous,” “anxious,” “masquerading,” “out of control,” “fraud,” and sometimes “exciting.” The participants’ descriptions of their inner feelings were supported by Porter-O’Grady and Malloch’s (2011) interpretations of the emotional risk found in leadership. They postulated that new leaders who lack feedback from their superiors, receive inconsistent feedback, or feel insecure in their job are likely to feel stress, lack or loss of personal confidence and passion, and negative emotional uncertainty. Porter-O’Grady and Malloch wrote that these emotional feelings are experienced on a daily basis by these leaders and cannot be eliminated but can be managed through developing emotional competence.

Another important point was that two of the female participants spoke about feelings of “masquerading as a person” or “feeling like a fraud sometimes.” Such feelings are supported by Clance and Imes (1978) who suggested these feelings are more often seen in high achieving women than in men. High achieving women may see themselves as impostors even though they have achieved success. The phenomenon is called the Imposter Syndrome. The interpretation of the findings from the two participants’ responses can lead one to believe these two female participants can possibly be identified as having the Impostor Syndrome.
Apparently these participants’ work life in health care organizations and systems presents constant daily challenges, which seem to be due to many demands, expectations, and obligations and to a rapidly changing external environment. One of the participants made the point that these senior-level positions are stressful and demanding and should not be permanent long-term positions. At some point, the participant explained, you do all you can do and then you become ineffective. The participant added that they knew they would not finish their career in this role. Other participants were trying to decide how long to remain in their current roles.

With the above information known, health care boards and human resources directors should be concerned. There is currently a shortage of experienced senior executive health care leaders. In 2014, the American College of Healthcare Executives released information indicating the overall CEO turnover rate had risen from 17% in 2012 to 20% in 2013. It would seem that working with these individuals and giving them tools and consistent feedback would probably help decrease costs for organizations in the long run.

Although the individuals in this study provided evidence of reasons for leaving these positions—including feelings of inadequacy, uncertainty, and fear—they continued to move forward with their work as leaders. Such behavior supports Porter-O’Grady and Malloch’s (2011) observation that this kind of leader finds a calling within themselves giving them the continuous persistence, courage, and drive to seek answers to difficult questions for themselves and those they lead. It is highly likely that the leader’s calling concept and values concept are linked or interrelated and provide a possible motive or
explanation for these first-time health care leaders taking on senior-level stressful and
demanding jobs.

**Finding Two**: *Multiple operations and requirements of multiple departments make up one system requiring multilevel leadership accountability.*

The participants were leaders of large health care systems with multiple
departments. Finding 2 is very important because it allows for deeper insight into the
organizations’ infrastructures and provides an in-depth understanding of the activities of
health care systems and the interactions of the multiple parts from within the systems.
The descriptions and activities of the health care organizations of today, as presented by
the participants, are supported by the literature. Dye (2010) explained that health care
systems were just structures 40 years ago. Today they include freestanding hospitals,
private doctors’ offices, nursing homes, mental asylums, and local pharmacies. Dye
further noted that health care organizations have combined and grown into large complex
systems resembling businesses and have created complex and unpredictable
environments. In addition, Porter-O’Grady and Malloch’s (2011) observations of the
multidepartment organizations and their activities were also in line with the participants’
organization descriptions. Porter-O’Grady and Malloch suggested such a system (such as
in the health care industry) is not mechanical but is more biological, allowing for fluidity
and flexibility between boundaries or integration between services. Again, this
description is in line with participants’ descriptions of how their organizations operated.
Porter-O’Grady and Malloch also noted that all health care leaders and managers are
accountable and responsible for the many departments (which are really mini systems)
within a system and are expected to keep “tightness” between each department. Such an
explanation and the next two observational statements by Porter-O’Grady and Malloch again validate those statements presented by the participants. Leaders must be both aware of and have an understanding of the connections, actions, and interactions of each department while ensuring clear communication. At the same time, they must focus on the safety of the patients who are the center of the whole system.

