Common Competencies for All Healthcare Managers: The Healthcare Leadership Alliance Model

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EXECUTIVE SUMMARY

Today's healthcare executives and leaders must have management talent sophisticated enough to match the increased complexity of the healthcare environment. Executives are expected to demonstrate measurable outcomes and effectiveness and to practice evidence-based management. At the same time, academic and professional programs are emphasizing the attainment of competencies related to workplace effectiveness. The shift to evidence-based management has led to numerous efforts to define the competencies most appropriate for healthcare.

The Healthcare Leadership Alliance (HLA), a consortium of six major professional membership organizations, used the research from and experience with their individual credentialing processes to posit five competency domains common among all practicing healthcare managers: (1) communication and relationship management, (2) professionalism, (3) leadership, (4) knowledge of the healthcare system, and (5) business skills and knowledge. The HLA engaged in a formal process to delineate the knowledge, skills, and abilities within each domain and to determine which of these competencies were core or common among the membership of all HLA associations and which were specialty or specific to the members of one or more HLA organizations. This process produced 300 competency statements, which were then organized into the Competency Directory, a unique and interactive database that can be used for assessing individual and organizational competencies. Overall, this work helps to unify the field of healthcare management and provides a lexicon and a basis for collaboration among different types of healthcare executives.

This article discusses the steps that the HLA followed. It also presents the HLA Competency Directory; its application and relevance to the practitioner and academic communities; and its strengths, limitations, and potential.

For more information on the concepts in this article, please contact Dr. Stefl at mstefl@trinity.edu.
Peter Drucker (2002) has said that large healthcare institutions may be the most complex in human history and that even small healthcare organizations are barely manageable. Some time has passed since Drucker's observation, but the complexity of healthcare organizations, along with the demands on managers and leaders, has not diminished in any way. Today, executives in all healthcare settings must navigate a landscape influenced by complex social and political forces, including shrinking reimbursements, persistent shortages of health professionals, endless requirements to use performance and safety indicators, and prevailing calls for transparency. Further, managers and leaders are expected to do more with less.

Since 1999, the Society of Healthcare Strategy and Market Development and the American College of Healthcare Executives have been producing Future-scan, a compendium of healthcare trends and projections for the next five years. In Futurescan 2008, the publication's executive editor, Don Seymour, reflected on the past ten years in healthcare:

society appears to be sending a clear, overarching message to the nation's hospitals: Take care of more people who have growing expectations and more complex medical needs while providing increasingly sophisticated care with relatively fewer resources.

In an environment of escalated public demand, it is only logical to question the competence of healthcare leaders and managers. As noted in Griffith (2007), the increased difficulty of running a healthcare organization has led to the need for managers with more sophisticated capabilities.

The questions now become, Have mid- and senior-level managers been keeping pace with changing demands? Are healthcare academic programs attracting sufficient numbers of students and adequately preparing them to operate effectively in this dynamic environment? These concerns were the focus of the 2001 National Summit on the Future of Education and Practice in Health Management and Policy. Principally funded by the Robert Wood Johnson Foundation, this conference brought together practitioners, policymakers, and educators to examine the effectiveness of healthcare administration and the role of academic preparation and continuing professional development in tackling the current and future challenges of healthcare delivery.

The Summit's deliberations focused on evidence-based approaches (see Kovner 2001) to developing management talent, including how to measure the outcomes of health management education (Griffith 2001) and how to determine whether administration students and practicing managers had acquired the competencies necessary to perform effectively in their roles.

THE COMPETENCY MOVEMENT

The emphasis on measurable outcomes and competencies did not happen overnight. The widespread acceptance of evidence-based medicine was a natural precursor to an evidence-based approach to healthcare management (Kovner and Rundall 2006). Also, the development and promotion of competencies for graduate medical education (Batalden et al. 2002) set the stage for healthcare administration.
More broadly, higher education has struggled with the issue of competency-based education for some time (Calhoun et al. 2002; Westera 2001). The main idea behind this initiative is to design curricula based on the roles that graduates will assume after completing their degree and to incorporate the specific knowledge, skills, and abilities (KSAs) that future employees will need. Efforts to promote competencies have been undertaken in numerous fields, including public health (Council on Linkages Between Academic and Public Health Practice 2001) and the health professions (IOM 2003). The controversial Spellings report (issued in 2006 by the Secretary of Education's Commission on the Future of Higher Education convened by U.S. Secretary of Education Margaret Spellings) pushes universities nationwide to measure student outcomes and then make these results available to the public.

