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National Center for Healthcare Leadership Competency Model Use in a Midwestern Healthcare Organization

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This is to certify that the doctoral study by

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

The purpose of this study was to explore senior leaders integration of the National Center for Healthcare Leadership (NCHL) competency model within their employee evaluation system. This case study was conducted to explore how the NCHL leadership competency model is used within their organization's employee evaluation system. The NCHL leadership competency model guided this study. The research was an exploration of themes in leadership competencies used in the healthcare organization. Data collection included in-depth interviews with 10 healthcare junior leaders in a single healthcare organization in the Midwestern United States who had at least 1 year of experience as a leader and a review of secondary data related to their job skills and annual evaluations. Using Saldana's method of data analysis, 4 primary themes emerged: leaders are transformed by vision and focus, leaders need continuous training, leaders like accountability, and leaders like influence goal creation. The 4 themes indicated that participants perceived NCHL leadership competencies integrated in their performance evaluation system to be of benefit. The findings revealed senior leaders might benefit from integrating the NCHL competency model in new leader orientation competencies, leadership training, and performance assessment tools. Positive social change may result by successful implementation of the NCHL leadership competency model strategies from this study, improving societal healthcare through efficient healthcare delivery.

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Dedication

I dedicate this research to my family and friends, especially… to my Mom and John for instilling the importance of hard work and higher education; to my father who left us too soon; to Jo for always being there to support me and listen; to Nana for her encouragement and prayers; to my Aunts for their understanding and suggestions; to my close friends who are always there to get me going me when I am tired; and most of all, to my beautiful daughter Jasmine for opening my eyes to what truly is most important in this world. Your unconditional love, patience, and energy motivate me to achieve the impossible. My life has been blessed with your presence, and I am eager to watch you continue to flourish. Follow your heart, and reach for the stars!

Jesus In Me Loves You

Acknowledgments

The printed pages of this research study hold far more than the culmination of years of study and experience in the healthcare field. These pages also reflect the relationships with many generous and inspiring people I have met along my journey. I would like to acknowledge the guidance of the Walden Faculty, in particular Dr. Ann Claesson and Dr. Neil Mathur, for their guidance despite the many obstacles and challenges I faced. Most of all, I acknowledge my daughter and family for always being there to encourage me through the program.

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Section 1: Foundation of the Study

The National Center for Healthcare Leadership (NCHL, 2011) has made efforts to advocate for the adoption of evidence-based best practices of healthcare leaders to advance their leadership skills and development. Healthcare leaders are aware of the challenges they face to implement the best practices in daily operations (NCHL, 2011). The NCHL leadership survey, conducted in 2011, raised awareness of leadership best practices for hospitals and healthcare systems, allowing for benchmarking with their own organization the use of the best practices (NCHL, 2011). Evidence-based management, as defined by Briner and Rousseau (2011), described evidence-based practice as the conscientious utilization of multiple forms of data to assist in the decision-making process, such as practitioner expertise and judgment, critical evaluation of best available research, and consideration of the perspective of the population groups who may be affected by the decision. I focused on the problem of whether defined leadership practices and defined NCHL evidence-based leadership competencies are being applied in leadership practice in a real world healthcare environment in the Midwestern United States.

Background of the Problem

Healthcare organizations continue to be challenged by improving quality of care while decreasing operational costs (Calhoun, McElligott, Weist, & Raczynski, 2012; Cliff, 2012). Healthcare leaders need to focus on implementing a leadership competency that will allow them to use best practices within their organization (NCHL, 2011). Healthcare organizations are able to execute best practices in their business while

simultaneously accomplishing their goals by implementing a leadership competency model (NCHL, 2011).

The NCHL is an objective source for evidence-based healthcare leadership practices bringing leaders together to advance healthcare industry standards and innovation for leadership excellence (NCHL, 2011). The NCHL is a not-for-profit organization with a goal of assisting in the provision of high quality, accountable, and relevant leadership (NCHL, 2011). If used in healthcare settings, the NCHL competency model can meet defined challenges of delivering high quality patient care through effective healthcare management leadership (NCHL, 2011). One method used by senior leaders is the development and application of a healthcare leadership competency model to define expectations of leaders at differing stages of their careers (NCHL, 2011). Leadership competencies are needed for healthcare organizations to review their leader performance and enhance their training, resulting in achievement of organizational goals (NCHL, 2011).

It is beneficial to expand existing knowledge on factors that positively influence implementation of the NCHL leadership best competencies as applied to clinical and business practice (Calhoun et al., 2012). The second need is to understand why there may be minimal linkage found between identification of leadership development competencies during executive leader training and the implementation of such competencies that affect the outcomes of an organization (NCHL, 2011). Because healthcare leaders are expected to demonstrate leader competence, foster confidence among their stakeholders, and contribute to improved quality and patient outcomes, the

use of defined leader competencies could be beneficial in business practice while healthcare executives can simultaneously recognize and promote junior leaders (American College of Healthcare Executives, 2013, 2014; Graham & Malnyk, 2014; The Joint Commission, 2012; Thompson, 2010).

Problem Statement

With turnover and healthcare reform challenges, healthcare organizational senior leaders need to focus on implementing a leadership competency that will allow them to employ best practices (Calhoun et al., 2012; Gumus, Borkowski, Deckard, & Martel, 2011; The Joint Commission on the Accreditation of Healthcare Organizations, 2009, 2012). High chief executive officer (CEO) turnover rates negatively impact healthcare quality, with the CEO turnover percentage in 2013 for nonfederal, short-term, general medical/surgical hospitals as high as 20% (American College of Healthcare Executives 2014). The general business problem is senior leaders in some hospitals are experiencing challenges with effectively integrating the NCHL competencies to manage their talent management goals. The specific business problem is that some senior leaders lack strategies to integrate the NCHL competencies into employee evaluation systems.

Purpose Statement

The purpose of this qualitative exploratory case study was to explore the strategies that senior leaders need to integrate NCHL competencies into employee evaluation systems. I conducted telephone interviews with a purposeful sample of 10 junior leaders involved in the performance evaluation process in a single midsized healthcare organization in the Midwestern United States. I also gathered secondary

documentary data on the organization's leadership structure, job descriptions, hiring procedures, job instruments, performance evaluation systems, and procedures for promotion within the organization to define the presence of the NCHL competencies being used. The results of this research may influence positive social change and business practice by extending current knowledge of the NCHL practices and competencies of successful leaders and the process they use to evaluate the usage of those competencies. This study may reveal how the presence of leader evaluations and defined NCHL competencies may be used to enhance leadership growth and contribute to business effectiveness and goal attainment within a healthcare setting.

Nature of the Study

I used a qualitative method for the research on the practices and competencies of successful leaders. Qualitative research allows a step beyond the known and a look into the lives and perspectives of the participants (Sparkes & Smith, 2013). A qualitative research design facilitates the ability to collect the views of the participants in a given business and interpret collected data to analyze business phenomena (Cox, 2012). Sparkes and Smith (2013) stated qualitative research studies multiple meanings that people attach to their experiences as well as how they identify these experiences and describe the social structures that are used to shape these meanings. Qualitative exploration needs to be done initially to enable the kind of explanations and data needed to address the problem and fulfill the purpose of the study on how leader competencies are applied in practice (Goerig & Streiner, 2013).

The participants in this study responded to interview questions based on reflections of their work experiences as junior healthcare leaders and professionals in the Midwestern United States. A quantitative method was not appropriate for this study as it would have provided closed-ended answers, and its application is based on quantification, the measurement of variables and relationships between the independent and the dependent variables (McMillan & Schumaker, 2010). The mixed-method approach, a union of qualitative and quantitative methods, did not work for this study because it includes a quantitative component, which is not appropriate for this particular study as variables in the study are not defined prior to conducting the research (Goering & Streiner, 2013).

A single exploratory case study design was applied because the research focused on a single organization. A case study design served as a research medium to analyze a business model and conduct an exploratory analysis based on qualitative data gathered from organizational practices (Siau & Rossi, 2011). Through a case study design, an exploratory approach was used to analyze the junior leaders' knowledge of leadership competency model utilization within their organization (Barratt, Choi, & Li, 2011).

Research Question

This qualitative research was guided by one overarching research question.

What strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?

Interview Questions

The Research Question Matrix in Appendix A was used in the development of the

interview questions. It was also used to ensure that each interview question was specifically aligned to the study's research question. The following questions guided the interview process for this research:

1. What leadership competencies do you use to reach your organizational goals as a healthcare leader?
2. Based on your knowledge and experience with this healthcare system, how are leadership competencies being used or applied in this organization?
3. What has been your experience with leadership competency models?
4. How do you track leadership performance?
5. What types of tools do you use to track performance management?
6. What are the key skills or competencies tracked in your performance management evaluation system?
7. How do you determine if a leader or direct report has a specific competency or needs training to build up an existing skill of competency?

Conceptual Framework

In qualitative studies, the conceptual models and framework reveal how researchers use the literature to ground their business research (Yin, 2011). With qualitative research approach, it is acceptable to use a conceptual model or framework as it is the researcher's role to identify and describe the relativity of the theory to the study (Yin, 2011). In this study, I used a conceptual model, the NCHL leadership model, to frame this qualitative explorative research. Qualitative methods are predominately linked

with meta theoretical commitments related mainly to interpretivism, social constructionism, poststructuralism, and postmodernism (Yin, 2011).

This study was grounded in the NCHL leadership model as the conceptual framework (NCHL, 2011). The NCHL gained leadership focus in healthcare by channeling advocacy for evidence-based practices (NCHL, 2011). It remains challenging to implement best practices in daily operations (NCHL, 2011). The NCHL health leadership competency model was developed to provide the field of healthcare with a comprehensive competency model suited as a foundation for leadership assessment and development applications (NCHL, 2011).

This leadership competency model is widely used in many healthcare and academic organizations (NCHL, 2011). The developers recognized development before the passage of the Patient Protection and Affordable Care Act (Garman & Lemak, 2011). Therefore, plans for the revision of existing competencies to take into consideration new challenges and expectations by senior leaders are in the process of incorporation into the existing NCHL leadership competency model, as stated by Garman and Lemak (2011). Because the research focused on challenges to the implementation of the NCHL leadership competencies used in practice for this healthcare organization, it was appropriate to use this conceptual model to frame the research. The NCHL healthcare leadership model was the conceptual framework for the research.

Definition of Terms

The following key terms were used within the study to define a common understanding. These terms were used in the study the same way they are defined in their

sources.

Executive coaching: Executive coaching consists of methods and techniques developed in clinical settings that can be applied by executives to influence and manage their team (Sperry, 2013).

Healthcare leadership roles: Healthcare leadership roles are roles in organizations that consist of supervisors or above. For the purpose of this research, healthcare leadership roles are confined to supervisors, managers, and upper level executives who are CEOs, chief nursing officers, or vice presidents of healthcare organizations (ACHE, 2012).

Leadership assessment: Leadership assessment is an evaluation of leader performance (NCHL, 2011).

Leadership competencies: Leadership competencies are acts or behaviors leaders do to bring change in a group (NCHL, 2011).

Mentors: Mentors or mentorship refers to the relationship between midcareer or late-career leaders and someone they view as a younger version of themselves (ACHE, 2012).

National Center for Healthcare Leadership (NCHL): NCHL is a not-for-profit organization located in Chicago, Illinois dedicated to high quality, relevant, and accountable leadership practice to meet defined challenges in the delivery of high quality healthcare in the 21st century (NCHL, 2014b).

NCHL leadership model: The NCHL leadership model is a set of 26 competencies required for incomparable performance in a healthcare organization outlined by NCHL

(NCHL, 2011).

Assumptions, Limitations, and Delimitations

The following assumptions, limitations, and delimitations are present in this study. The four assumptions pertain to participants and lack of generalizability for this sample. The limitations for this study result from the choice of method, design, and purposeful sampling technique (Barratt et al., 2011). The study was delimited to a single group of participants and a single healthcare organization in the Midwestern United States.

Assumptions

I assumed that participants were honest in their responses to interview questions based on their consent to participate and understanding of their role in the study. I also assumed the participants understood the Informed Consent and promises of confidentiality related to data acquired from the study as explained during the consent process. I assumed the participant sample provided valid information on perceived usage of the NCHL leadership competencies within their healthcare organization (Francis et al., 2010). The participant sample for this research is representative of the population group of junior healthcare leaders and professionals from a midwestern hospital in the United States. Transferability is inferring that the findings found in one study can be stretched to apply to other samples or other settings (Francis et al., 2010).

Limitations

A limitation in this study was the choice of a qualitative method and small sample size of healthcare and professionals in the Midwestern United States. Other limitations

were the case study design and the use of a purposeful sampling technique rather than a random or snowball sampling approach in order to evaluate the leadership model within a single organization. The case study approach has limitations because findings are restricted to a single population of participants in an in-depth intimate manner and may be representative only of that group and not generalizable to other populations or geographic locations (Barratt et al., 2011)**.**

Delimitations

In a research study, delimitations are used to narrow the scope of the study or list items not intended in the study (Small, 2009). The scope of this study was delimited by the choice to focus on junior healthcare leaders and professionals of one organization in the Midwestern United States. Though it would have been ideal to reach out to as many as possible, it was unrealistic to connect with all leaders to have them as an active participant in this study. The study was delimited by the choice to use a single healthcare organization in the Midwestern United States (Small, 2009).

Significance of the Study

The results of this research may influence positive social change and business practice by extending current knowledge of the NCHL practices and competencies of successful senior leaders and the process they use to evaluate the usage of those competencies. It may reveal how the presence of leader evaluations and defined NCHL competencies may be used to enhance leadership growth and contribute to business effectiveness and goal attainment within a healthcare setting. Because senior healthcare leaders are expected to demonstrate leader competence, foster confidence among their

stakeholders, and contribute to improved quality and patient outcomes, the use of defined leader competencies could be beneficial in business practice while simultaneously recognizing and promoting junior leaders (ACHE, 2013, 2014; Graham & Malnyk, 2014; The Joint Commission, 2012; Thompson, 2010).

Contribution to Business Practice

With the presence of the NCHL competency model in healthcare, organizations could tailor leadership development and training to enhance their ability to execute organizational goals by implementing best practice evidenced based leadership competencies (Calhoun et al., 2012; NCHL, 2011). The NCHL competency model defines specific competencies based on best practices for senior leaders in healthcare environments (Calhoun et al., 2012). Organizations remain focused on the development of their current and future leaders, a topic that remains popular amongst researchers, to enhance their leadership abilities to face challenges in organizations and meet organizational goals (Sadri, 2012).

The findings of the study may provide insight to current healthcare senior leaders with information for leadership development, mentoring, and evaluation strategies for healthcare junior leaders. It is important for U.S. healthcare systems to focus on leadership development to enhance their success of achieving organizational goals (Sadri, 2012). It is also important for senior leaders of healthcare organizations to integrate the existing NCHL model into their evaluation and competency training to enhance leadership development and success (NCHL, 2011). The enhanced leadership development could benefit organizational junior leaders, which directly affects employee

engagement, and customer satisfaction.

Implications for Social Change

The implications for positive social change include the opportunity to enhance current knowledge and understanding regarding integration of the NCHL competencies into the employee evaluation system of healthcare organizations (NCHL, 2011). The results of this study may provide valuable information and awareness regarding how healthcare organizations, business leaders, and society might understand identified incentives, barriers, and possible impediments to enhancing their evaluation and training of leaders by employing the NCHL model competencies (NCHL, 2011). Evidence-based practice stresses that actions and decisions should be grounded in the best obtainable basis for decisions and leading the best scientific evidence (Hjørland, 2011). Evidence-based competencies are important for senior leaders to use because senior leaders face challenges of effectively applying learned changes that have urbanized among healthcare providers in daily operations (NCHL, 2011).