In the next statements is a description example of a health care organization shared by one of the participants. The organization was a public non-profit organization composed of a 166-bed hospital including a laboratory for public health and hospital, radiology, physical therapy, pharmacy, dietary, surgical operations, emergency, perinatal, medical, surgical, nursing, inpatient mental health, environmental services, admission/registration, communication center, volunteers, facilities maintenance, biomedical, and staff education departments. The organization discharged 12,000 inpatients per year. In addition to being a teaching and training organization of physicians (the top family-practice-training program in the U.S.), nurses, and other allied students, there are also eight ambulatory care centers (clinics) visited by an average of 450,000 outpatients per year. The organization bore the full medical/nursing responsibility for five jails with 26,000 inmates. Finally, this organization was also a hierarchical organization employing about 1,800 to 2,000 employees at any given time of the year and requiring multiple levels of leaders and managers.

**Finding Three: Organizational challenges for senior-level leaders in non-profit bureaucratic health care organizations are particularly discouraging and problematic.**

Seven of the participants were employed in non-profit systems producing many discouraging and problematic challenges. Finding 3 emerged because six of the nine
participants working in a non-profit organization spoke about the many challenges causing a major impact on their ability to create a knowledgeable and experienced workforce. Since an overwhelming majority of the participants were in the same health care system, this highly important finding is unique and is attributed to this one non-profit health care system. The challenge most often spoken of was the incredibly lengthy, complicated, difficult, and cumbersome human resource (HR) processes for hiring and making changes in position requirements within their system. They described the hiring process as taking up to three months to complete with an end result, most of the time, of losing the hire to another health care organization. In addition to the above challenges, the participants working in non-profit organizations faced barriers to recruiting in critical shortage professions, primarily due to inferior salary levels. The wage disparity for the physicians was felt to be of particular concern.

Finding 3 seems to indicate there is a strategic misalignment between the system and HR. While this is an important finding, the literature does speak specifically to the issues of lengthy HR recruitment and hiring procedures. Therefore, this finding seems to indicate a gap in the literature and requires further research. However, the literature is clear about the shortage of health care professionals, especially physicians and nurses, and the changes in the makeup of the health care workforce regarding ethnicity and multiple generations. Derkensen and Whelan (2009) found that by 2020 there will be a shortage of over 200,000 physicians and one million nurses. Derkensen and Whelan further suggested that in a complex workforce like health care, various professions in the workforce directly influence cost and quality of health care. Karoly and Panis (2004) and Derkensen and Whelan also noted that in the next 10 to 15 years, the U.S. workforce
would be shaped by demographic trends, technological advances, and economic globalization.

Participants working for this non-profit organization described their challenges in relation to their workforce and it is particularly concerning. If attention is not given and action is not taken to correct their current HR issues, the difficulty of building a competent workforce is probably on course to be a major organizational challenge of the future. With the prediction of workforce changes in health care, these leaders will have the battle of their life trying to recruit and hire in a timely manner. Clearly, the challenges compounding the non-profit leaders’ abilities to provide a competent workforce currently and in the future will have a direct impact on their expectations for the future of their organizations.

**Finding Four: Individuals in middle-management positions who aspire to or are promoted to senior-level leader roles in health care organizations would benefit from mentoring programs or succession-planning approaches.**

All participants indicated they had no formal mentoring, structured leader training, or orientation to their new role. Finding 4 is perhaps the most important finding as it entails preparing middle managers to take on new roles as first-time senior-level health care leaders leading complex organizations. It was apparent that the first-time senior-level leaders in this study all believed their transitions to their new roles could have been made easier (versus stressful) if they had received formal leader training, mentoring, coaching, and orientation. An overwhelming majority of the participants in this study came from middle-management positions (per demographic data) with background experiences and degrees in their professional specialty areas. In this case, the participants’ demographics also indicated they were licensed nurses and physicians,
except for one whose background was in women’s studies and public health immunization coordination.

All the participants indicated there was no previous executive-leader training leading up to the acceptance of their new positions nor did they have any orientation to their new roles after accepting their positions. A majority said they were put in their positions and left to fend for themselves. One participant described it as, “Tag, you’re it.” Looking deeper at the participants’ responses regarding the lack of formal leader preparation and job orientation, the most likely conclusion is that the current board and senior executive leadership of their organizations had not made leader- and leadership-development programs a priority. Competing priorities was likely the reason for the lack of development programs.