To meet the needs of healthcare administration, a number of university programs have developed a set of competencies (e.g., Cherlin et al. 2006; Shewchuk, O'Connor, and Fine 2005; 2006; White, Clement, and Nayar 2006) or competency models (e.g., Campbell et al. 2006) for their students. A review of these efforts is beyond the scope of this article, but note that these various programs typically use a similar process for developing their competencies: (1) existing competency literature is reviewed, (2) subject matter experts (either faculty or practitioners) are approached to provide depth and content validity, and (3) a survey of practitioners is conducted. In other words, academic programs take steps to ensure that their competency models are tied with the realities and needs of healthcare management practice. However, little evidence shows a link between actual performance and competency attainment (Bradley 2003), an area of inquiry that clearly needs more attention as competency models continue to develop.

Aside from this work in academia, the National Center for Healthcare Leadership has expended considerable effort in creating a competency model that can be applied to professional development and to academic programs (Calhoun et al. 2004; NCHL 2005). In addition, many healthcare associations have used expert opinion and job analysis surveys to delineate the KSAs that form the basis for their credentialing exams. However, these KSAs were not usually shared with the broader healthcare management community.

THE HEALTHCARE LEADERSHIP ALLIANCE
The Healthcare Leadership Alliance (HLA) is a consortium of major professional associations in the healthcare field:

- American College of Healthcare Executives (ACHE);
- American College of Physician Executives (ACPE);
- American Organization of Nurse Executives (AONE);
- Healthcare Financial Management Association (HFMA);
- Healthcare Information and Management Systems Society (HIMSS); and
- Medical Group Management
Together, these associations represent more than 100,000 management professionals.

In response to concerns about the adequate preparation of healthcare managers and administrators, the HLA convened the Competency Task Force to examine the credentialing and certification processes of its member organizations. First meeting in late 2002, the Task Force was composed of a representative from each organization and a facilitator (this author). The Task Force was charged with a straightforward responsibility: Determine if there were management competencies shared by all members of the HLA organizations. If so, the Task Force would determine how these competencies could be used to advance the field.

**Reviewing the Credentialing and Certification Processes**
Task Force work began with an exchange of information regarding each association's credentialing and certification processes. Five of the six organizations had well-established processes, while AONE was considering launching its own certification program. Certification programs are designed to ensure that individuals in a professional position meet the basic educational, skill, and/or experiential requirements of their respective profession (Raymond 2001). Thus, credentialing or certification exams should be job-related and should be designed to test whether the professional possesses the KSAs essential for his or her job. For large organizations, certification exams are typically objective, with questions constructed following the job analysis studies.

Four associations (ACHE, HFMA, HIMSS, and ACMPE) used well-established psychometric processes (job analysis surveys or role delineation studies, review by subject matter experts, and content analysis) to determine the KSAs for their certification exams (NCCA 2007). All engaged reputable psychometric firms to ensure the reliability and validity of their processes. The ACPE's certification process was slightly different from that employed by the rest of the group. Following an on-site tutorial session, ACPE candidates were tested by faculty experts using an in-basket exercise and requiring a verbal presentation. All associations' certification exams were discriminatory; first-time pass rates ranged from 60 percent to 85 percent (Stefl 2003a).

In general, the certification processes of the HLA organizations were intended to provide early careerists an opportunity to demonstrate their competence. At the time of the Competency Task Force's review of KSAs, most HLA associations (except AONE) offered a fellowship status for those with more senior-level accomplishments and contributions. Most associations (except HIMSS) awarded the Fellow status only after that member had attained certification and the requisite competencies. Thus, the Task Force's review excluded the fellowship processes.

**Identifying Common Competencies**
The extensive review of the credentialing and certification processes of the HLA
members revealed a number of overlapping and complementary competencies. The Task Force determined that these KSAs clustered into five competency domains that were common among the membership of all six associations (Stefl 2003a):

1. **Communication and Relationship Management**: The ability to communicate clearly and concisely with internal and external customers, to establish and maintain relationships, and to facilitate constructive interactions with individuals and groups.

2. **Leadership**: The ability to inspire individual and organizational excellence, to create and attain a shared vision, and to successfully manage change to attain the organization’s strategic ends and successful performance.

3. **Professionalism**: The ability to align personal and organizational conduct with ethical and professional standards that include a responsibility to the patient and community, a service orientation, and a commitment to lifelong learning and improvement.