Review of the Professional and Academic Literature

In this section, I present the development of healthcare organizations' integration and usage of the NCHL model competencies into their training and evaluation procedures. I demonstrate how the usage of the NCHL model competencies affect (a) healthcare leadership traits, (b) leadership relationships, (c) educational impact, (d) healthcare industry trends, (e) leadership competencies, (f) the NCHL leadership model, (g) performance evaluation systems, and (h) leadership training. The research strategy was to connect the categories to sociocultural theory and the NCHL model as a

conceptual framework. This review is organized around concepts and applied business practices that have converged to generate a high degree of interest in health care leadership models.

In this review of the professional and academic literature, I reviewed and critiqued the existing literature pertaining to the challenges and intricacies of effectively integrating the NCHL competencies into the employee evaluation system of a midsized healthcare organization in the Midwestern United States. A number of subtopics are defined and analyzed in relation to the study topic as a means of laying the groundwork for this research. Literature database searches were conducted using Academic Source Premier, Thoreau, Business Source Premier and ABI Inform, EbscoHost, government-based data on employment, NCHL and ACHE websites, and healthcare associations. Keywords used in the searches were *health care executives, leadership traits, leader competencies, core competencies, competency measurement, NCHL model, performance evaluation systems, leadership training,* and *leadership models*.

This literature review critique includes research from 121 sources; 111 of those are peer-reviewed, on leadership traits and models, forms of leadership competency identification and measurement within the healthcare industry, and the impact on health care organizations' ability to execute organizational goals, evaluate leadership competencies, and effect social change in the United States. My review of this information revealed perceptions of attitudes or business models but did not provide any factual data to define reasons why there is not usage of the NCHL model competencies in healthcare organizations for further research into this area. These studies demonstrate

support for the need for additional research in examining the strategies to effectively integrate the NCHL competency model into healthcare organizations to assist in managing goals. The additional research addresses the research question for this study: What strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?

Healthcare Challenges

Health care is one of the greatest regulated industries (Stiefel, 2012). Richardson (2011) revealed a change to prospective payment systems in 1983 was a government spending reduction effort. Gumus et al. (2011) noted that healthcare leaders in the United States face unprecedented challenges and uncertainty related to healthcare reform. With the demands to overhaul the U.S. healthcare system to provide patient-centered, accessible, and integrated care, healthcare leaders are required to have essential traits and competencies to adapt and respond (Gumus et al., 2011). Moreover, the American College of Healthcare Executives (ACHE, 2012) noted that the CEO turnover percentage for nonfederal, short-term, general medical/surgical hospitals is as high as 20%. The healthcare challenges in the United States continue as healthcare reform is put into action, and healthcare organizations are aiming to improve quality care with fewer resources (Davis, Schoen, & Sremikis, 2010).

Healthcare reform. Leadership is particularly important in the United States as patient safety initiatives, healthcare reform, and technology change rapidly (NCHL, 2011). Fortune 500 business leaders understand these huge investments will deliver reward with focus on leadership performance, building leader skills, and ensuring

alignment with organizational goals (NCHL, 2011). Leadership development is accomplished when leaders adopt competencies that enhance leadership ability to manage a changing environment (NCHL, 2011).

The United States spends more on healthcare per capita than other countries, at a rate of 17% of the U.S. gross domestic product (Davis et al., 2010). According to the Centers for Medicare and Medicaid Services (2010), healthcare costs exceed $9,000 per capita and are expected to increase 6% annually for the next decade. The increased cost of providing healthcare increased the level of healthcare administration as an attempt to contain and control health care costs (Marciarille, 2011). The shift in the delivery of health care drove the expansion of management, resulting in a shift of influence to the managerial controls aspect of health care business (Kuhlmann & Annadale, 2012). Innovative approaches to educating and deploying healthcare workforce are imperative to reduce costs for care while improving quality (Davis et al., 2010). Organizations must match the skills and capabilities of leaders to impact care delivery and population health (Davis et al., 2010).

Healthcare leader succession. Leadership development and succession planning must be components of the strategic development plan in health care organizations (NCHL, 2011). Leadership development programs are used to promote leadership skills and abilities for any level of leadership within the organization (NCHL, 2011). Research by the American College of Healthcare Executives (2013), Graham and Malnyk (2014), and Thompson (2010) recognized that healthcare executives and leaders are expected to demonstrate leadership competence, foster confidence, and practice evidence-based

management for healthcare quality and improved patient outcomes. The Joint Commission on the Accreditation of Healthcare Organizations (2009, 2012) and ACHE (2014) linked leader competencies to organizational success and enhanced senior leader succession planning. The annual 2013 CEO survey by ACHE identified annual hospital CEO turnover increased to 20% in 2013, the highest rate since the organization began tracking CEO turnover in 1981.

Integrating a set of leadership competencies within the organization allows for effective response to better coordinated, cost-effective patient care (Shortell, Casalino, & Fisher, 2010). The NCHL (2011) stressed four key components that healthcare organizations should address regarding leadership and performance by use of evidence-based best practices. These four key components are (a) how to assure leadership is ready to work through challenges that may arise, (b) development of highly effective teams through individuals, (c) alignment of performance management programs with organizational culture and (d) creating a focus on quality. Due to the high rate of change in healthcare, it is vital for healthcare organizations to establish purposeful leadership development models, evaluation programs, and training to address the patient care needs in the United States (NCHL, 2011).

Roles of Healthcare Leaders

Two leadership measures have recently emerged: the *general inventory of lasting leadership* (Gill, 2012; Rupprecht, Waldrop, & Grawitch, 2013) and the *360° refined* (Bradberry & Greaves, 2012). Gill's (2012) theory extended the leadership behavior paradigm, taking into account the follower and the context of leadership. Organizations

can use these leadership competencies in their performance evaluation systems, leadership training, and promotional assessment evaluations (Sperry, 2013). Sperry (2013) believed executive coaching and leadership assessment will continue to be influential in organizations to help develop their leaders and reach organizational goals by implementing the leadership competency assessments into their leadership evaluation systems in the upcoming decade.

Drivers of organizations. Sarwar (2013) stated that everyone is a leader because they are held responsible and accountable for all interactions with other people. The American College of Healthcare Executives (2013) defined healthcare leadership as the ability to inspire organizational excellence, create a shared vision, and successfully manage change to attain the organization's strategic successful performance. Leaders determine, communicate, and guide the vision of their organizations (Charmel, Frampton, & Guastello, 2013).

Surveyors from the Institute for Healthcare Improvement conducted a study in 2011 to identify key factors in achieving exceptional patient experience of inpatient hospital care (Cliff, 2012). The primary driver was leadership and the idea that effective leaders focus the organization's culture on the needs of patients and have the skills to create a patient-centered care culture (Cliff, 2012). Leaders from executives to front-line managers share a commitment to a patient-centered organizational culture goal and understand it is led by senior leaders (Balik, Conway, Zipperer, & Watson, 2011). The Joint Commission (2009) stated that leaders must clearly communicate a hospital's commitment to meet the distinctive needs of its patients and to establish an organizational

culture that values patient and family-centered care.

Embracing change. Business as usual will not be sufficient for organizations in coming years (Ross, 2012). Leadership capability will be a key differential in the future. Managers will require a new focus on leader capacity for development (Ross, 2012). Ross (2012) focused on the interpersonal connection of leaders in an organization. Individuals respond to situations in different ways depending on context (Ross, 2012). Leaders should collaborate and integrate several disciplines across an array of fields by understanding the complexity of each individualized group (Balik et al., 2011). Leaders need to be diverse with knowledge and experience and seek out best practices to integrate in their organization (Ross, 2012). Ross also suggested that the current leadership capability is not adequate to meet the emerging global challenges.

Health Care Leadership Traits

The ACHE conducts studies every 5 years to compare the career attainment of healthcare executives with information garnered from a sample of ACHE affiliates who have been in the field between 5 and 19 years (ACHE, 2012). For the first time in 17 years, ACHE in 2012 found a narrowing of the gender gap in the healthcare field (LaPierre & Zimmerman, 2012). However, no gender differences in the total amount of time accrued in management was discovered with a general total of 12 years (LaPierre & Zimmerman, 2012). Westphal (2012) recognized that strong leadership and increased diversity were still prominent issues in today's health services workforce. Healthcare leaders continue progress by improved equality at the highest levels of healthcare organizations (Westphal, 2012).

Courageous leaders. Forck (2011) listed three traits of a courageous leader: (a) caring, (b) keeping cool, and (c) consistently pushing through the daily challenges to keep forward motion in an organization. Forck referenced that the way to be a courageous leader is to quietly and effectively get results by defining three specific behaviors. The first way is showing empathy (Forck, 2011). Empathy earns the trust of employees and reaps benefits for the organization (Forck, 2011). The second way is keeping cool in tough situations (Forck, 2011). In the moment these situations may be challenging, but the rewards are exponential (Forck, 2011). The third way is addressing barriers to overcome the daily challenges faced as a leader (Forck, 2011). Forck also labeled leadership as a tough and unrewarding job.

Leader-group performance. In a postmodern world, leaders who had the liberty to act and test their limits exceeded organizational goals and outperformed other leaders (Brocato, Jelen, Schmidt, & Gold, 2011). Brocato et al. conducted a content analysis of leadership studies from 1999 to 2008 in peer-reviewed journals and management texts to identify leadership traits and characteristics (Brocato et al., 2011). Successful leader-group performance would rise if leaders implemented dynamic sociocultural systems (NCHL, 2014b).

Professional associations. Two logistic regression models designed to identify CEO and hospital characteristics associated with member and fellow status in the American College of Healthcare Executives were discovered (ACHE, 2012). Khaliq and Walston (2012) conducted a study based on a 2008 survey of 582 hospital CEOs in the United States to explore their professional organizational memberships. The survey

results revealed that 74% of the participants considered ACHE their primary professional association (Khaliq & Walston, 2012). Fellow status in ACHE was predominantly associated with a master's degree in healthcare administration, male gender, and age (Khaliq & Walston, 2012). It was also noted that membership and fellowship at a professional association such as ACHE were influenced by individual characteristics and employer incentives (Khaliq & Walston, 2012).

Mentorships. Mentorships and relationships help to develop leaders and provide experience to attribute to tenure within an organization and career accession (NCHL, 2014c). Mayfield and Mayfield (2010) examined the role of leader-level communication in employee performance and job satisfaction using partial least squares analysis to test how leaders affect employee outcomes. A survey sample of 151 health care workers in a Southeastern health facility indicated leader-level motivating language positively affected follower performance at measurable magnitude (Mayfield & Mayfield, 2010). The research indicated leaders gained insight to improve organizational interventions that are designed to improve follower outcomes through leader communication (Mayfield & Mayfield, 2010).

Educational Impact and Healthcare Leadership Training

When students were not graduating from college with experience or the opportunity to put their learning into practice, they lacked confidence when facing challenges (Singh, Verma, & Singh, 2014). Benjamin and O'Reilly (2011) explored the importance of Masters of Business Administration (MBA) graduates as future leaders and how they faced challenges. They investigated the early career challenges of 55 young

leaders who had graduated from an MBA program in the past decade (Benjamin & O'Reilly, 2011). Based on in-depth interviews, the findings revealed as the young leaders faced challenges, they were forced to change the way they thought about and practiced leadership (Singh et al., 2014). MBA programs can be modified to help students prepare for early career experiences (Benjamin & O'Reilly, 2011).

Translating to work. Career growth and potential for advancement were the strongest predictors of industry shifts (Hwang, Bento, & Arbaugh, 2011). A longitudinal study performed by the Management Education Research Institute Global MBA graduate survey dataset and MBA Perspectives Survey Datasets explored the impact on industry shifts (Hwang et al., 2011). The biggest predictors of industry changes related to the graduates' behavior were the value of importance they placed on career factors (Hwang et al., 2011).

Continuing education. There are continued studies of influences on executives' continuing education in hospitals (Walston, Chou, & Khaliq, 2010). Walston et al. used data from a national survey on professional development conducted in 2009 by the ACHE (2011). The findings revealed CEOs from for-profit, larger hospitals and ACHE members usually took less continuing education (Walston et al., 2010). ACHE membership was associated with lowered amounts of personal CEO continuing education (Walston et al., 2010). Education is influential on the success of leaders in healthcare organizations and remains important for leaders to continue their education as they progress in their careers (Singh et al, 2014).

Smit (2013) recognized that leaders needed to have education and training to

develop their skill set in alignment with organizational goals and to maintain sustainability. Leadership development, as currently practiced, is based on an ethical foundation and builds the framework for responsible leadership proponents in the field of management education (Wolfe & Werhane, 2010). Smit also outlined the need to explore approaches within leadership development programs to integrate ethics and responsibility across all training subjects.

Developing responsible leadership through training and continued education is not primarily focused on introducing more subjects such as business ethics or social responsibility (Kleymann & Tapie, 2010). Training focuses on educating a leader who will pursue what is best for the common good in ways that are ethical, responsible, and attainable (Schneider, Zollo, & Manocha, 2010). Effective leadership development is more than just educating a prepared and knowledgeable leader (Smit, 2013).

Leadership and Competency Models

Healthcare organizations are putting programs and evaluation systems in place to prepare for leader succession within organizations (Shortell et al., 2010). Healthcare leaders will evolve and drive organizational goals and strategy (Charmel et al., 2013). Leaders must embrace change, finding new and efficient ways of achieving goals (Ross, 2012). Leadership styles and models are emerging in literature through research and development of best practices (Ross, 2012). Leaders use many models such as (a) situational, (b) transformational, (c) transactional, and (d) organic leadership, and (e) the NCHL healthcare leadership model (Ross, 2012; NCHL, 2011). In this section, I will provide more insight on the aforementioned leadership styles and models.

Situational leadership model. The situational leadership model of Hersey, Blanchard, and Johnson (2013) is one of the best known, and brought added value to the leadership domain (Franco & Almeida, 2011). The model proposed dynamic and flexible leadership and includes two essential variables (a) the behavior of the leader and (b) the maturity of collaborators (Franco & Almeida, 2011). The leader's behavior is described according to the way task behavior is crossed with relationship behavior (Franco & Almeida, 2011). According to the situational leadership model, task behavior refers to the leader's directions; telling people what, when, where and how to perform (West & Noel, 2013). The leader's behavior is characterized by establishing patterns, communication channels, and ways of completing tasks (Hallinger, 2011).

Leadership styles. Leadership styles considered in the model by Hersey et al. (2013) are telling, selling, participating, and delegating (Kelly, McCarty, & Iannone, 2013). There is no one best way to influence people in situational leadership, because different situations call for different types of leadership orientation and action (Bernstein & Barrett, 2011; Hersey et al., 2013; Kelly et al., 2013; Trajkovski, Schmied, Vickers, & Jackson, 2013).