Today, a number of health care organizations are beginning to develop leadership programs for their new leaders of the future. At the time of this study’s interviews, all participants indicated they had not received leadership training from their organizations before taking their new roles; however, one participant mentioned that a program began at their organization 2 years after the acceptance of his new role. In addition another participant indicated starting in a leadership program one year after accepting the new role at their organization. In terms of leadership-development programs, this finding indicates these participants’ experiences are in line with the literature as it relates to training. In a study regarding executive leadership development in U. S. health systems, McAlearney (2008a) found that of the 104 health systems surveyed, 52% reported having an executive leadership-development program, 88% linked their program to the organization’s strategic goals, 73% customized their program to the needs of the
participants, 86% utilized executive coaches, and the majority indicated the program was worth the investment. Currently, literature indicates many competency models and leader and leadership training programs are available that could be modified or used in their current form. Redman (2006) suggested hands-on learning opportunities, coaching, and mentoring are strong essentials for leadership development even if there are no formalized training programs. Such a suggestion is in agreement with Lee and Herring (2009), who pointed out that such a program will be seen as creditable if it is supported, articulated, or sponsored by senior executive leadership, regardless of whether a leader development program is formal or informal. Such support sends a message to employees that internal leader development is valued and important. Without senior commitment, these programs are not likely to be seen as creditable.

As stated above, the participants believed formal leadership programs along with mentoring and coaching would have assisted them in their transitions. Also, the participants said some feedback and verification as to whether they were meeting expectations in their jobs would have helped. While a majority of the participants thought formal mentoring and coaching were most important, a few participants acknowledged they had received some valuable informal mentoring along the way in their career. However, when listening to their interviews and watching their faces during their interviews as they spoke about the assistance they needed, it seemed these participants would have been happy to receive guidance in any form in their initial days of their new jobs. They sought out help from leaders outside the organization who were in similar positions, joined leader groups, and asked to attend leadership conferences. One thing stood out about these leaders: they were aware of their strengths and weakness.
The participants made suggestions about what they would like to see in leadership programs for first-time senior-level leaders. They would like to see formal leader programs started early, including meeting with a mentor for at least 12 months. Shadowing and observing teams, followed by discussions and reflections, was also considered as well as a combination of real life and classroom training. All these suggestions are supported by the literature. Redman (2006) and Melum (2002) strongly suggested targeting individuals early in their careers and working with them to provide exposure to leadership and development processes.

Finally, there were three physicians in this study who were first-time senior-level leaders. Their backgrounds were predominately clinical and their past leader experiences were primarily related to patient care. McAlearney et al. (2005) suggested that physicians are trained to be autonomous decision makers and not administrative managers. These participants spoke of being ambivalent about giving up patient care and physician teaching and admitted feeling bad when they could not see all of their patients on a regular basis. The physician first-time senior-level leaders in this study were currently managing a panel of patients in addition to leading and managing departments and teaching faculty. Conversely, nurse participants’ time was solely devoted to administration. In a study conducted on physician leadership development, McAlearney et al. found that leader development training for physicians aided in bridging the gap between the clinical and administrative sides of the organization, thus producing physicians with combined perspectives. With this information in mind, it is reasonable to assume first-time physician leaders are in need of special development attention when it comes to administrative leadership. The experiences of the physicians in this study
validate the need for some formal structured leadership training and mentoring prior to transitioning to a senior role.

**Summary**

Chapter 4 presented four primary themes and 16 sub-themes revealed from verbatim interviews of the nine study participants. The four primary themes were (a) career path, (b) first-time leader perception, (c) health care systems, and (d) leader and leadership development. Drawing from these themes, four findings were produced. Although there were many findings considered important, the following four findings were chosen to best display the lived experience of the study’s participants:

1. First-time senior-level health care leaders experienced daily personal feelings of inadequacy in their new roles.

2. Multiple operations and requirements of multiple departments make up one system requiring multilevel leadership accountability.

3. Organizational challenges for senior-level leaders in non-profit bureaucratic health care organizations are particularly discouraging and problematic.

4. Individuals in middle-management positions who aspire to or are promoted to senior-level leader roles in health care organizations would benefit from mentoring programs or succession planning approaches.

With the four findings secured, interpretations of each finding were discussed and supported by related literature. The findings and interpretations laid the foundation for answering the research questions in the Conclusions and Recommendations sections of Chapter 5.
Chapter 5: Conclusions and Recommendations

**Introduction**

The journey of this study began with the researcher’s desire to know more about the lived experiences of first-time senior-level leaders in critical leadership roles in health care organizations. Health care organizations are experiencing a shortage of skilled and experienced leaders at senior levels of the organization. These leaders’ responsibilities are multifaceted and critical to their organizations’ need for meeting regulatory and budgetary requirements as well as managing patient and staff satisfaction and safety. The size of the organization also plays a major role in the equation of skills and experiences needed for their roles. According to the participants’ descriptions, most of these organizations are large, complex, complicated, and demanding.