4. **Knowledge of the Healthcare Environment**: The demonstrated understanding of the healthcare system and the environment in which healthcare managers and providers function.

5. **Business Skills and Knowledge**: The ability to apply business principles, including systems thinking, to the healthcare environment; basic business principles include (a) financial management, (b) human resource management, (c) organizational dynamics and governance, (d) strategic planning and marketing, (e) information management, (f) risk management, and (g) quality improvement.

In keeping with the current focus on outcomes and evidence-based management, these five domains were viewed as common competencies or competency domains. While “competency” can be defined in a variety of ways, the Task Force adopted a definition from Ross, Wenzel, and Mitlyng (2002): Competencies are clusters that “transcend unique organizational settings and are applicable across the environment.” That is, the domains identified by the Task Force are generic and demonstrable.

The Task Force viewed these competency domains as interdependent (see Figure 1). Because leadership competencies are central to a healthcare executive’s performance, the Leadership domain anchors the HLA model. All other domains draw from the Leadership area, but the other competencies also feed and inform leadership. In Figure 1, the two-way arrows outside the circles indicate that the other four domains draw from each other and share overlapping KSAs.

The identification of these five domains sends a powerful message to the healthcare field: Healthcare managers in a wide range of positions and settings share a common body of knowledge and a common lexicon. Such a message can break down barriers between various health management professionals, provide a stronger
basis for collaboration, and engender mutual respect and teamwork. Most importantly, the work itself suggests that a common background, expertise, and language are shared by members of the C-suite, the practice management community, and healthcare managers in a range of positions and settings (Rossiter and Stefl 2005).

**Using the Dreyfus Model**

Much of the discussion regarding competencies attempts to distinguish the performance expectations for entry-level, mid-career, and senior-level managers. In its deliberations, the Task Force was guided by the skill acquisition model developed by Stuart Dreyfus and Hubert Dreyfus (1986). The Dreyfus model has been applied to the nursing field (Benner 1984), and it guided the development of ACMPE’s competency and certification model. More recently, the Accreditation Council for Graduate Medical Education applied the model to develop core competencies for medical residents (Batalden et al. 2002), and the model has been discussed in relation to
health administration education (Stefl 2003b).

The original Dreyfus model outlined five stages for skill development: novice, advanced beginner, competent, proficient, and expert. As skills develop, the individual's reliance on rules decreases and the ability to make independent judgments increases. By the time a person reaches the proficient and expert levels, he or she can recognize patterns in the environment and operate (at least partially) on intuition.

For example, an entry-level manager will consult a policy manual to deal with a distraught and angry patient or family member. A mid-level manager, however, is already thoroughly familiar with the protocols governing the situation and will employ strategies and responses that have effectively diffused similar situations in the past. A senior-level executive will respond more intuitively, recognizing patterns in the situation and knowing implicitly when to apply rules and when to be more creative. This intuitive and discriminatory knowledge can only come from experience and practice in applying management skills. Each manager in this scenario is using KSAs in the Communication and Relationship Management domain.

This progression underscores the need for mentoring throughout career stages as well as the importance of continued professional development and lifelong learning.

The HLA Task Force recognized that the Dreyfus model could serve as a framework for individual development in all competency areas (Stefl 2003a). An individual who was competent in one domain (e.g., Knowledge of the Healthcare Environment) could be a novice in another (e.g., Professionalism). Members who achieved certification by each HLA organization were considered to be at the competent level. Members who sought Fellow status within their respective associations could operate at the proficient level. The Task Force believed that the expert level was beyond the realm of testing or credentialing. Experts are acknowledged by their peers and typically receive honors or distinctions from their professional associations.

Organizing and Generating Competency Statements

According to Shewchuk, O'Connor, and Fine (2005), broad competency domains have limited usefulness. Their lack of specificity prevents any real application in the work setting or for curricular design. Although core competencies common among all healthcare executives engender understanding and collaboration, they mask the different expectations for each type of healthcare manager. For example, chief financial officers are expected to have a wider range of financial analysis competencies (a subset of the Business Skills and Knowledge domain) than are needed by
the general membership of ACHE. Similarly, information systems managers are expected to have broader abilities in technology design and implementation than required of chief nursing officers.

Specialty competencies for the membership of each HLA association would likely complement the core competency domains. More specific KSAs within each domain would also be useful. In fact, many of the competencies outlined by the individual associations in their job analyses were more detailed and unique to their own group. What was needed was a mechanism that combined and compared the various KSAs and that determined which of the detailed competency statements could apply across the entire healthcare management field. A competency directory was conceived as a way to accomplish those tasks.