Transformational and transactional leadership. Bass's (1985) leadership model depicted two leadership paradigms, transformational and transactional (as cited in Tuan, 2012). Leadership models are criticized for having overlooked the capability of leadership to lead multiple people and departments in the organization (Tuan, 2012). The notion that leadership is not the maintenance of an individual but rather is at the core of the concept of distributed leadership (Harris, 2013). Jing and Avery (2011) also looked at

the distribution of leadership, seeing the distribution as not coming from a single leader, rather from multiple leaders in developing organizations. Organic leadership tends to establish the distinction between leaders and followers (Singh, 2010). Complementing actions, which this paradigm is based upon, implies that team members work together in roles of power they have, without being governed by power of position (Raelin, 2011). Employees become interacting partners to determine what makes sense (Tuan, 2012).

Organic leadership. According to Tuan (2012), an organic leader is a facilitator, sharing the vision and values predicated on self-control and self-organization, where people have a sense of purpose and autonomy within an organization. Leadership is an interaction between two or more members of a group that often involves a structuring of the situation and the expectations of the members (Tuan, 2012; Zhu, Sosik, Riggio, & Yang, 2012). Leaders are agents of change, influencing other people with their actions, more than other people's actions affect them (Tuan, 2012; Zhu et. al., 2012). Leadership happens when one group member modifies the competencies or motivations of others in the group (Tuan, 2012; Zhu et. al., 2012). Transformational and transactional styles in this leadership model are not associated with a particular leader, but distributed through the organization and transparent in the organization's culture (Tuan, 2012).

Bass and Avolio created a leadership questionnaire that consisted of 45 behavioral statements and used a 5-point rating system called the MLQ 5X and was launched in 1991 (as cited in Lowe, Avolio, & Dumdum, 2013). The original MLQ has been examined in a number of studies and on a broad range of sample populations (Lowe et al., 2013). The findings suggested that leaders need to discern the distinction between

business and social competencies (Barreto, 2010).

Leadership logic. Two leadership models revealed by Wikström and Dellve (2009) defined and differentiated ways of meeting demands of leaders in the healthcare sector. The first model supported untying leadership logic and time fragmentation (Wikström & Dellve, 2009). With this model, the leaders supported defining structures and allocating tasks (Wikström & Dellve, 2009). The second model integrated leadership logic and current solutions (Wikström & Dellve, 2009). In this model, leaders wanted support in improving proactive leadership and increasing employee participation (Wikström & Dellve, 2009). Through the application of this model it was defined that contemporary leadership was accomplished in healthcare by applying different leadership models to meet organizational goals and strategies (NCHL, 2014c).

Leadership is a process with trust as a foundation that interacts with the model's other components (NCHL, 2014c). Leaders convince employees to willingly and effectively execute organizational goals and objectives (Gordon & Gilley, 2012). This happens readily with employee trust in the leadership (Gordon & Gilley, 2012). Employees tend to act more creatively in achieving the organizational goals if they understand the importance of their stake in the organization (Gordon & Gilley, 2012). Employee trust in a leader is part of the leadership model that can nurture positive employee behavior (NCHL, 2014c). Gordon and Gilley believed a leadership model based on trust is easy to implement and is a key element to any successful leadership model.

NCHL health leadership competency model. It is necessary for organizational

leaders to have an effective leadership model in place to foster a culture of leadership development (NCHL, 2011). Leadership is critical to the initiation of success, creativity, and innovation (Mumford, Robledo, & Hester, 2011). There are many leadership models available for leaders to utilize such as transactional, transformational, leadership logic, organic leadership, situational leadership, and the NCHL model (NCHL, 2011). Several theoretical models for leadership have been developed that focus on key leadership traits to benefit an organization (Mumford et al., 2011). The National Center for Healthcare Leadership (NCHL) Health Leadership Competency Model remains the most influential in healthcare organizations (Davidson, Azziz, Morrison, Rocha, & Braun, 2012). The NCHL leadership competencies within the model provide guidance to assist organizations to successfully develop talent, collaborate, achieve strategic goals, and effectively lead teams (Davidson et al., 2012).

In the initial development of the NCHL leadership competency model, a leadership survey was designed and implemented by the NCHL to assess leadership practices and competencies at benchmark healthcare organizations in 2006 and 2011 (NCHL, 2011). The results of this survey were used in the design of this model. The NCHL competency model defined expected competencies for leaders at different levels within an organization (NCHL, 2011). A goal of this survey was to acquire an overview of how healthcare organizations utilized certain best practices to develop their potential leaders (NCHL, 2011).

The national healthcare leadership model integration of leadership development, investment in people, and execution of goals brings transformation (NCHL, 2011).

Transformation of an organization is achieved when the people can apply analytical thinking, innovation, and strategic direction to achieve organizational goals (NCHL, 2011). University leaders incorporate the NCHL processes, model, and competencies into their curriculum and graduate programs for healthcare leadership (NCHL, 2011). Twenty-one university leaders worked with NCHL to assist them with curricular development of competency-based learning and assessments of which nine are state-based universities and three are intentional (NCHL, 2011.

The NCHL model contains three domains: transformation, execution, and people with 26 competencies (NCHL, 2014a). The three domains capture the vibrant and complex nature of healthcare leader's role and reflect the challenging realities in healthcare leadership today (NCHL, 2014a). Of the 26 competencies, eight are skills and knowledge competencies (NCHL, 2014a). The skills and knowledge competencies include communication skills, financial skills, information technology management, human resources management, performance measurement, process management, organizational design, strategic orientation, and project management (NCHL, 2014a). Figure 1 lists the three key areas of emphasis of transformation, execution, and people stressed in the NCHL model.

Figure 1. From *The National Center for Healthcare leadership model*, by the National Center for Healthcare Leadership, 2014a. Retrieved from http://www.nchl.org/static.asp?path=2852,3238. Reprinted with permission.

The model was developed and validated using interdisciplinary subject matter experts, and then refined by educational psychologists (NCHL, 2011). The need for advanced improvement in American healthcare was documented in the first two Institute of Medicine watershed reports in 1999 and 2001 (Calhoun et al., 2012). The third Institute of Medicine report in 2003, stressed the goal of enhancing quality of care in the United States could not be accomplished without the reforming of education and professional development across the health professions (Calhoun et al., 2012). Also addressed in the 2005 Joint Commission white paper, competency, or outcome-based

education was endorsed by professional certification bodies across the health professions (Calhoun et al., 2012). In response, the NCHL committed to the development of a model focusing on leadership acumen in healthcare (Calhoun et al., 2012). The model provides a method of measuring the skills necessary for effective performance in all types of levels and management, from front line clinical managers to the senior management team (Calhoun et al., 2012).

The model remains the leading model used by accredited graduate programs in healthcare management (NCHL, 2011). The model provides common language and framework to guide future health management leadership, discussions, performance improvement planning, educational, and professional development (Calhoun et al., 2012). The NHCL leadership model is a catalyst for leadership development (2011).

According to NCHL (2011), there are five key principles for managing innovation and performance improvement in order to maintain sustainable change in a healthcare organization. First, the leadership development and organizational business strategy are aligned (NCHL, 2011). Then the board is accountable for leadership succession (NCHL, 2011). Learning is competency-based, inter-professional, and action-oriented (NCHL, 2011). Key talent management and strategic human resource processes are integrated and aligned (NCHL, 2011). Last, leadership development dashboard tracks key measurable outcomes (NCHL, 2011).

The NCHL leadership model engages leaders to empower front line staff with knowledge, and ability to execute decisions which enhance outcomes in an organization (NCHL, 2011). With this model, all leaders are engaged in a talent development

atmosphere that provides continuous opportunities for advancement and improvement (NCHL, 2011). The NCHL model creates an inherent culture of relationship building, collaboration, and accountability that improves the ability to execute strategic goals (NCHL, 2011). Leaders in the NCHL healthcare model may be viewed as charismatic leaders as they influence positive relationships (NCHL, 2011). The NCHL health leadership competency model will be utilized for this study.

NCHL Leadership Model Survey

The National Healthcare Leadership Survey was created by the NCHL to determine the adoption of healthcare leaders' best practices as they relate to identified healthcare quality measures (NCHL, 2011). In 2007, an extended version of the NCHL Survey was rendered collaboratively with the National Research Corporation (NCHL, 2011). The original survey encompassed over 80 survey questions reflecting leader best practices (NCHL, 2011). NCHL's (2011) initial survey results of 256 hospitals revealed many healthcare executive leaders do not perform leader assessments or plan for progression of high performing leaders. Specifically, only 17% of leaders received performance management, and 18% of leaders used a 360-degree feedback tool (NCHL, 2011).

NCHL survey questions. NCHL collaborated with the National Research Corporation and developed a Leadership Index Survey (Yessis, Kost, Lee, Coller, & Henderson, 2012). The finding of the Leadership Index Survey showed healthcare systems were deficient providing direction for leaders to be promoted in comparison to

non-healthcare organizations (Yessis et al., 2012). They also found the disparity to be greater for medical and nurse leaders (Yessis et al., 2012).

Specifically the NCHL (2011) suggested the need for two points of clarification with future research. The first need is to reveal what are instrumental triggers that enhance the adoption of leader practices that are effective (NCHL, 2011). The NCHL 2011 study revealed NCHL leadership competencies are implemented at a higher rate in for-profit hospitals than not-for profit (NCHL, 2011).

The 2008 NCHL leadership survey included 59 questions for hospital executives to respond in nine areas including (a) leadership competencies, (b) governance, (c) diversity and cultural proficiency, (d) succession planning and talent management, (e) recruitment and selection, (f) leadership learning and development, (g) performance management, (h) leadership reward and recognition, and (i) job design/work systems (NCHL, 2011). Based on the results of the survey, it was revealed that further research was needed to understand the challenges and barriers inherent in healthcare organizations to implementing these practices (NCHL, 2011).

NCHL survey 2010 process. The NCHL 2010 survey was sent to 4,247 hospitals and 366 healthcare systems in the United States (NCHL, 2011). There was an 8% rate of response from healthcare system and 12% from hospitals (NCHL, 2011). The 2010 NCHL leadership survey was compiled of leader development questions around the topics of (a) governance, (b) leader performance assessment, (c) leader advancement, (d) education and training, and (e) selection (NCHL, 2011). The NCHL merged their 2010 survey data with data from the American Hospital Association (AHA) survey performed

in 2008 to compare practices by (a) number of hospital beds, (b) owners, (c) location, and (d) services provided (NCHL, 2011). The survey participants were generally public hospitals, a mixture in size of hospital, and same geographical region of the United States (NCHL, 2011).

The NCHL 2010 survey results were linked to data from Centers of Medicare & Medicaid Hospital Compare database to determine the correlation between leadership development best practices and quality performance (NCHL, 2011). Specifically, the NCHL narrowed scores down for participating hospitals founded on their quality measures (NCHL, 2011). NCHL reviewed heart attack, pneumonia, and mortality rates for participating hospitals (NCHL, 2011).

NCHL 2010 survey results. The result of the NCHL 2010 survey revealed an overall higher rate of adopted best leadership practices for leadership development in healthcare systems over the rate at freestanding hospitals (NCHL, 2011). The most frequently used best leadership practices by healthcare organizations resulted from the selection category, specifically for recruiting and selecting new talent (NCHL, 2011). The leader practices that were used minimally were related to (a) direction, (b) performance management, and (c) succession planning categories (NCHL, 2011). Leaders of small hospitals were behind in implementation of leader best practices compared to larger hospitals (NCHL, 2011). Similar lagging of leadership development best practices was noted with public hospitals compared to not-for-profit or for-profit hospitals (NCHL, 2011). There was a slightly noticeable, positive correlation between hospital leaders implementation of leadership development best practices in comparison to their quality

measure scores (NCHL, 2011).

The NCHL remains focused on a multilevel competency model for leadership best practices by continued identification and development of additional competencies acquired by and research (Garman & Lemak, 2011). NCHL evolved the interdisciplinary competency model to incorporate new challenges that healthcare leaders face (Garman & Lemak, 2011). This included the identification and emphasis on actionable areas that could be used for organizational and leader performance improvement (Garman & Lemak, 2011). The NCHL catalyst framework, in Figure 2, is made of actionable tools to enable measurement, benchmarking, and best practices (2011).

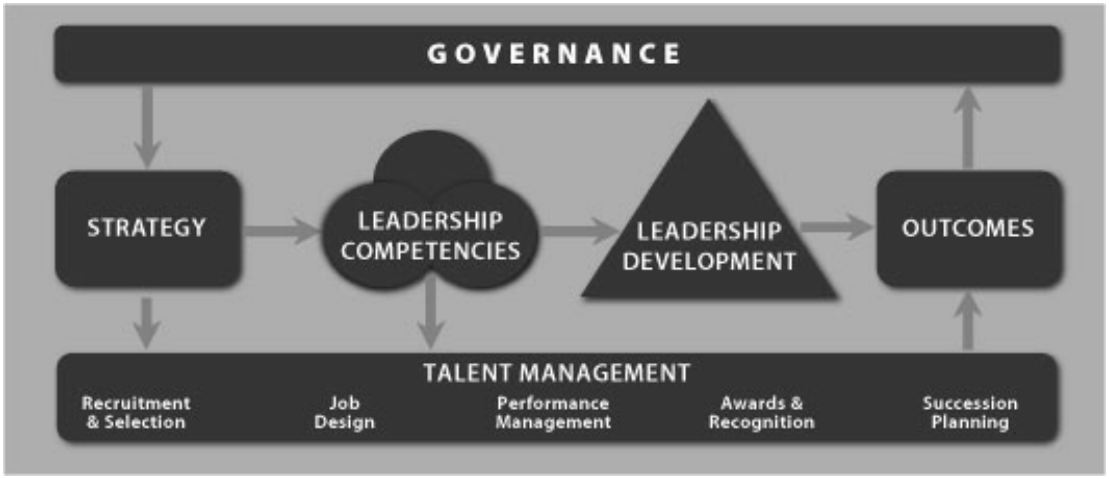

Figure 2. From *NCHL catalyst framework*, by the National Center for Healthcare Leadership, 2014b. Retrieved from http://www.nchl.org/static.asp?path=2852. Reprinted with permission.

Innovative approaches to evolving competency models are significant for healthcare leaders to be flexible and develop a broader group of leaders that are adaptive to organizational needs (Garman & Lemak, 2011). Healthcare leaders have embraced a focus on performance management, integrated with patient experience, financial and

operational goals, and leadership development (Garman & Lemak, 2011).

Since 2001, NCHL has focused on effective leadership teams in healthcare (NCHL, 2011). The NCHL remains poised to grow evidence-based leadership performance competencies through research (Garman & Lemak, 2011). This organization has developed nine assessment instruments for the measurement of leadership, governance, diversity, culture, learning, and organizational climate as listed by type of assessment instrument (Table 1).

Table 1

NCHL Assessment Instruments

Assessment type	Name of assessment
Organizational	National Leadership Assessment
	Strategic Human Resources Alignment Assessment
	Governance Alignment Assessment
	Governance Effectiveness Assessment
	Organizational Diversity and Cultural Proficiency Assessment
	Learning Program Inventory
Individual	Lifelong Learning Inventory
	Health Leadership Competency Assessment
	Organizational Climate Survey

Note. From *NCHL assessment instruments*, by the National Center for Healthcare Leadership, 2014c. Retrieved from http://www.nchl.org/static.asp?path=2852,3241. Reprinted with permission.

To stay ahead of the changes in healthcare, the NCHL model continues to evolve (NCHL, 2011). As researchers identify new areas of focus such as changes due in part to

the Affordable Care Act and healthcare reform, revisions to the existing NCHL model are being developed to assist healthcare leaders with alternate pathways for system optimization and population health (Garman & Lemak, 2011).