The purpose of this study was to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who have worked 6 months to 4 years in their first senior-level leader role in a health care organization or system. There is a gap in existing literature regarding such leaders and their initial experiences in senior-level positions. This qualitative research study adhered to the protocol found in a phenomenological design. The interviews, observations/field notes (see Appendix D), and artifacts allowed nine participants (novice health care leaders) to reveal their personal experiences as they lived the phenomenon being studied. The captured data were analyzed, coded, and categorized into four primary themes and 16 sub-themes; four findings resulted: (a) first-time senior-level health care leaders experienced daily personal feelings of inadequacy in their new roles, (b) multiple
operations and requirements of multiple departments make up one system requiring multilevel leadership accountability, (c) organizational challenges for senior-level leaders in non-profit bureaucratic health care organizations are particularly discouraging and problematic, (d) individuals in middle-management positions who aspire to or are promoted to senior-level leader roles in health care organizations would benefit from mentoring programs and succession planning approaches.

This study sought to answer the following three research questions:

1. What are the lived experiences of novice health care leaders promoted or hired into critical leadership roles for the first time?
2. How do these participants describe the challenges they faced and the leadership lessons they learned that influence their current actions in these roles?
3. What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?

Conclusions

First-time senior-level health care leaders who lack senior-level experience are being hired and promoted to replace experienced health care leaders leaving positions as CEOs, CNOs, and other higher level roles for retirement or because of the heavy demands and stressful expectations of the role. These replacements are stepping in at a time when the health care industry is at the height of uncertainty, morale is low for health care workers in general, and costs are rising as reimbursement decreases.

This research was an exploration into the described journeys of relatively new senior-level health care leaders both before and after accepting these roles. This study is important because it allowed those who experienced this phenomenon to provide insight
and understanding of the critical training and support needs essential to novice health care leaders transitioning to higher leader roles. On the following pages, conclusions in response to the research questions are detailed and recommendations offered.

**Research Question One: What are the lived experiences of novice health care leaders promoted or hired into a critical leadership role for the first time?**

The participants were forthright with responses, at times sharing confidential life issues and eye-opening events that critically impacted their careers and personal lives. Their motivations for taking these jobs without having the necessary skills, experiences, and competencies of more experienced senior-level leaders were very noble. However, the tough realities of new roles that included complex political situations, everyday navigation through the system, and weighty critical decisions brought about an awareness of the intense in-depth nature of their jobs. Having this awareness led to initial uncertainty and created feelings of insecurity, anxiety, and fear—fear that a wrong decision may negatively impact their organization’s operations or cause staff to lose their jobs or patients to lose their lives. Every day, as they performed the duties of executive leadership, they simultaneously experienced these and other daunting concerns. Without vital emotional support and feedback, an organization may run the risk of losing these individuals, possibly triggering an exodus of others in critical leadership roles.

Knowing that each of their multiple departments are equally important, novice health care leaders are understandably in need of guidance and support to navigate many interconnecting networks and pathways in their areas of responsibility. In addition to understanding the complexities of multiple departments and outside entities, the novice
leader is expected to analyze vast amounts of incoming information and formulate plans for the benefit of the organization as a whole.

Several participants spoke of the size and breadth of their organizations as well of their responsibility for the many operating parts under their purviews. They were concerned about their inability to stay in control of the many events occurring in their various departments. One participant spoke about the shooting death of a patient that occurred in one of the participant’s many departments the very first day on the job. The incident was so unexpected and devastating for the participant as well as staff who had not had an opportunity to interact with each other before the incident. The tragic incident in a department with which the participant was not familiar required complex administrative logistics and coordination of internal and external departments, as well as attention to the staff’s emotional state. Such a devastating event is one of many serious dynamic occurrences that first-time senior-level health care leaders are experiencing when leading health care organizations. Such occurrences surely add to their feelings of fear, anxiety, and uncertainty.

How did these participants find the inner strengths to continue in these fast-paced demanding roles? Some of the participants indicated they found strength in the challenges while others looked for guidance and support from outside their organizations. Still others made conscious efforts to form alliances with other newly promoted leaders within their organizations and created stronger connections and collaborations with their frontline staff.
Research Question Two: How do these participants describe the challenges they faced and the leadership lessons they learned that influence their current actions in these roles?