A psychometric firm assisted the Task Force in developing the HLA Competency Directory. The firm reviewed the competency statements from all HLA associations and, in the process, eliminated or combined overlapping KSAs and then prepared an initial competency listing. All competency statements were then organized according to the five competency domains (see Figure 1).

The preliminary competency listing was reviewed and expanded by a panel of experts (or subject-matter experts [SMEs]) during a two-day meeting in September 2004. Each HLA association nominated three of its members, one of whom had some academic involvement/background, to serve on the SME panel. In general, panel members were senior-level executives who were certified by the association they represented (except those assigned by AONE, which had no formal certification process) and were actively engaged with the association and its professional activities. The use of SMEs is a standard practice in competency studies (NCCA 2007); experts are often used to provide content validity to the competencies identified in job analysis studies.

During the SME review meeting, other competencies were added to the initial listing. Some of the added KSAs were clearly specific to an individual association, while others were more generic and thus were judged appropriate to all healthcare managers. The discussion revolved around identifying the appropriate domain for a specific competency and determining whether a competency was common or specialty. Subsequent to this meeting, a series of webinar-enhanced conference calls was conducted with the Task Force, the psychometric consultant, and the SME panels for each HLA association. The purpose of these calls was to review and refine the individual competency statements, determine whether the competency should be listed as a skill or knowledge, and categorize whether the competency was common or specialty. Throughout this iterative process, two surveys were administered to all SME panelists. These surveys allowed experts to rank the perceived relevance of each competency statement and to identify gaps or omissions in each competency domain.

Competency statements were categorized as either knowledge areas or skills. All skills were coded using 11 action verbs, such as “manage,” “execute,” and
"develop." Finally, approximately 32 key words were assigned to each of the competency statements, including "technology," "physicians," and "outcomes." The Task Force developed and assigned key words and skill areas in an attempt to fit the needs of association members.

THE HLA COMPETENCY DIRECTORY
The process resulted in the creation of the HLA Competency Directory, an Excel-based interactive tool. It contains a series of filters that allow the user to sort by skills versus knowledge, core versus specialty, key word, skill area, or professional association. This design enables the user to customize searches according to the user's need or circumstance.

The Directory contains 300 competency statements organized under the five domains of the HLA model. The vast majority (232 or 77.3 percent) of the skills and knowledge listed are common to all the management professions represented by the HLA associations; only 68 specialty competencies were identified. Table 1 shows the number of core and specialty competencies by the five domains. Also, the table divides the Business Skills and Knowledge domain into various functional areas.

Virtually all of the specialty competencies fall within the Business Skills and Knowledge domain, providing further evidence that healthcare managers in different roles share an extensive common knowledge and skill base. Because the Professionalism domain incorporates ethical codes and standards, the lack of variance in this area suggests that a common value set for all types of healthcare managers exists.

The Financial Management and Information Management functional areas produced the highest number of specialty competencies, reflecting the highly technical aspects of these functions. Even so, the number of core competencies in both areas is substantial. Fewer specialty competencies were listed under Risk Management or Strategic Planning and Marketing. This may suggest that these areas are generic, or it may reflect the lack of expertise in these categories among those involved in developing the directory. Few specialty competencies were noted under Other Business Skills and Knowledge, reflecting the general nature of this category. This functional area, for example, incorporates skills and knowledge related to quantitative and analytical decision making, project management, and systems thinking.

When the specialty competencies were examined, most (45 or 66.2 percent) pertained to the membership of two or more of the HLA associations. Twenty of the specialty competencies were relevant only to ACMPE; these competencies reflected the unique aspects of practice management. HIMSS claimed the remaining three specialty competencies, which related to aspects of the information technology field. No competencies were unique to financial managers, nurse executives, or the general managers represented by ACHE. All other specialty competencies were claimed by two or more associations.