Performance Evaluation Systems

Performance evaluation of leadership in an organization is a functional component of an effective leadership model (Wall & Knights, 2013). It is important for executive healthcare leaders to access the direction their manager and supervisory leaders are going, and leadership progression in relation to organizational goals (Wall & Knights, 2013). Leadership assessment is a driver of sustainable performance, and a strategic activity that drives the next steps of an organization (Wall & Knights, 2013). Leadership assessments are an effective and efficient way to develop leadership behaviors and enhance leadership talents, which expands to other employees within an organization (Wall & Knights, 2013).

Leadership assessment. Two leadership evaluation systems recently emerged, the Gill theory and the *360° refined* (Sperry, 2013). Gill's theory (2012) identified five facets of leadership behavior: creating a vision and mission, developing a strategy, building shared values, empowering followers, and engaging followers (Gill, 2012; Sperry, 2013). The *360° refined* measures 22 leadership skills in seven subsections: strategy, action, results, emotional intelligence, character, organizational fairness, and development (Bradberry & Greaves, 2012). Sperry (2013) believed leadership assessment will continue to be of high importance within organizations.

Prinsloo (2012) evaluated the assessment of leadership benefits for an

organization. The challenge in evaluating leadership assessment is the fact organizations are as complex as humans in that multiple variables can obscure the research results (Prinsloo, 2012). The evaluation of leadership assessments requires a system model approach (Prinsloo, 2012). Prinsloo revealed an approach to provide specific techniques to assess leadership potential, with critical factors being levels of consciousness, cognitive capacity, preference, and motivational patterns. This particular method of leadership assessment can be viewed as a step towards creating an integrated, process-based, and systems modeling research approach (Prinsloo, 2012).

Leadership potential assessment. Guidelines identified by Dries and Pepermans (2012) help executive leaders assess leadership potential that aid in performance, achievements, and career succession. Silzer's (2010, 2011) data from two studies, one qualitative and one quantitative, identified a two-dimensional leadership model assessment consisting of four quadrants. They were as follows:

1. The *analytical skills* quadrant explores leader intellectual curiosity, decision-making, problem solving, and strategic knowledge (Silzer & Church, 2010).
2. The *learning agility* quadrant focuses on leaders' willingness to learn, adaptability, and emotional intelligence; emphasizing the critical significance of leaders' willingness and ability to learn from experience (Silzer, 2011).
3. The *drive* quadrant factors leader perseverance, dedication, and results orientation; stressing not everyone who is able to be a leader is willing to

make the sacrifices that come with leadership (Silzer, 2011).

4. Finally, the *emergent leadership* quadrant emphasizes leader motivation, self-promotion, and stakeholder sensitivity; a leader has to personify high potential (Silzer, 2011).

Some executive leaders in organizations force people with expert knowledge in their field into leadership tracks based on their performance record (Dries & Pepermans, 2012). Often, leaders in organizations are identified based on ability alone, without considering career orientation (Dries & Pepermans, 2012). It is important for leaders to be self-motivated into managerial careers (Dries & Pepermans, 2012). Forced distribution evaluation systems are a typical approach of leadership assessment within organizations (Dries & Pepermans, 2012). Most executive leaders in organizations would argue that their high potential leaders are those employees who scored in the top 2% to 20% of their organization's performance assessment (Dries & Pepermans, 2012; Silzer & Church, 2010).

NCHL evaluation. The NCHL survey is a collection of leader competencies (NCHL, 2011). The outcomes reveal which strategies impact a long-term approach to growth of leaders (NCHL, 2011). NCHL was able to determine commonly used leader skills and the correlation with the broader goals of the organization (NCHL, 2011).

The survey had 16 core questions, each relating to a best practice for leadership development and succession planning (NCHL, 2011). To analyze and interpret the data, the NCHL broke the core questions into five categories of best practice for leadership development: (a) leadership competency model, (b) governance, (c) succession planning,

(d) learning and development, and (e) performance management (NCHL, 2011). The NCHL model served as the anchor for discussing healthcare organizational leader use of leadership development competencies with their evaluation, training and development systems (NCHL, 2011).

Researchers' use of performance assessment has identified positive trends (Dries & Pepermans, 2012). There is a growing awareness that the identification of leadership potential is a strategic must for organizational leaders (Dries & Pepermans, 2012). There is an increased engagement from organizational decision makers to invest in formal leadership development programs, and there is a trend toward quantifiable tools in assessment of leadership potential (Dries & Pepermans, 2012). Leaders' use of performance assessment programs within their organizations will enable career succession for leaders with high potential (Dries & Pepermans, 2012: Silzer & Church, 2010).

Leadership Development

Organizational learning is a process through which organizational leaders continuously acquire new knowledge, and enable leaders to adapt successfully to internal and external environmental changes (Franco & Almeida, 2011). While organizational leaders are in a constant state of learning, they maintain sustainability and development (Franco & Almeida, 2011). Learning is important for organizational leaders in knowledge-intensive industries such as the health sector, where the learning development rate should be greater than the rate at which its operating environment changes (Singh, 2010).

Organizational learning. Improving organizational leadership performance through learning has been a crucial survival factor due to the technological advances in healthcare and highly competitive markets (Rijal, 2010). Franco and Almeida (2011) chose the healthcare sector for their study to access how organizational leaders learning contribute to required management attention and efforts. Healthcare organizations not only represent a knowledge-intensive sector, they also are complex (Rijal, 2010). According to Rijal (2010), a learning organization requires leaders who bring out the best in others, who are adaptive and flexible.

Practitioners and managers know that competition and challenges are derived from rapid and unexpected changes in the global world (Franco & Almeida, 2011). Developing new competencies and capabilities for leaders to develop is the learning center of the organization (Franco & Almeida, 2011). This has led to the development of organizational learning (Franco & Almeida, 2011).

Reflective learning. Critical to the achievement of any leadership development lies in the ability to encourage participants to reflect on learning experiences which allows for knowledge sharing and skills to utilize within an organization (Franco & Almeida, 2011). The concept of a leadership development culture is similar to the idea of a learning organization (Ghadi, Fernando, & Caputi, 2013; Harun & Mom, 2014; Senge, Cambron-McCabe, Lucas, Smith, & Dutton, 2012). A learning organization empowers leaders to facilitate change, encourages collaboration and sharing of information, and promotes leadership development (Franco & Almeida, 2011). Leadership plays an important role in helping an organization become a learning organization (Singh, 2010).

A learning organization develops mechanisms to promote productive learning for leaders (Ryu, 2011). Learning organizations need efforts to create a focus for learning and development of leaders (Weir & Örtenblad, 2013).

Leadership development culture. The response to the challenges faced today by health organizational leaders is only possible through adoption of the roles of leadership (Franco & Almeida, 2011). It is crucial to develop the competencies and effectiveness of leadership at various levels, defining goals, ensuring objectives are transparent, developing the best talents, stimulating learning, and creating a culture based on cohesiveness of teams and quality of service provided (Edmonstone, 2011; Kilpatrick, 2009).

Franco and Almeida (2011) provided four recommendations for organizational leaders to maintain a learning culture focused on leadership development. These four recommendations are (a) health managers/leaders must recognize the value of productive organizational learning as a continuous collective process for the quality of working life, (b) health organizational leaders that engage in organizational learning enable staff at all levels to learn collaboratively and continuously in response to social needs impacted by their environments, (c) leadership practices are important in developing specific training programs, technical and behavioral, to maintain a shared organizational vision that is task-oriented, inspiration-oriented, and communication-oriented, and (d) the role of a leader is crucial to help establish certain mechanisms of organizational learning, encouraging staff to act in ways that seem helpful in making the vision operational within the healthcare organization (Franco & Almeida, 2011).

The application of a learning culture focused on leadership development in healthcare organizations is accomplished by first acknowledging the value of productive organizational learning (Franco & Almeida, 2011). Engaging staff at all levels to learn collaboratively and continuously and establishing training programs to ensure that learning occurs are integral components of the learning culture (Franco & Almeida, 2011). As a result, leaders and staff are motivated to operationalize the vision of the organization (Franco & Almeida, 2011).

Transition and Summary

Section 1 of this study includes the background, barriers, conceptual framework, and phenomena relating to the business problem that exemplifies this study. The purpose of this qualitative case study was to explore the usage of the NCHL model competencies by leaders in a single healthcare organization in the Midwestern United States by interviewing a sample of healthcare leaders and professionals. The research question guiding the instrumentation of this study was: what strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?

The NCHL leadership model and competencies were developed in 2008 based on best practices in the healthcare industry of leaders (NCHL, 2011). Even though the NCHL model is fully available, and accessible to utilize, it remains unknown how frequently they are utilized by leaders in healthcare organizations (NCHL, 2011). There remains a significant lack of data to support the reasons why this occurs. The function of all health care executives is to oversee the operations and strategic functionality of healthcare organizations (NCHL, 2011). Leaders of the healthcare industry may need to

find ways to mentor, develop, train, and evaluate executive leadership teams to carry out their strategic goals (Sperry, 2013).

Further research was needed to determine the link between implementation of these leadership best practices and performance measures that are relevant in healthcare organizations (NCHL, 2011). This study will make a contribution to scholarship in the areas of NCHL model competency implementation and challenges related to the lack of prominence in organization's evaluation of leader's performance management systems. Many facets of the use of leadership competency models and best practices are worthy of further study.

In Section 2 the population and sample, role of the researcher, and participants are described. In addition, the rationale for the choice of a qualitative research method and case study design are expanded upon from the Nature of the Study area in Section 1. This section culminates with further discussion of the sources of data, data organization, data collection, data analysis, limitations of the choice of method, design, and data sources and ethical considerations for this study. Section 3 will conclude with an analysis of the theoretical proposition, discrepant data, and rival explanations.

Section 2: The Project

This section is a description of the research method that was used to conduct this study, including a description of the specific research design and my role as the researcher. The specific methodology used to conduct this study is also described, including participant selection, instrumentation, participation, data collection, ethical procedures, and data analysis. Finally, this section includes the specific strategies that were used to enhance the credibility, transferability, and dependability of this study.

Purpose Statement

The purpose of this qualitative exploratory case study was to explore the strategies that senior leaders need to integrate NCHL competencies into employee evaluation systems. I conducted telephone interviews with a purposeful sample of 10 leaders involved in the performance evaluation process in a single midsized healthcare organization in the Midwestern United States. I also gathered secondary documentary data on the organization's leadership structure, job descriptions, hiring procedures, job instruments, performance evaluation systems, and procedures for promotion within the organization to define the presence of the NCHL competencies being used. The results of this research may influence positive social change and business practice by extending current knowledge of the NCHL practices and competencies of successful leaders as well as the process successful leaders use to evaluate the usage of those competencies. It may reveal how the presence of leader evaluations and defined NCHL competencies may be used to enhance leadership growth and contribute to business effectiveness and goal attainment within a healthcare setting.

Role of the Researcher

I was the data collection instrument for this qualitative study. Xu and Storr (2012) observed that the researcher is considered a data collection instrument and his or her perspective can influence data acquisition in qualitative research. With 17 years of experience in the healthcare industry, I am familiar with healthcare systems and leadership structures of healthcare organizations within the Midwestern United States. Distancing and bracketing also assisted me to mitigate my personal lens and bias of the population based on my experience and sampling I identified for this study. I remained unbiased in my research by remaining neutral in my tone and not influencing the respondents' answers. I did not give personal opinions to the respondents during their interviews and used the research question matrix to avoid bias questions. Bracketing can support social science researchers in extending beyond the constraints of egocentrism and ethnocentrism to facilitate innovation and transformed insights into current social science (Tufford & Newman, 2012).

Yin (2011) recommended the use of a defined interview protocol as a guide to the interview process. I formulated a research question matrix (Appendix A) composed of interview questions that are semistructured and open-ended to use to guide this part of the data collection. The research question matrix was designed to not lead or overwhelm the participants, with follow-up questions and options for additional interviews as necessary for clarity. For this study, I gathered all data from the identified study participants and secondary data from the organization, conducted the participant interviews, and analyzed the data. I explained all details of the research process to ensure high ethical standards

and practices are maintained (Abbott & Grady, 2011). I followed the ethical principles identified in the Belmont Report for using any human subjects for research, which are respect for persons, beneficence, and justice (American Psychological Association, 2010).

The interviews conducted were semistructured based on the research question matrix to gain information about the participants' perception of the intricacies and challenges they face when effectively integrating the NCHL competencies into their performance evaluation systems. Interviews were conducted via telephone. I also used alphanumeric coding to protect the privacy and confidentiality of the study participants. After the study, I provided feedback to the participants on the results of the research findings with a summary sheet of the findings.

Participants

I interviewed a purposeful sample of 10 healthcare leaders who are supervisors, managers, or executives as participants from a single healthcare organization in the Midwestern United States that has over 800 employees. Goering and Streiner (2013) recommended the use of a purposeful sampling technique from a population that is accessible and appropriate for the study. Smaller sample sizes are common in qualitative research when used with secondary data (Francis et al., 2010; Goering & Streiner, 2013).

I recruited potential study participants through the assistance of the human resources (HR) staff and networking among identified leaders by the HR staff at the targeted study site in the Midwestern United States. I asked the HR staff for e-mail contacts for potential participants. Potential participants were contacted by e-mail,

inviting them to participate in the study. I answered any questions or concerns prior to and during the research commencing. The participants e-mailed me confirmation of agreement to the Informed Consent before any interviews or data collection began. If I would have got insufficient response to the e-mail request to participate in the study, I would have called the potential participants to follow-up on my email request.

Dillman, Smyth, and Christian's (2014) total design method (TDM) for participant recruitment was used to maximize potential participant participation. This approach, developed by Dillman et al., identified specific steps to enhance potential participant recruitment for survey research focused on mail and telephone surveys. Since the initial design of Dilman et al.'s TDM approach in the 1970s, multimode formats for surveys and data collection have evolved, requiring revision to the original format. A revised version of the Dillman et al. approach was used for this research. This approach consists of the following: (a) initial contact providing a clear description of the purpose of the study, requirements for participation, request for participation and Informed Consent, and copy of interview script and (b) follow-up procedures including additional requests for participation sent at weekly intervals after the initial contact. Email and networking with the leaders at the organization(s) was used rather than the recommended postcard approach (Dillman et al., 2014).

Alphanumeric coding was used to protect the privacy and confidentiality of the study participants. Each participant was assigned a unique alphanumeric code to identify him or her for the study while keeping personal information private. These alphanumeric codes are known only to me and will be stored with all acquired data in a secure locked

safe box at my home, also accessible only by me, for a period of 5 years. Any personal identifying characteristics have been removed and only aggregate data were used for publication and presentation purposes with permission of the study participants. After 5 years, I will destroy all data by shredding hard copies and audio tapes and using a three phase overwrite process for electronic and digital data (Leong, Bahl, Jiayan, Siang, & Lan, 2013).

Research Method and Design

Qualitative research is viewed as a method for descriptive analysis, whereas quantitative research is a method for statistical or quantifiable data (Lawrence & Tar, 2013). Quantitative research determines reasons for outcomes and attempts to quantify those outcomes (Young, McGrath, & Filiault, 2009). Qualitative research allows the opportunity to triangulate multiple sources of data for the purpose of validation of themes, which was acquired in interviews, and is the opposite of quantitative research that collects statistical data to test hypotheses (Lawrence & Tar, 2013).