In terms of challenges and lessons learned, most of the participants were focused on one particular challenge occupying most of their time: human resources (HR) issues. The participants in this study shared their frustration with hiring barriers restricting their ability to hire in a timely manner, with some recruitments taking up to three months to complete. The novice leaders have been trying to manage in a system of restrictive, antiquated guidelines and policies that lead to ambiguity and may no longer be effective in health care today. Along with hiring barriers, delays, and recruitment, a majority of participants also faced loss of institutional knowledge due to retirements as well as resignations due to the lack of competitive salaries. To be successful at their jobs, novice senior leaders need assistance from the Board of Supervisors and higher health care administrators to overcome the above mentioned challenges.

A related conclusion regarding lessons learned was that the array of initial experiences provided them a broader and in-depth understanding of the big picture of their jobs. They stated they gained new skills allowing them to communicate and collaborate with other entities, both internal and external to their areas of responsibility, in order to tear down silos. They learned to involve and include their managers and frontline staff when making decisions critical to their departments and the organization. Most importantly, they indicated they learned to ask questions and not be afraid of not knowing everything, which is an important lesson.
Research Question Three: What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?

The chaos of the initial 2 years of the participants’ transitions could have been a little bit more tempered if appropriate training had been provided. They entered their positions without prior executive training or experience and with minimal knowledge and understanding of the extent and depth of their new roles. In addition, there was no structured orientation offered nor was there time to become familiar with the daily operation of the organization at the senior level. In the absence of a structured orientation, each of the participants found their way through a maze of policies, external regulations, budget cuts, unfriendly and unsupportive peers, angry unions, political navigations, the mysteries of HR, and the ever-changing unexpected daily activities of complex organizations. As one participant explained, no “operation manual” comes with this role.

Recalling their initial transition experiences, the participants agreed leader development was critical to the success of new novice health care leaders and their organizations. In support of professional development, they stressed the importance of novice senior leaders needing to find a mentor and a coach immediately upon entering their new positions. In addition, they recommended up-and-coming leaders enroll in executive leadership training or become part of a “leadership fellowship” (as one participant put it) offering group discussions with “a cohort of people going through the same thing together” and “coupled [with] real experience.” They cautioned novice leaders to stay alert and constantly research the issues and topics that are presented to broaden and inform personal knowledge. In addition to the above advice, the participants
advised that new first-time senior leaders develop a positive relationship with their employees—know your own personal boundaries, show humility, be respectful, be accountable, be open, and be a critical listener.

**Recommendations**

This study focused on the health care industry and the critical need to recognize and begin structured development plans for future senior-level health care leaders in health care organizations before these individuals reach these critical roles. These recommendations are strong suggestions for (a) boards and higher level administrators and (b) aspiring and current first-time senior-level leaders. Recommendations are also offered for further research.

**Recommendations for Boards and Higher Level Administrators**

These recommendations are for boards and higher level administrators who select and promote new first-time health care leaders. With the growing and changing health care industry, there are currently individuals assuming senior-level roles without the necessary training. It has become essential that health care organization boards and higher level administrators recognize the lack of executive skills and experience of novice leaders and provide the necessary training and development needed to support these leaders if they are to move successfully through their transitions.

- Boards and higher level administrators need to create, lead, and support leader and leadership development programs that have a combination of classroom, challenging project, and work experiences to prepare potential managers for senior-level leader roles.
To decrease the stress and anxiety of the role transition, novice health care leaders would benefit from having assigned coaches who provide consistent feedback and emotional support during the initial year of transition. Create and implement formal mentoring programs but encourage mentoring, whether formal or informal.

- Provide structured orientation for first-time senior-level leaders in new roles.
- Encourage novice-leader attendance at various leadership conferences outside the organization that allow for developing different points of view through conversation with colleagues at other institutions.
- For future training and support, bring back or retain retirees who possess the tacit knowledge and hands-on skills in the senior and executive leadership roles to provide assistance in leader and leadership training.