MODEL AND DIRECTORY APPLICATIONS
To the Practitioner Field
The HLA model and the Competency Directory offer a number of benefits...
TABLE 1
HLA Core and Specialty Competencies by Domain

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number Core</th>
<th>Specialty</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and relationship management</td>
<td>22</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Leadership</td>
<td>23</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Professionalism</td>
<td>23</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>Knowledge of the healthcare environment</td>
<td>20</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Business skills and knowledge</td>
<td>144</td>
<td>61</td>
<td>205</td>
</tr>
<tr>
<td>Financial management</td>
<td>18</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Human resource management</td>
<td>16</td>
<td>8</td>
<td>24</td>
</tr>
<tr>
<td>Organizational dynamics and governance</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Strategic planning and marketing</td>
<td>17</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Information management</td>
<td>24</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td>Risk management</td>
<td>15</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>10</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Other business skills and knowledge</td>
<td>33</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>232</td>
<td>68</td>
<td>300</td>
</tr>
</tbody>
</table>

Acknowledging the fact that a common body of knowledge and skills exists can engender teamwork and mutual respect (Rossiter and Stefl 2005). The competency domains and individual competency statements can serve as the basis for joint educational programming between various professional associations. These KSAs are also helpful in clarifying job descriptions or in constituting work teams with complementary skills and knowledge. This project represented an unprecedented collaboration among the HLA organizations, an effort that can be a model or a foundation for future interprofessional teamwork among these associations, within the practice setting, and within educational or academic programs.

Other tangible benefits of this project include the following:

- AONE (2005) has produced a self-assessment tool that incorporates competencies for nurse executives into the HLA competency framework. These nurse executive competencies were developed by AONE simultaneous with but independent of the HLA model and the Directory. Consequently, this tool is more reflective of the clinical setting. The tool provides space for respondents to rate their performance level—from novice to expert on the Dreyfus scale—for
each competency area. Respondents are then encouraged to prepare a development plan for areas in which they are lacking. Feedback has revealed that this tool has been valuable in writing job descriptions and in conducting performance reviews (Thompson 2006). The tool is available on the AONE website to members only.

- ACHE has produced the ACHE Healthcare Executive Competencies Assessment Tool 2008. This tool organizes the 300 statements in the Directory into convenient subcategories. For example, Relationship Management, Communication Skills, and Facilitation Skills are components of the Communication and Relationship Management domain. Like the AONE tool, the ACHE self-assessment instrument allows respondents to rate their performance on a five-point scale, ranging from novice to expert. This tool also provides resources for improvement in each subcategory, directing users to available publications, educational programming, self-study courses, and other assessment means. ACHE encourages its affiliates to use the tool, which is updated annually, for personal and professional improvement. Distributed to all ACHE affiliates, the tool is available for download on the ACHE website: www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

To the Academic Community
The HLA model and the Competency Directory were originally envisioned to be useful for academic programs. Effective in the fall of 2008, the Commission on Accreditation for Healthcare Management Education’s (2007) criteria require that graduate health administration programs adopt a competency model as the basis for curricular offerings. The HLA model has been considered by many of these programs. Because programs will need to link course content as well as individual student achievements to the model, thus far few programs could adopt all 300 statements in the Directory. However, the five competency domains and the subcategories listed in the ACHE assessment tool represent a framework that programs can readily use.

Drawing on the HLA model and assessments conducted at individual universities (Shewchuk, O’Connor, and Fine 2005; 2006; White, Clement, and Nayar 2006), four graduate programs collaborated to produce a set of 30 competencies (O’Connor et al. 2008). These competencies are more macro than the HLA statements. For example, only one statement pertains to financial management, a distinct difference from the 24 finance-specific competencies found in the Directory. The intent of this collaborative project was to determine if a joint competency model, based on the HLA domains, could be developed by the four separate entities. The programs involved were natural partners. Each had strong relationships with the practitioner community, each offered both full-time on-campus and executive program options, and three of the four required a year-long administrative residency for on-campus students. All programs were located in the southeastern United States and had

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students whose primary interest was operations.

In 2007, a web-based survey was conducted with faculty, preceptors, and recent graduates of the four university programs. Respondents were asked to indicate, on a five-point scale, how strongly they felt new graduates needed each of the 30 competency areas. Overall, 340 individuals responded, or 49.2 percent of the total number of people contacted. Respondents indicated that all competencies were necessary, although some were judged more important than others. However, ratings of the individual competencies were remarkably consistent across respondents from all four programs. Further, ratings from all three respondent groups were similar, especially between faculty and preceptors.

These results provide a good field test and validation of the HLA competency model and demonstrate that the model can be simplified and adapted for use in health administration graduate education. The success of this collaborative project may encourage other university programs to draw on the HLA model in the future.

Limitations and Future Adjustments
The HLA Competency Directory is a work in progress. Building consensus around the 232 common competencies was an iterative process, with each review further refining the list. With the healthcare industry changing rapidly, healthcare management competencies clearly will require continual updating and validation. Since the Directory was made available in November 2005, many of the HLA associations have conducted new job analyses, requiring any new information to be added to the Directory.