Method

I used a qualitative methodology for the research on the challenges and intricacies of how leaders effectively integrate the NCHL competencies into the employee evaluation system of a midsized healthcare organization in the Midwestern United States. Preference for the qualitative method over mixed methods or quantitative method resulted from the opportunity to gather data on the participants' pespectives directly from their words and comments through interviews rather than predetermined responses on surveys (Bansal & Corley, 2012; Goering & Streiner, 2013). Denzin and Lincoln (2013)

recommended the use of a qualitative approach when the goal of the research is to capture the individual's point of view, explore constraints of everyday life, and secure rich decriptions of experiences and situations.

A quantitative method was not appropriate for this study as it would have provided closed-ended answers and its application is based on quantification, the measurement of variables and relationships between the independent and the dependent variables (McMillan & Schumaker, 2010). The mixed-method approach, a union of qualitative and quantitative methods, was not used for this study because it includes a quantitative component, and the variables are not predefined for this study (Goerig & Streiner, 2013).

Data collection for this study was through the use of interviews, researcher field notes during the interview process, and secondary data acquired from the organizations such as job descriptions and performance evaluation tools. Through the aforementioned process with the participants, I gained a clearer understanding of challenges and realities leaders face to integrate the NCHL leadership competencies within their healthcare organization leadership development and evaluation programs.

Research Design

For this qualitative exploratory research, I used a case study design. Case study design is appropriate when the research focus is on the *how* or *why* of a specified situation and stresses contemporary events (Gibbert & Ruigrok, 2010; Yin, 2014). Yin also stated that a case study is an in-depth empirical inquiry focusing on a contemporary phenomenon in a real-world context. Case studies are also used when decisions made

pertaining to a particular situation or topic is a primary focus of the research (Baxter & Jack, 2008). A case study qualitative research design was best to address the research question for this study due to the emphasis on decision-making strategies used by senior leaders to integrate NCHL competencies into employee evaluation systems (Gerring, 2011; Hotho & Champion, 2011). The choice of a case study design can assist researchers in exploring experiences and views of one or more individuals or organization(s) and linking events over time (Lawrence & Tar, 2013). Case studies conclude with a systematic analysis of the defined organization or case findings (Lawrence & Tar, 2013).

Denzin and Lincoln (2013) and Smith (2011) recognized that there are other types of qualitative design such as grounded theory, narrative inquiry, phenomenological, and ethnography. Phenomenological designs enable in-depth intimate explorations of little-known phenomena or lived experiences of individuals sharing a common experience or situation (Denzin & Lincoln, 2013). A phenomenological study design is chosen when the goal is to focus on a central phenomenon and why a problem evolved or continues (Denzin & Lincoln, 2013; Smith, 2011; Yin, 2014). According to Denzin and Lincoln's phenomenological study is the depiction of the essence or basic structure of experience based on an individual's perspective. Phenomenological studies require in-depth interviews of 10 or more participants, resulting in time as a significant factor for single researchers (Denzin & Lincoln, 2013). Phenomenology was inappropriate for this study due to the time factor and the challenge of having to carefully select individuals who

have all experienced the phenomenon in question to be able to forge a common understanding from my research.

Ethnography is a collection of direct observation, interviews, and biographies of an individual or group (Jorgensen, Dahl, Pedersen, & Lomborg, 2012). The nature of ethnographic analysis allows the researcher to construct knowledge about a topic by immersing himself or herself in the environment being studied through interactions with participants over a prolonged period of time (Lambert, Glacken, & McCarron, 2011). Ethnographic studies are best suited for interpreting a group's culture (Lambert et al., 2011). Ethnographic studies occur over an extended period of time; the time allotted for this study and the focus on cultural patterns made ethnography unsuitable.

Grounded theory research reveals human traits that evolve from circumstances in life (Jorgensen et al., 2012). Grounded theory continues to compare acquired data over a period of time, grounds the analysis in the field under study, and is used to develop a specific theory (Jorgensen et al., 2012). In order to saturate the categories and represent all viewpoints, grounded theory designs require interviews with 20 to 30 individuals (Jorgensen et al., 2012). With no intention to generate a theory from this study, but rather to explore the phenomenon of interpersonal relationships within the interview process by collecting data from multiple participants and sources, grounded theory was not appropriate (Jorgensen et al., 2012).

Narratives and biographies are life stories of a person or group of people told through the eyes of the researcher (Jorgensen et al., 2012). Narrative studies present personal depictions of life experiences, generally first-person accounts told in the form of

a story having a beginning, middle, and end (Jorgensen et al., 2012). The primary interest of this study was to explore interactions between participants, thus a narrative design was not appropriate.

Grounded theory, narrative inquiry, biography, phenomenological, or ethnography designs were not appropriate for the study due to the timeframe required for data collection as seen in ethnographic designs (Jorgensen et al., 2012). The use of an existing conceptual model to ground the study was used rather than developing a new theory or model to guide research on this topic. The focus of this research was on leaders and their application of the NCHL leadership competencies as applied in practice rather than an in-depth view of individuals' experiences.

Population and Sampling

I interviewed 10 healthcare leaders and professionals from a single midsized healthcare organization in the Midwestern United States for this research. The healthcare organization has approximately 23,000 employees within the hospital and clinic system. This facility is part of a larger not-for-profit system with over 90 clinics, 12 hospitals, 15 pharmacies, 5,000 associated and directly employed physicians, and 4,100 volunteers.

Inclusion criteria for participation in this research was healthcare leaders and professionals who (a) have held healthcare leadership positions such as president, vice president, manager, supervisor, or HR generalist within the organization for at least 1year and (b) have participated in a leadership or professional evaluation program related to their healthcare work experience. Secondary data related to leader performance management systems and leadership competency models used within the organization

were gathered from the human resource department staff. The secondary data afford examples of leader evaluations or competencies, such as checklists, provided another source of information for this case study.

Purposeful sampling is used when the inclusion is narrow, and the participants are chosen precisely because the researcher can learn the most from them (Goering & Streiner, 2013). I chose a purposeful sampling technique due to the potential narrow inclusion criteria. Sandelowski, Voils, Crandell, and Leeman (2013) recommended the use of a purposeful sampling technique in order to identify a sample of participants in a sufficient size to draw inferences of their experiences. Because a maximum of 10 participants were used in this research, this technique was the best choice for this study because this research was limited to a single healthcare facility in a specified geographic location, and selected participants that meet criteria were part of the study.

Participants were interviewed until the point of saturation had been reached where the same comments were stated repeatedly (Carlsen & Glenton, 2011; Kerr, Nixon, & Wild, 2010; O'Reilly & Parker, 2012). Saturation is a common technique used in some qualitative designs (Denzin & Lincoln, 2013; Walker, 2012). Mason (2010) identified that the use of saturation can also assist in determining the final sample size due to choices made by the researcher as the same comments and statements occur repeatedly by the study participants. I interviewed 10 leaders but could have interviewed fewer if I reached the point of saturation. If saturation was not acquired after interviewing 10 leaders, then I would have interviewed more participants. During the data collection process, saturation was reached when the same comments and points occur repeatedly, no

new information appeared to be forthcoming, no new themes were identified, and the study can be replicated to get the same results (Sandelowski et al., 2013).

I acquired permission to recruit from this organization from leaders within their human resources and education departments. I made an initial email recruitment contact to potential study participants and elicit a response for interest in study participation. The email message outlined the intent of the study, interview questions, and information about consenting to participate in the study related to confidentiality and requirements. The interviews occurred over the telephone with the participants at a predetermined time that allowed for the participants to be uninterrupted.

Dillman et al.'s (2014) TDM for participant recruitment enhanced potential participation. Specifically, the version consists of the Dillman et al.'s approach includes the initial contact, clear description of the purpose of the study, requirement for participation, request for participation and informed consent, copy of interview script, and follow up recruitment procedures. I used e-mail and networking with leaders at the organization instead of the recommended post card approach (Dillman et al., 2014). Any changes required for my study based on feedback from expert review required IRB review and approval prior to implementation.

Ethical Research

I used the guidelines set forth by the *Belmont Report* (Sims, 2010). Participants completed the agreement to participate in interviews prior to the interviews. Prior to scheduling of any interview appointment, I explained the requirements and request for participation in the study to each potential participant. I sent a copy of the Informed

Consent document by email to each participant with a copy of the interview script questions to familiarize the participants with what would be asked during the interview process. I followed up with each participant for any questions related to the Informed Consent by phone to ensure him or her read and understood the contents. Participants confirmed by email they consent to the Informed Consent prior to data collection.

Participants had the opportunity to ask any additional questions, refuse to answer any question(s), or withdraw from the study at any point during the study without penalty. They could let me know they did not desire to continue via email or telephone conversation. The Informed Consent was confirmed from email by study participants prior to any data collection. No incentives were offered for participation in this research study. The data collected from the study, physical documents, or zip drives are password protected and maintained in a secured locked box for 5 years, accessible only by myself. I avoided use of any personal identifying characteristics, and only aggregate data will be used for publication purposes with permission of the study participants. After 5 years, I will destroy all data by shredding hard copies and audio tapes and using a three phase overwrite process for electronic and digital data (Leong et al., 2013).

While there may no direct tangible benefits from participation in the study, participants will have the opportunity to have their story and experiences heard. This research may contribute to healthcare organizational leaders' gained knowledge of the NCHL competency model and the challenges, which may have affected their organizational leaders' use of the model for evaluation and training. The results of study

will be shared with the community partner and participants in a one to two page results summary.

Data Collection Instruments

I was the primary data collection instrument. Participant interviews and secondary data are the sources of data for this research. I used semi-structured interviews with healthcare leaders and professionals to explore the use of leadership competencies, specifically if they use any of the NCHL competencies in their employee evaluation system for this healthcare organization in the Midwestern United States. The secondary data was job competency forms, performance evaluations, and data collected by the human resources and education professionals within the organization.

The semi-structured telephone interviews occurred at a convenient and preferred time for the study participants. Cachia and Millward (2011) recognized the value of telephone interviews in qualitative research. O'Toole, Schoo, and Hernan (2010) encouraged conducting and telephonic interviews as participants are in an environment in which they feel comfortable sharing their experience regarding the topic. The use of the telephone interview is a viable data collection method in qualitative research and supported in research by Block and Erskine (2012), Glogowska, Young, and Lockyear (2011), Irvine (2011), and Holt (2010). The telephone interview was preferred due to extended geographical differences between participants and me.

By using the consent form, I was clear about the goals to be achieved from the interview, established key information I needed to acquire from the participants and outlined the key questions and points to be covered. The interviews were based on a

researcher-designed semi-structured interview script and were developed in alignment with the research question by using a Research Question Matrix in Appendix A (Yin, 2011). The Research Question Matrix allowed me to ensure that each question used in the process was directly aligned with the study's research question and ensured that enough data was acquired to answer fully the research question (Yin, 2011; 2014).

Data collection consisted of a telephone interview scheduled for one hour in length, understanding that they may extend beyond the hour due to the variability in length of participants' responses. I interviewed the participants by telephone for the convenience of the study participants. All interviews were audio-recorded to assist in the accuracy of the transcriptions with the participant permission. The audio-recordings were used only to transcribe the interviews. Copies of the transcribed interviews were sent to participants.

Another data source included archival secondary data. Secondary data included documents related to performance, evaluation, competencies or training. Secondary data was acquired from professionals in the human resources department such as samples of blank leader annual performance evaluations. By working with the education department professionals, I also collected secondary data such as samples of their leader orientation checklists or competencies. The study participants were able to volunteer unique employee evaluation tools or assessments that were unit- or discipline-specific during the interview process.

The data may was sent to me via e-mail or hard copy through the mail, with a stamped self-addressed envelope provided by myself as needed. The additional secondary

data added to any leader evaluation competency model components or systems in place that was not mentioned by the study participants. The data was another secondary source of reference along with the participants' experiences spoken during the interviews.

The privacy and confidentiality of the identities of the participants was maintained through the use of randomly generated alpha-numeric coding which will be known only by me (Yin, 2011; 2014). All identifiable characteristics have been removed from the data collection materials including interviews, demographic questionnaire, and secondary data (Yin 2011; 2014). Only aggregate data has been reported and used in publications or presentations of the study results (Yin, 2011; 2014). The code-sheet is stored in a safe secure locked location along with all raw data and files (digital, audio, electronic, hard-paper copy and any other associated content pertaining to the research) accessible only by myself (Leong et al., 2013). The data are kept for a period of 5 years after which everything will be destroyed by shredding hard copy, secure erasure of audio tapes, and using a three phase overwrite process for electronic and digital data (Leong et al., 2013).

In the course of collecting data through interviewing, I did not assume anything (Cachia & Millward, 2011). The process included listening, understanding, and explaining the participants' experience (Cachia & Millward, 2011). I bracketed myself and remained neutral in the data collections and data analysis process by mitigating my personal feelings. Bracketing is a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to research and thereby to increase the rigor of the project (Tufford & Newman, 2012). I used secondary

data in the data collection and analysis phase of the study to cross-reference the participants' spoken experiences related to their evaluations and competency models that exist on paper within the organization.

I used all of the sources of data from the interviews; my field notes observations during the interview process, and the secondary data sources to explore the challenges and intricacies of leaders effectively integrating the NCHL competencies into the employee evaluation system of a midsized healthcare organization in the Midwestern United States. I organized the data in categories such as performance evaluation, educational training, and competencies. These sources of data provided a comprehensive view of the healthcare organizations leadership competencies and use related to the NCHL model competencies and if they are integrated within the organization. The raw data will be available from me by request.

Data Collection Technique

After IRB approval was obtained, expert validation from three faculty members determined reliability of the researcher-designed research question matrix. Mero-Jaffe (2011) recognized that evaluation of planned interview protocols through expert validation can assist in reliability and accuracy of acquired data for qualitative research. I used expert validation to share the semi-structured interview questions with three doctoral prepared faculty, since the questions are researcher designed and have not been previously tested. I shared the content of the research question matrix that I used in the design of this data collection source with these experts. Based on the results of the expert validation, the interview questions in this protocol did not need to

change.

Multiple forms of data were used for this research for triangulation purposes. The forms of data included interviews, secondary data related to performance management systems, and leadership competency models utilized within the organization. Goering and Streiner (2013) recommended the utilization of more than one source of data in qualitative research to assist in the validity of the data acquired and enhance the quality of the information through this methodological triangulation from multiple sources.

Once participants were identified and it had been determined that they meet the inclusion criteria for the study, telephone interviews were scheduled. Total anticipated time for the interview was approximately one hour in length. All interviews were recorded with the permission of the participant (Leong et al., 2013). Participants were asked to be honest and truthful during their participation and the process for the interviews was explained to them in detail prior to their consent.

The interview consent form was emailed to each study participant prior to the interview. The interview process began with completion of the participant's consent, and I answered any questions the participant had before starting the interview. The interview questions (Appendix A) were also emailed to each study participant upon agreement to participate in addition to the participant's consent form. The reason for emailing in advance was to allow participants time to prepare for the interview and have a better understanding of the type of questions that would be asked.

I anticipated that interviews would last one hour in length. Participation in this study was strictly voluntary. Participants could withdraw from the study at any time

without consequence. The participants also had the right to choose not to answer any of the interviews questions. While there is no direct benefit to the study participants, I anticipate their involvement in this study may contribute gained awareness of the NCHL competency model and how it can be applied to healthcare organizations. All interviews were transcribed using the audio recording of the interview (Yin, 2011; 2014). Copies of the transcribed interview were returned to the participants.