**Recommendations for Aspiring and Current First-Time Senior-Level Leaders**

Aspiring and current first-time senior-level health care leaders must be their own advocate and take the responsibility for creating their own journey to their desired position. The participants in this study were risk takers and highly motivated to empower people and make a difference in their organizations. The commitment to become an effective and successful health care leader must begin from within oneself. Self-exploration is required, which involves examining your own internal motives, confronting personal conflicts and fears, being accountable, and always treating others with respect. Finally, when ready, embrace future challenges, recognize and acknowledge mistakes or failures, and turn mistakes into positive outcomes. The
following points are in line with the advice shared by the study’s participants’ suggested recommendations of actions for preparation:

- It is important to find a person or leader inside or outside your organization whom you trust and respect; these kinds of support leaders are called mentors.
- Make others aware of your career dreams and volunteer for department and organizational projects as well as committees to build relationships and get a better understanding of the organization’s operations.
- Ask to meet senior leaders and ask for a day of shadowing different senior leaders to get a big picture view from their perspective of the organization.
- Always seek opportunities to gain new knowledge, both professional and personal; this may include getting advanced degrees and certificates as well as leader development programs, conferences, and workshops.
- When moving to a new role or position, advocate for a structured orientation (including expectations) along with a coach or someone assigned as a go-to person; then ask for regular feedback and be open to change.
- Give back to your community and organization by assisting in the motivation of others and sharing of knowledge and experience.

**Recommendations for Future Research**

The following are recommendations for future research:

- Repeat this study with a larger number of participants from across the country to validate the findings and gain a broader understanding of the experiences and developmental needs of first-time health care leaders.
Conduct a quantitative study to gain a broader understanding of the experiences of first-time senior-level health care leaders.

**Overall Summary**

The answers to the research questions provided evidence leading to major conclusions indicating the first-time senior-level leaders experienced anxiety, fear, and uncertainty during their initial crucial 2 years of transitioning, which caused extreme insecurity. Upon entry into their new roles, these leaders could have benefitted tremendously from an organized transition including an initial structured orientation with an assigned peer partner. In addition, an on-going structured leader development program as well as a structured mentoring and coaching program could have provided further stability.

The health care industry is changing and evolving day-by-day and no one is really sure where the industry will end up. However, it is known that health care organizations and systems are in need of many competent and savvy leaders prepared to guide the health care industry and its many changing components through this ongoing transformation. The organizations will need to include a structured leader development program that will help prepare new leaders for leadership at senior and executive levels of a health care organization and system.

The nine first-time senior-level leaders in this study were participants and leaders in the current health care industry transformations. It will be their turn to build a talent pipeline of ready leaders by providing essential leader development for their organizations to succeed in this era. The participants in this study have true grit with a strong desire to make a difference in their organizations in spite of their mistakes,
failures, challenges, and achievements. They assumed they could do it; assume you can do it:

A powerful first step in getting anything done is to assume you can do it. When you start by assuming you can do it, you don’t have to fight your doubts all the way there.

Even if you don’t know how to take the first step, assume that there’s a way. Assume you can do it, and you’ll find that way.

You are extremely good at solving difficult problems because you’ve done it all your life. You are very good at making things happen when you have a good enough reason to do so.

So make sure your objective is what you really, truly desire, and make the assumption that you can indeed reach it. With a meaningful purpose and a positive perspective, you’re already well on your way.

Instead of complaining that it’s too difficult or complicated or unfair, just get busy. Work under the powerful assumption that it’s possible for you, and it will be.

Dare to dream and dare to believe without a doubt that you can reach your dreams. Assume you can, and eventually, with effort and commitment, you will. (Marston, 2014, entire post)
List of References


Appendix A: Letter of Invitation

October XX, 2013
Dear ____________.

My name is Olivia Y. Stringer and I am a doctoral candidate pursuing an Ed.D. in Educational Leadership and Management at Drexel University, Sacramento under the supervision of Dr. Kathy Geller, Principal Investigator and dissertation Supervising Professor. This study is being conducted as part of the dissertation requirement for my doctoral degree. I am writing to invite you to participate in a research study on the experiences of first-time senior-level health care leaders. The title of my dissertation is: Exploring the Experiences of First-time Health Care Leaders in Critical Leadership Roles: A Phenomenological Study. The purpose of this study is to explore and describe the lived experiences, challenges, concerns, and perceptions of first-time senior-level health care leaders who have worked 6 months to 4 years in their first senior-level health care leader role in a health care organization or system.