The Directory may have other limitations. First, although physicians were well represented in ACMPE's original job analyses and ACPE was a full participant in delineating the competency domains, clinical concerns may have been inadequately represented as a result of ACPE's nonparticipation in the Directory's development (Griffith 2007). Second, the SMEs chosen by the HLA associations may have unknowingly introduced some bias. In the future, the number of SMEs may be increased or a general membership survey may be conducted to further validate the competencies. Third, Griffith (2007) argues that the Directory lacks emphasis on insurance and quality management and measurement, and it does not offer a clear distinction between skills and knowledge. All of these concerns may be easily addressed in future versions of the Directory.

Future updates should also focus on specialty competencies, which were unevenly distributed among the HLA associations. The largest number of specialty KSAs was attributed to ACMPE (2003), which may be a reflection of the organization's extensive previous work on its Body of Knowledge for Medical Practice Management.

Conclusion
The HLA common competencies make an important contribution to the growing body of knowledge about competencies in healthcare management (Garman and Johnson 2006). The HLA model, complete with the Dreyfus framework,
can be used for individual and organizational assessment, employee selection, and team development. In addition, the model can be adapted for use in academic programs, as demonstrated by the joint project by healthcare administration graduate programs. A unique and useful tool for individuals and organizations, the HLA Competency Directory can be used to foster collaboration and advancement across the broad spectrum of healthcare management. In this environment of constant and dramatic changes, these are important benefits.

NOTES
1. The members of the Task Force were Cynthia A. Hahn, FACHE (ACHE), Roger Schenke (ACPE), Andrea Rossetter, FACMPE (MGMA/ACMPE), Pamela Thompson, FAAN (AONE), Joseph Abel, PhD (HFMA), and Julianna Kazragys (HIMSS).
2. In October 2008, AONE launched a certification program. For more information visit www.aone.org.
3. ACPE did not participate in this phase of the project.
5. Medical University of South Carolina, Trinity University, University of Alabama–Birmingham, and Virginia Commonwealth University

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Thompson, P. 2006. Communication to HLA Task Force, August 15.


Peter Drucker's observations about the complexities of healthcare organizations coupled with Don Seymour's comments about society's do-more-with-less expectations of hospitals and health systems compel us to read this article by Mary Stefl. Healthcare leaders are well aware of the changing market forces, trends, and challenges in today's healthcare environment. In the last ten years, leaders have confronted reduced operating margins, limited reimbursements, and escalated expenses under the increased scrutiny by the public in general and by governments (federal and state) in particular. Now more than ever, everyone is focused on how healthcare organizations function and how well leaders can balance margin and mission. With the emergence of evidence-based medicine, the growth in the number of public-disclosure states, and public and private oversight of errors and other events in hospitals, no wonder the competencies of healthcare leaders and managers are now being questioned.

This article resonates with the current environment in which leaders and managers must operate. It offers a competency tool that can be highly effective in meeting ever-present challenges. For more than 30 years, educators, psychologists, and practitioners turned to competency modeling to bridge the gap between intelligence and practical application and outcomes. The job of a healthcare professional was evolving quickly, and competency modeling appeared useful, universal, and tied to corporate strategy. This article presents a model that is a logical expansion of competency modeling.

Stefl describes the competency work of the Healthcare Leadership Alliance (HLA). What should draw the reader's attention is the product of the HLA's efforts: a compendium of common competencies for all healthcare leaders and managers. This tool, the HLA Competency Directory, is composed of 300 competency statements organized under five domains. Because the tool represents the background, expertise, and language common among healthcare leaders and managers, it helps to align everyone involved in executing the mission and the patient care, safety, and quality efforts in a highly performing organization.

The tool can be powerful. It is interactive, enabling the user to assess his or her own competencies for a specific managerial position and to develop a professional improvement plan with the assistance of his or her immediate supervisor. Effective use of this tool can unite individual performance and organizational strategies to generate substantial payoffs for the organization. In addition, this competency model and directory can be used by academic programs and can inform the curricula in healthcare administration. In fact, some programs have already applied the model to their own competency framework. As Stefl observed, other programs have not yet adopted all 300 statements included in the directory.

The potential of integrating this model into healthcare management programs is great and is encouraging to those of us who are committed to the profession and to the appropriate development of future leaders and managers.