Data Organization Technique

After the interviews were complete, I first transcribed the interviews for each participant from the audio recordings, and categorize the participants by alphanumeric code. Yin (2011, 2014) supported the organization of data by participant code to assist the researcher in defining themes and patterns by participant during the data analysis process. I then analyzed data from the interviews for meaningful themes, characteristics, and descriptions that emerge. The information from the secondary data was categorized by participant code, aligned with the interview data and further analyzed for commonalities and patterns. The data was organized by type of data source, date acquired during the data collection process pertaining to the organization and filing of these data.

Only I have access to any of the data or transcriptions, kept in a locked safe at my home. This minimized a breach in confidentiality of participants, which decreased their discomfort for participation. All raw data, including audio-recordings of interviews and any hard-copy and electronic and digital files, is stored in a locked secure location accessible only by me for 5 years. Five years after the end of the study, all hard copy and audio data files will be destroyed (Leong et al., 2013).

Data Analysis

I used methodological triangulation by using multiple interviews and secondary data to align the information acquired for the hand coding data analysis process. Goering and Streiner (2013) supported the use of triangulation of at least three data sources to assist in alignment of the quality of data acquired and to provide a means to verify insight concerning the phenomenon through a variety of lenses. Once all data was acquired and confirmed via transcript, organization by participant code and data type, I hand coded the data. The data analysis was the basis to determine the relationships, if any, between the strategies senior leaders use to integrate the NCHL competencies into employee evaluation systems.

Yin (2011, 2014) and Goering and Steiner (2013) suggested analyzing the data by identifying, coding, and pattern matching themes. Therefore, the specific steps I utilized in this process was to (a) identify common themes in the interviews and secondary data, (b) color code the common themes by highlighting them in a designated color, (c) list useful terms and meanings of statements, (d) case study analysis for pattern matching, and (d) keep each participant confidential using alphanumeric codes known only to me. Saldaña (2012) recommended the use of a two-stage coding method for qualitative research. In the initial stage I identified common words and patterns and categorized them together defined by participant and data source codes. Saldaña also recommended categorization of specific aspects of data by categories such as process, themes, or emotions. Since processes and themes are significant to this research, I used process and

thematic coding in the second stage. Next, a more definitive description of the planned coding and data analysis procedures per research question was provided.

Research Questions and Data Sources for Data Analysis

The overarching central research question that I used to guide the design and data collection and analysis processes for this research was: what strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?

The participant's perceptions of the influence of their career succession were used to answer this question. Seven specific interview data collection questions were designed to obtain data on experience and perceived opinions/views for the study participants during the interview process. Table 2 lists the overarching research question and interview data protocol questions that I used to answer that question. Table 3 lists the data sources of data aligned with the research question.

Table 2

Interview Protocol and Research Question for Data Analysis

Research question	Interview protocol
What strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?	1. What leadership competencies do you use to reach your organizational goals as healthcare leader? 2. Based on your knowledge and experience with this healthcare system, how are they being used or applied in this organization? 3. What has been your experience with leadership competency models? 4. How do you track leadership performance? 5. What types of tools do you use to track performance management? 6. What are the key skills, or competencies tracked in your performance management evaluation system? 7. How do you determine if a leader or direct report has a specific competency or needs training to build up an existing skill of competency?

Table 3

Data Sources for Analysis

Research question	Secondary sources
What strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems?	Documentary data on the organization's leadership structure
	Job descriptions & instruments
	Hiring procedures
	Performance evaluation systems
	Procedures for promotion within the organization
	Leader orientation checklists or competencies
	Unique employee evaluation tools or assessments that are unit - discipline-specific

The primary data collection was data from interviews based on the seven questions listed in the interview protocol (Table 2). Secondary data collection was from the documentary data related to leader orientation, competencies, and evaluation systems. Each data source was organized by participant code and type of data source, and prepared for the coding process.

Coding and Software

Information provided by participants in the interviews was hand coded with potential master themes following the pattern coding approach recommended by Yin (2011, 2014) and Saldaña (2012). As suggested by Saldaña, I carefully inspected the interviews and analyzed the data for themes, useful terms, and meaningful statements

utilizing iterative hand coding. Saldaña's procedures for the initial hand coding process provide cohesive data analysis by highlighting themes by color, process, and theme in the body of the data documents. Common terms, themes, and processes were assigned color codes to detect the presence of similarities between the data from the interviews and secondary data.

Reliability and Validity

Reliability and validity in qualitative research has been questioned because the results are not always precise or statistically represented with countable answers (Ali & Yusof, 2011; McConnell-Henry, Chapman, & Francis, 2011). Healy and Perry (2000) asserted in qualitative research the terms reliability and validity do not reflect the true nature of the process taking place, they suggest using words such as credibility, dependability, consistency, neutrality, and applicability instead.

Reliability

In order to enhance the reliability of this qualitative case study, I used the Research Question Matrix (Appendix A) to ensure their alignment with the research question. Other methods to assist with the reliability of the data that were acquired from the interviews were transcribed review by me, and the use of thorough interviews to clarify and expand on points made (Mero-Jaffe, 2011). Participants were allowed to review the interview transcripts to preserve research ethics, and allow for content revisions that accurately capture the participant's perspective of their lived experiences (Irvine, Drew, & Sainsbury, 2013).

Mero-Jaffe (2011) suggested participant responses related to content validation,

the authenticity of the interview, language corrections, and changes between the researcher and participant were important to confirm the reliability of the information acquired. Changes or expansion on points can be requested by the participants by using the multiple interviews format for member checking. Participants reviewed the interview transcripts and could have expanded on points made to preserve research ethics, and allow for content revisions that accurately capture the participant's perspective of the event (Mero-Jaffe, 2011). Houghton, Casey, Shaw, and Murphy (2013) and Mero-Jaffe (2011) identified that transcript review and member checking is intended to validate content, preserve research ethics, and to empower the participants by allowing them to control the written content and expand on points made. Member checking ensures research is conducted in a rigorous manner demonstrated in qualitative case studies (Houghton et al., 2013).

Validity

Goerig and Streiner (2013) recognized that the use of only one form of data in qualitative research tends to limit credible representation of the phenomenon being studied. Triangulation of at least three data sources is a method to assist in the quality of data acquired providing an avenue to verify insight about the phenomenon through a variety of lenses (Goering & Streiner, 2013). To assist in understanding the business problem from more than one perspective, I used methodological triangulation which is a cross-referencing technique to enhance the quality of data acquired as recommended by Goering and Streiner. I compiled the data from interviews and the secondary data gathered from the professionals in the human resources and training departments. If

conflicting data was found during triangulation, I would have resolved it by clarifying during the interview process, asking for clarity of documents, using follow up questions with or interviewing more participants.

The potential for conflicting or incomplete information from the data sources is one reason why Saldaña's (2012) a two-phase hand coding process, triangulation of data sources and member checking is being used. I used the documented literature about the NCHL competencies, and data from previous NCHL surveys by permission of NCHL to compare to data accumulated from this study, leaving transferability to the reader or future researchers (Malterud, 2001).

Transition and Summary

In this section, qualitative research traditions and justification for the choice of a case study design as the most appropriate model for this study were provided (Ali & Yusof, 2011; Goerig & Streiner, 2013; Yin, 2014). Interviews with a purposeful sample of participants in this case study provided the diverse description needed to understand the reasons for the challenges and barriers to effectively integrate the NCHL competencies into their employee evaluation system for healthcare leadership roles (NCHL, 2011; Yin, 2014). Sample members were from the Midwestern United States geographical location, and leadership or professional roles in a healthcare organization. Data was gathered from participants by interviews. The data analysis was driven from the theoretical and conceptual bases established in the literature review, which is the NCHL model as the conceptual framework and sociocultural theory (Yin, 2014). Theme coding and pattern matching techniques were used to analyze data gathered from the interviews

(Saldaña, 2012).

Master themes were expected to evolve as data gathering and analysis occur (Saldaña, 2012). The report of findings will provide a description of each interview for context, but will emphasize an overall analysis organized around the research propositions (Saldaña, 2012). In Section 3 the results of the research are defined. It will provide a description of the study population, data analysis, and study results from the data collection as well as the meaning of the results for social change and business practice improvement.

Section 3: Application to Professional Practice and Implications for Change

In Section 1, I described the general and specific business problems. I noted that the purpose of this qualitative exploratory case study was to explore the central research question: What strategies do senior leaders need to integrate NCHL competencies into employee evaluation systems? I discussed the primary conceptual frameworks for this study and the review of the literature. Section 2 was an overview of my role as the researcher, ethical precautions, population, and participants of the study followed by a discussion of the research approach and data instruments and data collection and analysis.

Section 3 contains an overview of the findings and the applicability of the findings to professional practice in a business setting. This section includes a discussion on how employers or researchers might use the findings and recommendations from this study to effect social change. Section 3 includes a review of areas of the study that might necessitate further research. The conclusion area of this study contains a section of final reflections from completing the research process.

Introduction

The purpose of the qualitative exploratory case study was to identify the strategies that senior leaders need to integrate NCHL competencies into employee evaluation systems. Addressing this important area of research provides healthcare senior leaders with information that may improve or build NCHL competencies within their employee evaluation and training systems and become agents of positive social change. All participants in this study expressed the desire for integration of the NCHL competencies into their performance evaluations.

The findings revealed 80% of the participants recognized leadership competencies in their leadership training and evaluation system. The participants identified an evaluation system that is used to identify goal tracking and leadership performance. Half of the participants believed there was a stronger focus on system goals versus NCHL leadership competencies within their leadership evaluation system. In the study, 100% of the participants realized the importance of the NCHL leadership competency model and the need to identify and foster competencies for leadership development.

Presentation of the Findings

I used open ended interview questions to gain an in-depth understanding of what strategies senior leaders need in order to integrate NCHL competencies into employee evaluation systems. I interviewed 10 participants to identify themes of how the NCHL leadership competencies are used in a healthcare organization. Participants were male and female junior leaders who worked in the Midwestern United States. Prior to conducting the interviews, each participant responded to an email that contained the Consent Form, with the words, *I Consent*. During the audio-taped telephone interviews with each participant, I asked seven interview questions (see Appendix A). I had approval #05-12-15-0330758 from Walden University's IRB for the Consent Form and interview questions.

The 10 study participants from a single midsized healthcare organization in the Midwestern United States consisted of a diverse group of directors, managers, and supervisors associated with the delivery of health care services. The selection of this sample provided valuable insight into strategies senior leaders need to integrate the

NCHL competencies into their organizations' leadership development and performance evaluation systems. All 10 participants had 1 year experience and knowledge of leadership competencies and performance evaluation, which contributed to the validity of the data (Kerr et al., 2010; Lakshmi & Mohideen, 2013).

Triangulation methods are used by researchers to check results. I used methodological triangulation in this study by combining interviews, document analysis, and secondary data. During the triangulation process, I discovered the leader evaluations and competency forms aligned with the responses by study participants during interviews. Using this triangulation technique validated the data, and diminished biases. The secondary data explored were participant annual performance evaluations and leadership competencies used during orientation. The secondary data relates to the NCHL leadership competency model as it provided the fundamental components of the model senior leaders used to access junior leaders in their annual reviews and during orientation. Reviewing the leader evaluations assisted with interpretation of categorized decisions invented for leadership competencies, leadership development, and performance management. Reviewing the additional data supported the emerging themes of feedback from participants in the organization.

Throughout the preliminary review of the data, keywords were recognized and developed common themes. The coding of data sustained the development of emergent sets of comparable data allowing the early classification of patterns (Neuman, 2011). The findings were structured using color coding and bunching the data into main themes. The results of this study addressed the central research question. Coding was time-consuming

by hand but allowed me to obtain familiarity with the data rather than using a computer software program. During the middle of interviewing Participant 10, data saturation commenced and no new themes or responses occurred. I confirmed this during the data analysis process.

When data analysis occurred, four ubiquitous themes emerged from this study. The themes were (a) transformation of leaders by vision and focus, (b) continuous training is needed, (c) leaders like accountability, and (d) leaders like to influence goal creation. The themes that emerged are noteworthy factors that persuade leadership performance strategies (NCHL, 2014c). The consequence of exploring performance in the workplace may support organizational senior leaders with fulfilling strategies to sustain organizational development while achieving strategic goals (NCHL, 2014b).

The results of this study revealed 100% of participants were familiar with the term leadership competencies; however, they were not specifically aware of the NCHL leadership competency model. Participants reflected on leadership competencies in the participants' annual performance evaluations and their orientation competencies. Leadership competencies were noted in secondary data that reflected the NCHL leadership competency model. Some of the competencies reflected were achievement, analytical thinking, community involvement, financial skills, innovation, accountability, collaboration, professionalism, development, and strategic orientation (NCHL, 2014c).

Theme 1: Transformation of Leaders by Vision and Focus

During interviews, study participants identified leadership growth within the organization by vision and focus of organizational goals. Strategic orientation, as

described in the NCHL competency model, is the organization's ability to draw implications and conclusions of the business, economic, demographic, ethnocultural, political, and regulatory trends and developments, and to use these insights to develop an evolving vision for the organization and the health industry that results in long-term success and viability (NCHL, 2014c). Though the participants all acknowledged there was the use of leadership competencies in the organization, the participants did not agree on how the goals are integrated into their organization. Sixty percent of the participants did not think leadership competencies were a leader's prime focus; they stated organizational goals cascaded down by executive leadership.

The leaders of the organization use a performance management system (PMP) software system to enter data that measure leadership performance. All the junior leaders reflected the PMP is a required tool; however, not all the junior leaders believed the organizational goals aligned with their work. Half of the junior leaders employed a PMP tool throughout the year to track their performances based on metrics. Others used a PMP tool at the end of the year to reflect on their performances for the last full year in review.

Leaders track system strategies within the PMP tool at year end to measure leadership achievement. Participants 2 and 6 described the PMP system as a computer-based model that allowed them to enter a goal and enter a different target level that meets, or excels. The leaders used the PMP tool to target and align the organization's strategy to specific leadership targets. Each quarter, the participants can reflect on what plans are working and continue to gauge the leader's success or discontinue the current path and adjust to align better with their target. Participant 2 stated that the PMP system

is the only tool aligned with certain initiatives within the hospital, for example focusing on inpatient falls versus building trust.

The importance of healthcare senior leaders identifying competencies used within the organization is a primary step to realize expectations associated with job performance. Participant 1 described an objective group and subjective group of competencies. Leaders' objective competencies include process improvement goals set at the beginning of the year with a specific rating such as achieves results, meets results, or does not meet and needs improvement. The subjective competencies referenced were business knowledge, collaboration, proactive communication, service excellence, and technical expertise. As described in the NCHL competency model (2014c), achievement orientation may be one's past performance, an objective measure, outperforming others, challenging goals, or innovation.

The answers and comments of the participants demonstrated a variation of how leadership competencies are used to reach organizational goals. The participants identified how their performance evaluation system drives them toward their goals and measured competencies that confirm organic leadership, and how the NCHL leadership competency model is relevant to the organization (NCHL, 2014c; Tuan, 2012). Participant 5 identified "leadership competencies such as collaboration, financial analysis, and team building were the fundamental competencies used to reach organizational goals." Participants think the development of those leadership competencies positively affected their ability to achieve organizational goals. They mentioned the leadership development training courses they attend quarterly and books

they are required to read to expand their leadership knowledge.