If you choose to participate, participation will consist of a single 45-90 minute face-to-face interview that will be recorded. In addition, I will request to review publications, curriculum vitae, letters, and awards relating to your journey to your current position and experiences since your acceptance. Interviews will likely be conducted in October and November. I will be available to meet with you at your convenience and at a location of your choosing.

Participation in this study is completely voluntary; all participants will remain anonymous (identified only by a pseudonym). You are free to withdraw from the study at any time without consequence. There are no known risks and/or discomforts associated with this study.

If you have any questions, I would be happy to talk to you in more detail. I can be reached at [redacted] or by email at [redacted]. You may also contact the Principal Investigator: Kathy Geller, Ph.D., Drexel University (Sacramento Campus), School of Education, (916) 213- 2790 Kdg39@drexel.edu

Thank you for your time. I look forward to your response.

Sincerely,
Olivia Y. Stringer
Co-investigator
Doctoral Candidate
Ed.D. in Educational Leadership and Management
Drexel University, School of Education
(707) 678-8763 or (707) 332-9558
[redacted]
Appendix B: Interview Protocol/Semi-Structured Questions

Time of Interview:

Date:

Location:

Interviewer: Olivia Y. Stringer

Participant #:

Position Title of Participant:

Introductory Statement:

The purpose of this research is to study the lived experiences of first-time health care leaders in their everyday roles as senior-level health leaders. I would like to gain insight and knowledge about the impact and influences of the various challenges on your ability to lead. The data collected will come exclusively from recorded interview sessions with you, the participants. This interview is expected to last between 45-90 minutes.

Confidentiality is important. Your name as an interviewee will be replaced with a fictitious name (pseudonym) to maintain confidentiality. All data collected will be maintained in a secure locked cabinet at Drexel University, Sacramento.

As a requirement of this research project, I must have your stated consent to participate in this study. I would like to remind you that you can withdraw from the study at any time. At this time, I am inviting you to ask me any unanswered questions and when your questions are answered, provide me with your verbal consent. I want to thank you for your participation.

I will now turn on the recording devices and begin recording.
Background and Demographics Information:

1. Current position title:
   ______________________________________________________

2. Internal or external candidate for your current position?

3. What was your position title before accepting your current position?
   ______________

4. Age when hired or promoted into your current position:
   _________________________

5. Gender: Male____ or Female____

6. Education:
   - Bachelor’s Degree(s) in ____________, ____________,
     ____________________
   - Master’s Degree(s) in ____________, ____________,
     ____________________
   - Doctoral Degree(s) in ____________, ____________,
     ____________________
   - Professional Degree(s) in______________________,
     ____________________

7. Number of years at your current organization: ____. Organizational leadership-development program: yes/no

8. Number of years in management:
   _________________________

9. Number of years in health care:
10. Did you receive any of the following in prep for your current position:

- Formal structured leadership training_______
- Worked with superior before accepting current position______
- Coaching______ Mentoring______

Semi-Structured Interview Questions:

**Research Question 1:** What are the lived experiences of novice health care leaders promoted or hired into critical leadership roles for the first time?

- To understand your path to your current position, please describe your family, childhood, and community?
  - Probe: How did these life components influence you?

- How do you describe your career path leading up to your current position?
  - Probe: Did you have a coach or mentor?

- What motivated you to accept your first senior-level leader role?

- What is it like being in a senior-level leader role for the first time (goals, excitement, concerns, fears, stresses, achievements)?

- How would you describe your initial orientation to your new leader role?

- What does being a leader mean to you?

**Research Question 2:** How do these participants describe the challenges they faced and the leadership lessons they learned that influence their current actions in these roles?

- How would describe your health care organization or system in terms of its
complexity (dynamics and interactions)?

- What are your most difficult organizational challenges besides budgets (workforce, technology, regulations, and others)?

- What are your thoughts on the current state of health care?

- What are some of the leadership lessons learned since accepting your current position (influences on actions)?

**Research Question 3**: What professional development efforts might offer a needed foundation for the initial success of other novices promoted into similar positions?

- What professional development efforts would you advise for aspiring first-time senior level leaders?

- How important is leader and leadership development to your organization?

- Explain how leader/leadership development programs would engage your employees or not.

- How important is practical hands-on learning, coaching, and mentoring in leader development?
Appendix C: Phenomenological Research Process
Appendix D: Field Journal Document

Descriptive Notes

Reflective Notes

Diagram of Room

Shelf

Chair (Participant)  Chair (Researcher)

Desk