Participant 4 commented on a new leader orientation and competency sign off during training but did not believe the competencies were maximized or developed after orientation. Participants suggested an ongoing process outside of the annual review to encourage leadership competency development with the focus on under- or over-developed skills. Participant 1 explained the integration of the competencies with specific targets; did not think senior leaders actively evaluate their direct reports on proactive communication. The competencies were actively reviewed for junior leaders because the competencies are specific goals reviewed monthly within the organization.

Lam, Xu, and Chan (2015) posited that leadership effectiveness is a mediating mechanism and under conditions of high information sharing, links participative leadership and objective performances. The relationship pattern remained significant even after controlling for the effect of individual differences (Lam et al., 2015). Carter, DeChurch, Braun, and Contractor (2015) revealed patterns of leadership relations develop over time and are shaped by top-down contextual factors and bottom-up through individuals' traits. The findings extended knowledge of the NCHL competency model as the participants confirmed senior leaders aligned objectives with organizational goals by providing vision on how to attain the goals.

Transformation of junior leaders by visioning, energizing, and stimulating a change process that guides communities, patients, and professionals around new models of healthcare and wellness is important for healthcare organizations (NCHL, 2014c). Healthcare organizations invest in training areas such as performance evaluation,

development, and processes to run their healthcare organization (Furtado, Batista, & Silva, 2011). According to Kerfoot (2013), quality leaders challenge themselves to assemble energized leaders who believe in the organization's mission and develop shared values together. Frish (2012) stated that leaders must structure their organizations for outcomes by creating a leadership team to organize the work within their organization to achieve goals. Leaders must consider various external and internal variables but be designed to produce positive outcomes (Cummings et al., 2010). Theme 1 is rooted in the notion that senior leaders of the organization provide vision and focus for junior leaders to align goals with the overall strategy.

Theme 2: Continuous Training

Study participants reflected that their skills are enhanced by the organization senior leadership's approach to leadership development is through the leader orientation process and the Leadership Development Institute. Participants described how ongoing leadership training influences development because the training encompasses a variety of topics that apply to the participants' daily operations. The organization offers professional development speakers to discuss change management and how to adapt to a rapidly changing healthcare field. The speakers and specialists have the participants interact in tabletop discussion sessions to solve problems and to use hands on exercises on how to expand their leadership skill sets.

Participants 1, 5, and 10 stated that after their training at the Leadership Development Institute, they were assigned specific tasks to complete related to taking the information back to their staff. Participant 1 said, "We report the tasks we have been

assigned on a grid to senior leadership such as educating staff on the new quality indicators for next year." Junior leaders track the information within their organization and report to executive leadership. The participants believe continued leadership development is important. Rehman, Shareef, Mahmood, and Ishaque (2012) agreed with the argument that leaders face challenges in a complex business environment.

The study participants were able to identify ways to determine if direct reports need to improve a specific competency by evaluating the direct report with the PMP tool, and implementing the use of interdepartmental competencies. Eighty percent of the participants identified the need for a specific and focused evaluation of leader competencies and skills aside from goal achievement. Participant 4 explored his/her perspective of leader skill development:

> For people who report to me, I review them yearly, and review their competency sheet to see if anything has changed in the department that we may have missed. If we have, I create a new document for that and retrain everybody on that and make sure that they are competent. As far as the other junior leaders there is not anything set up like that so I think a new leader gets it during orientation. Nobody looks back on that to see if anything has changed or if there are any holes in the system.

Health senior leaders are challenged to create work climates that motivate high-quality, patient-centered care and to retain high-demand talent in a competitive marketplace (NCHL, 2014c). Leaders need to be information seeking, develop an underlying desire to know more about people, or issues, and stay current with health, and

professional trends and developments (NCHL, 2014c). Leaders should be innovative thinkers, exuding the ability to apply complex concepts, develop creative solutions, or adapt previous solutions for breakthrough thinking in the healthcare field (NCHL, 2014c).

Bullough, Sully De Luque, Aldelzaher, and Heim (2015) stressed the importance of training leaders to be aligned with organizational goals. Education and training topics such as networking, negotiating, leading change, can help leaders address work-life balance issues (Bullough et al., 2015). Critical thinking, problem solving, and decision making skills should be part of training curriculums for leaders to apply what they teach (Bullough et al., 2015). Goleman, Boyatzis, and McKee (2002) suggested a link exists between emotional intelligence, leadership, and strong performance. Some successful leaders possess a strong sense of self-awareness, motivation, empathy, and adaptive social skills (Goleman et al., 2002). The exceptional leader should have intellect and the ability to be a visionary (Goleman et al., 2002). If the organization's leaders identify strengths in potential leaders, the organization should be committed to the development of an emotional intelligence program (Goleman et al., 2002).

Treven, Treven, and Žižek (2015) argued that organizations that are above average for caring that employees understand their duties and responsibilities are perceived as well-being organizations. Well-being organizations are above average in providing the necessary training to employees (Treven et al., 2015). The study participants valued continuous development to grow as leaders within the organization and enhance their abilities. These findings relate to the conceptual framework because the

NCHL competency model identifies talent development, team leadership, self-development, and human resources management as fundamental competencies senior leaders can implement in an organization to ensure the success of junior leaders (NCHL, 2014c).

Theme 3: Leaders Like Accountability

The study participants were able to communicate the organization's performance evaluation system, and that they were all evaluated annually, which is tied to an annual raise. Seventy percent of the participants were not able to identify how their leadership competencies were evaluated, such as communication, emotional intelligence, and interactions with other leaders. The participants' perceptions correlated with their annual performance evaluation regarding emotional intelligence. During a review of secondary data, their performance evaluations did rate their communication, collaboration, and teamwork as an overview of the organization's leadership performance. The following quotes expand on this thought:

> My leadership competencies are so part of who I am that I don't think necessarily about well I need to be sure I'm doing this and this. I think they are just part of how I do my work. I reflect on them whenever I hire someone new, which helps me to ground myself and reflect on if my style is still the same, and how I handle things. (Participant 3)

> You figure out if people have needs for development by human instinct. It's like how you rate emotional intelligence. Being a leader really revolves around your emotional intelligence. It's a really hard thing to quantify. (Participant 8)

Bouckenooghe, Zafar, and Raja (2015) contended that the instrumental role of ethical leadership shapes job performances. Ethical senior leaders can ensure accountability in a manner that is respected by followers. Ethical leadership may foster positive motivations (Bouckenooghe et al., 2015). Pucic (2015) argued that ethical leadership may be associated with concrete and pragmatic effects on followers. Ethical leadership is instrumental in employment relationship for leaders and enhancing the employee relationship for followers (Pucic, 2015). As related to this study, the participants identified direct correlation of how the senior leaders in the organization were integrating the NCHL competency model by holding them accountable with an annual performance evaluation system and orientation competencies.

The NCHL leadership competency model explains that execution is the translation of vision and strategy into optimal organizational performance (NCHL, 2014b). Leaders can execute strategies and visions by implementing personal accountability. Accountability is the ability to hold leaders accountable to standards of performance and using the power of one's position with the long-term good of the organization in mind (NCHL, 2014b). Organizations have wanted ways to access and advance the performance workers (Cailler, 2014). Differences exist among theories, however the agreement is that leadership strategies are common (Cailler, 2014). A system without sufficient response mechanisms is out of control (Smith, 2009). Implementing tools such as employee evaluation systems, positive feedback and improved decision-making mechanisms may shape positive behaviors and performances (Smith, 2009).

Theme 4: Leaders Like to Influence Goal Creation

Participants 1, 2, 3, 4, 7, and 9 described annual performance evaluation reviews that they completed with their staff and an interactive conversation about their skill sets and the need for further education and training. External organizations drive some departments that have specific competencies their staffs have to maintain. Study participants ensured that their staffs signed off annually to meet job-specific requirements. Participants 2, 3 and 7, reflected regular one-to-one meetings with their staffs, which allowed an opportunity to assess their leadership skills and implement growth opportunities. Participants 1, 4, and 10, think leadership competencies are not evaluated beyond orientation, which results in their inability to develop skills that they may be lacking. These participants expressed a dislike for personal goals that cascaded down from senior leadership because it took away their ability to influence their own goals.

The people component of the NCHL competency model is focused on creating a culture within the organization that values employees and energizes them (NCHL, 2014c). The people component includes the leader's responsibility to understand employee capabilities and how leaders influence others (NCHL, 2014c). Specific competencies include interpersonal understanding, relationship building, self-confidence, talent development, and team leadership (NCHL, 2014c). The participants reflected the organization is focused on mission, values, and norms, and there is accountability of leaders for group results (NCHL, 2014c). There was an apparent desire from participants to have more self-development opportunities. NCHL competency self-development is the

ability to see an accurate view of one's strengths and needs, and the willingness to address those needs through self-directed learning and new leadership approaches (NCHL, 2014c).

Simola, Barling, and Turner (2012) suggested leadership influences service quality and profitability by influencing employee engagement. Organizations that focus on interpersonal attitudes allow psychological ownership to take hold, and develop a team-oriented mentality (Sieger, Zellweger, & Aquino, 2013). Performance awareness provides an environment for setting goals, expectations, training, and development (Mone, Eisinger, Guggenheim, Price, & Stine, 2011). Leaders influence employee motivation and engagement (Mone et al., 2011). Lunenburg (2011) found a link between expectancy theory attributes and positive employee motivation. Motivated employees who understand expectations met goals and became more engaged in the organization (Robertson, Birch, & Cooper, 2012).

It is important for everyone for senior leaders to practice listening to achieve excellence (Carillo, 2015). Chartering and empowering teams to solve problems also means training them in communication skills (Carillo, 2015). Using the strategic goals of the organization, the teams need to create their own charter that can be approved and supported by the senior leaders (Carillo, 2015). This directly ties to the findings from the study participants as they reflected a desire to have contributions to goal setting rather than have goals cascaded down from organizational senior leaders. If the goal setting shifted to allow junior leaders to set individual goals, they would have the opportunity to develop their own leadership potential.

Conclusions From Themes

The research question that I used in this study was an outgrowth of previous research findings. The findings from the current study extend knowledge in the discipline, assisting current efforts. Specifically, the key tactics utilized in the leadership styles explored in the literature review, which included organic leadership, leadership logic, and transformational leadership, support the findings of this study. The study participants found importance in transparency, communication, education and training, and focused goals. The findings tie to the conceptual framework because participants were able to correlate key strategies senior leaders used to integrate the NCHL competency model into their organization.

The conclusions of the theme analysis create an opportunity to enhance strategies senior leaders are using to implement the NCHL leadership competency model. Specific responses from participants supported the results of the theme analysis, with specific conclusions: (a) junior leaders are transformed by vision and focus of senior leaders within an organization, (b) participants are influenced by the continuous training within their organization in a positive way, and (c) like accountability, which the participants reflected occurs within their organization using performance evaluation and measurement systems. Junior leaders like to influence the goals they will be held accountable to. The themes tie directly to the conceptual framework for this study, reflecting components of the NCHL competency model discussed in the literature review.

The purpose of this qualitative case study was to explore the strategies senior healthcare leaders use to integrate the NCHL leadership competency model in their

organizations. From these findings, I posit that the current study's participants reflected senior leaders' desires for their organizations to integrate the NCHL competency model in their new-leader orientation, through leader training and development, and in their leader performance evaluation systems. The specific conclusions underscore the need for further integration of the NCHL leadership competency model for the improvement of leadership evaluation and development, which creates positive organizational outcomes. The findings suggest there is opportunity to educate senior leaders on the specific components of the NCHL competency model that may promote additional integration of the model within the organization.

Application to Professional Practice

This study contributes to the accessible body of knowledge to expand business strategies and provide relevance to business practices, which may add to the effectiveness of implementing the NCHL competency model in a healthcare organization. The study may be of value to business leaders and healthcare senior leaders because effective integration of the NCHL leadership competency model within an organization aids in the development of junior leaders and alignment with organizational goals. Human performance regulates through cognitive, emotional, motivational, and decisional processes during challenging conditions (O'Sullivan & Strauser, 2009). Senior leaders should invest in the development of adaptive mindsets, and goal achievement in an effort to improve leadership skills (Yukl & Mahsud, 2010). Job, Dweck, and Walton (2010) found that written goal implementation plans, compared to motivational incentives, provided a sensible self-regulation technique for leaders.

Recommendations for practices are being made that, if implemented, (a) could enhance the success of seniors leaders ability to train and develop junior leaders, (b) could enhance focus and communication amongst senior leaders and direct reports, and (c) could improve the success of the junior leaders attaining their organizational goals. The majority of study participants said that they find importance in the use of the NCHL competency model within their organization by use of orientation competencies, performance evaluation systems, and training and development of their skills. However, the study results revealed some insufficiencies in how the senior leaders are integrating the NCHL competency model with their direct reports.

Leadership competencies are variables of knowledge, skills, and practices (Boyatzis, 2009). Hannah, Woolfolk, and Lord (2010) surmised that an advantage of competency modeling was its transferability to multiple leadership roles. Empirical observations are congruent with the existing theories. Leadership skills frame specific capabilities as indicators of performance-based skills, and abilities evidenced through practices (Hannah et al., 2010). The leadership competencies assessment provided an empirical frame as a starting point for periodic developmental evaluation (Berdrow & Evers, 2009). It remains imperative for senior leaders to appreciate how to build up leadership skills for constructive workplace performance. I recommend senior leaders integrate the NCHL competency model within their leadership model of their organization by use of the model in their competency assessment and leadership development and training.

Implications for Social Change

The implications for social change reflect the importance of Section 1 and conclusions presented in Section 2. This qualitative case study may help increase awareness in the related healthcare leadership journalism by rendering supplementary perspectives into the effective integration of the NCHL competency model by senior leaders executing strategic decisions for healthcare organizations. The results of the study may support positive social change by senor leaders expanding their understanding of the NCHL leadership competency model. Integration of the model in a healthcare organization can positively influence both the organization through goal achievement and the community receiving care from the healthcare organization. Without a baseline assessment of prior senior leaders' knowledge, skills, and practices as leadership competencies, it remains unknown whether the needs of junior leaders were addressed adequately.

Junior leaders receive positive insight and knowledge about integrating leadership competencies and how the skills from those competencies can influence organizational goals. Organizational senior leaders can appreciate employers' responsibilities to create an environment that supports leadership growth and evaluation through professional training and education (Singh et al., 2014). The findings found in Theme 3 on leadership competencies, integration, assessment, and development could further highlight the importance of support for implementing the NCHL leadership competency model (NCHL, 2014b).

The recommendations maintain enhanced long-standing sustainability strategies for senior leaders of organizations and communities. Specifically, if senior leaders ensure their junior leaders know the components of the NCHL leadership competency model, they may be more efficient with the healthcare delivery in the organization. Ensuring junior leaders know the model will allow senior leaders of an organization to integrate it in their new leader orientation, competencies, training, assessment, and development. The significance of exploring the strategies senior leaders use to integrate the NCHL leadership competency model in their leader performance evaluation systems may help senior leaders achieve organizational, operational, and strategic goals (NCHL, 2014b). Successful organizational senior leaders know that their prime aim is to enhance the performance of their employees, but the deficiency of integrating the NCHL competency model may have a negative effect on healthcare organizations. Senior leaders who successfully integrate the NCHL model could remove organizational barriers to allow them to achieve goals that would decrease healthcare costs. Society at large may benefit by making healthcare more affordable for everyone.

Recommendations for Action

Senior leaders who integrate the NCHL leadership competency model into their organization may supply a positive collection of leadership abilities, improvement, appraisal, and opportunities to augment performance (NCHL, 2014b). Efficient organizations know that their primary objective is to enhance the performance of their junior leaders. Office design can be a powerful tool for sustaining workplace performance (NCHL, 2014b). For instance, implementing the NCHL leadership

competency model may provide senior leaders with direction, expectations, and identify the need for training and development.

The study participants provided perceptiveness into leadership competencies and the importance of applying competencies to achieve work success. I recommend that healthcare senior leaders in the United States enhance strategies to implement and teach their junior leaders NCHL leadership model competencies. The successful implementation of the model may improve expectations, leadership qualities, and leader skills that need to be developed or used as strengths within the organization. The NCHL leadership model was developed and validated by interdisciplinary experts in collaboration with industrial and educational psychologists (NCHL, 2014b). The model has been adapted for use in healthcare settings, and has been the leading model used by accredited graduate programs in healthcare management (NCHL, 2014b). The results from this study might be disseminated via organizational training and development sessions for leaders, senior leader conferences, or shared by email.

Improving NCHL leadership competency model skills may enhance leadership development and training (NCHL, 2014c). Organizational senior leaders may employ the study outcomes to improve workplace performance and reduce barriers to assessing and increasing their junior leaders. The NCHL leadership competency model is focused on healthcare leadership, transformation of leaders, people, and the execution of leadership skills (NCHL, 2014c). Some of the interview participants had a positive outlook on the NCHL leadership competencies and think they were integral to leadership development within their organization. Organizational senior leaders can implement the NCHL

leadership competency model in their healthcare organization to ensure junior leaders continue to grow and achieve organizational goals. The organizational goals positively affect the patients served because leaders are engaged and focused on common healthcare goals such as quality care and patient satisfaction (NCHL, 2014b).

In Theme 1, participants identified the use of the NCHL leadership competency model by transformation of junior leaders through focused vision within the organization. Organizational senior leaders might consider implementing the NCHL leadership competency model, as well as formal training about the model (NCHL, 2014c). Providing the education about the NCHL leadership competency model allows senior leaders to integrate fundamental leadership skills into their daily operations, competencies, and leadership development. Integration of such leadership competencies may be profitable to the organization through enhanced goal achievement of organizational goals such as the financial health of the organization, patient satisfaction, employee engagement, and quality care. Theme 1 revealed that the senior leaders' strategy was to provide transparent communication and focus to their direct reports within the organization.

Based on the findings in Theme 2, organizational junior leaders benefit from continuous training of junior leaders by integrating the NCHL leadership competencies in educational development. Motivating junior leaders to gain education and training that advance their skill set enhances the organization, and positively influences employees. Identifying the primary leadership competencies from the NCHL model will help develop junior leaders. Some focused topics an organization could apply to enhance leadership development are community orientation, organizational awareness, change leadership,

accountability, and interpersonal understanding (NCHL, 2014b). Organizations may enhance their leadership development by identifying important leadership competencies junior leaders are struggling with to improve specific skills. Leader competencies may demonstrate senior leadership's concerns for achieving operational and strategic goals, while giving junior leaders the tools to be successful by maximizing and developing their leadership skills. Senior leader strategy in Theme 2 was to provide continuous training and development to their direct reports.

In Theme 3, eight participants noted junior leaders like accountability. Leadership assessment is critical for creating positive organizational results (NCHL, 2014b). The organization has specific leader orientation and NCHL competencies tied to their leadership assessment and evaluation systems. Leader competencies were recognized in job descriptions within the secondary data. Organizations that do not assess their leader performance will not know what skills their leaders are proficient in, or what skills they need to develop. The strategy by senior leaders for Theme 3 identified the implementation and use of a comprehensive performance evaluation system and orientation competencies to ensure leader accountability.

Based on the findings in Theme 4, junior leaders like to influence the goal creation assessed throughout the year. Communication between managers and employees during regular meetings fostered feedback and opportunities to improve leadership performance. Eight participants mentioned goals were cascaded down from senior leaders that did not apply to their job role, or a goal they could influence within the organization based on their direct responsibilities. As a result, the participants lost engagement for the

goal achievement. Engaged leaders may be an organization's best source of success (NCHL, 2014c). Theme 4 revealed senior leaders use the strategy of assigning goals to junior leaders to be assessed by use of the performance evaluation system.

The participants will be given a summary of the results from the completed doctoral study, and the study will be published in ProQuest. The study may be helpful to healthcare leaders by distribution of data and promoting their interest in how to advance the integration of the NCHL leadership competency model in their healthcare organization. The findings may also stimulate interest in leadership development programs to support leadership growth and use of the NCHL leadership competencies from the full scope of leadership development including leader orientation, leader competency assessment, and leader training.

Recommendations for Further Research

The NCHL leadership competency model remains the leading healthcare model to develop leader skills, assess the alignment of leader competencies with organizational goals, and positively impacting the organization through goal achievement. In Theme 2 the principal findings revealed organizations that develop their senior leaders are likely to achieve organizational goals cascaded to their junior leaders. By continuous integration of NCHL leadership competencies in the leader training, organizations have a greater opportunity to achieve results (NCHL, 2014b). Leadership competencies within an organization can be affected by the use of training, development, and assessment (NCHL, 2014b).

I analyzed data from one healthcare organization in the Midwestern United States using a sample size of 10 participants. The study was delimited by the choice to use a single healthcare organization in the Midwestern United States (Small, 2009). Gaining the experiences of participants from a single organization might have restricted the application of results. An additional limitation is connected to researching precise aspects of leadership performance and competencies before all components of performance in the organization. A single exploratory case study approach has limitations because findings are restricted to a single population of participants. Therefore, the study may not be representative of other populations or geographic locations. The limitations and delimitations resulted in a recommendation for further research of other senior leaders in healthcare organizations, and how they apply strategies to implement the NCHL leadership competency model. Thus, further research could expand to broader geographical regions and participant samples from multiple healthcare organizations.

Because the elements of leadership competencies are broad, conducting further studies on how the NCHL leadership competency model used in healthcare organizations may be useful to gain knowledge. The NCHL leadership competency model may affect leader development and achievement of organizational goals by providing healthcare organizations with abundant assets to reduce barriers and amplify organizational performance. The recommendations in this study may help senior leaders in healthcare organizations enhance leadership development, performance, and organizational achievement through a focused use of the NCHL leadership model and competencies. The justification for integration of the NCHL leadership competency model is to advance

the awareness of leadership skill sets, and to advance the development of junior leaders for organizational success. Leaders seeking employment may use leadership competency models within an organization as they grow and advance (NCHL, 2014c). As healthcare organizations in the United States continue to face challenges, it remains important for organizational senior leaders to understand how to develop their principal performers to ensure sustainability of the organization.

Reflections

The data participants divulged in this doctoral study provided results of the problem from mixed perspectives. The data collection process allowed interviews with open-ended questions with participants. Coding and interpretation of data were increasingly more compound than originally perceived. I identified common themes that added validity to the study findings. The participants had not heard of the NCHL competency model prior to their participation in the study; and they were using primary competencies from the model within their organization.

The participants answered questions with ease. Participants seemed involved in the study. For the duration of the interviews, participants were engaged. I followed the interview protocol outlined in the research design by trying to make participants at ease and asked the interview questions in a conversational way to elicit thoughtful answers from the participants. During the progress of the interviews, the importance of leadership competencies, leadership development, and assessment prevailed.

When I began the research, it was my assumption that all the participants had familiarity with the NCHL competency model. In the course of interviewing the

participants, I found that they did not. I assumed the participants would have different perspectives on their senior leaders' strategies to integrate the model into their leader evaluation systems. Junior leader views on how their senior leaders impact their growth and development by integrating the model, was enlightening, and objective. Their openness to share their lived experiences with me assured me of their passion for leadership in the field of healthcare. Not only was I enlightened by the responses, working with my participants enabled me to enjoy the interview process.

Some participants addressed concerns about leader competency evaluations for specific leader competencies such as emotional intelligence, communication, and collaboration. Those participants think improving in these areas might increase leadership success with organizational goal achievement. All participants appreciated leadership training and development. Participants believed the organization integrates leadership goals and competencies at some level. Moreover, my personal skills enhanced the data collection, analysis, and reporting of study findings because I am organized and attentive.

Summary and Study Conclusions

The purpose of this qualitative single exploratory case study was to determine what strategies senior leaders use to integrate the NCHL competencies into their employee evaluation systems. Purposeful sampling selection was applied to explore the experiences of employees in a healthcare organization in the Midwestern United States. The findings revealed the senior leaders integrated the NCHL competency model within the organization. The following strategies were used; (a) ensuring they are part of new leader orientation, (b) focused development and training around specific competencies

such as change management, and (c) leader assessment tools that highlight specific competencies. The findings may be beneficial to organizational awareness and continued development of strategies in leadership competencies and performance. With turnover and healthcare reform challenges, healthcare organizational senior leaders need to focus on implementing a leadership competency that will allow them to apply best practices (Calhoun et al., 2012; Gumus et al., 2011; TJC, 2009, 2012). A focused approach by senior leaders to educate junior leaders within the organization on the fundamental components may enhance the success of their strategies to integrate the model within their leadership assessment, development, and training.

Some of the study participants were aware that leadership competencies are part of leader development in an organization. However, the study participants agreed that there was a specific leadership competency model implemented within their organization, or that leader skills were evaluated related to such a competency model. Healthcare senior leaders should evaluate their existing leadership competency models to identify what strategies they are using to develop and enhance their junior leaders' skills. Evaluation of existing leadership competency models will allow senior leaders to tailor strategies to their organization to gain optimal approach for developing and assessing junior leaders, and align their organizational goals.

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Appendix A: Research Question Matrix

Research Question	Interview Questions
What strategies do senior leaders need to integrate NCHL competencies into employee evaluation system?	1. What leadership competencies do you use to reach your organizational goals as healthcare leader?
	2. Based on your knowledge and experience with this healthcare system, how are they being used or applied in this organization?
	3. What has been your experience with leadership competency models?
	4. How do you track leadership performance?
	5. What types of tools do you use to track performance management?
	6. What are the key skills, or competencies tracked in your performance management evaluation system?
	7. How do you determine if a leader or direct report has a specific competency or needs training to build up an existing skill of competency?

Appendix B: Permission to Cite NCHL

National Center for Healthcare Leadership
1700 W. Van Buren, Suite 126B, Chicago, IL 60612

PERMISSION TO USE, CITE OR REPRINT

Please complete the requested information below and email to xxxxx mail the form to the address above, or FAX to xxxx.

1. **REQUEST**
Name: Jimby Hams
Address:
Email:
Phone: FAX:

Material and Specified Use:
Materials: NCHL model diagram
Use: doctoral study

Permission is granted for the specified use only, except that you must obtain authorization from the original source if any material appears in our work with credit to another source. Permitted use is limited to your request described above and does not include the right to grant others permission to photocopy or otherwise reproduce this material.

Appropriate credit should appear on the first page of the quoted text or in the figure legend, by using the following: Reprinted with permission from the National Center for Healthcare Leadership (www.nchl.org), Chicago, IL. Lengthy use or discussion of the NCHL Health Leadership Competency Model should include: Used with permission from the National Center for Healthcare Leadership, 1700 W. Van Buren, Suite 126B, Chicago, IL, 60612, USA. Phone: 312-563-6630; FAX: 312-563-6631. We request that no changes or adaptations be made to the Venn diagram, the competencies, or competency definitions without prior request, review, and approval of NCHL.

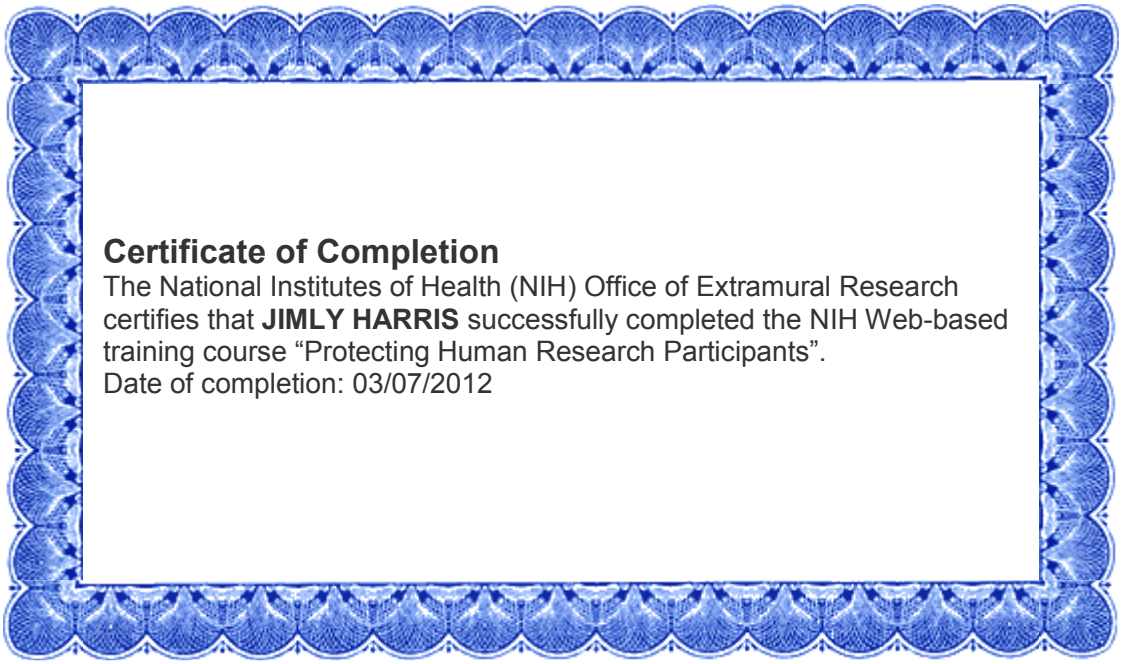
2. **SIGNATURE(S)**
Permission is granted when requestor has notified us of his/her acceptance of its terms by returning this form with a handwritten signature, and with all information listed as noted above. Please retain a copy for your records.

I (we) agree to the conditions described above.

Requestor Print Name	Title	Signature	Date
Jimby Hams	Student	J. Hams	9/19/14

Requester Print Name	Title	Signature	Date
NCHL Signature	Title	Vice President	10/17/14

Appendix C: Certificate of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **JIMLY HARRIS** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 03/07/2012

Appendix D: Letters of Cooperation

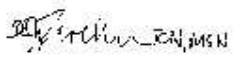
February 12, 2014
Walden University
DBA program
Re: Jimly Harris

Dear Jimly,

This letter serves as permission for you to use xxxxx as a facility to recruit voluntary participants to participate in your doctoral study for Walden University DBA program, following the program requirements and appropriate approvals by the IRB for research. It is my understanding you will provide potential participants with consent forms, and detailed information about the study beforehand.

Best wishes with completion of your program.

Sincerely,



April 30, 2015
Walden University
DBA program
Re: Jimly Harris – addendum to letter of permission on February 12, 2014

Dear Jimly,

xxxx gives permission for you to receive and review the following documents that pertain to the participants: documentary data on the organization's leadership structure, job descriptions, performance evaluation systems, leader orientation checklists or competencies, and any leadership assessment tools. The documents may be provided by the Human Resources Specialist or the Education Department.
Best wishes with completion of your program.

Sincerely,