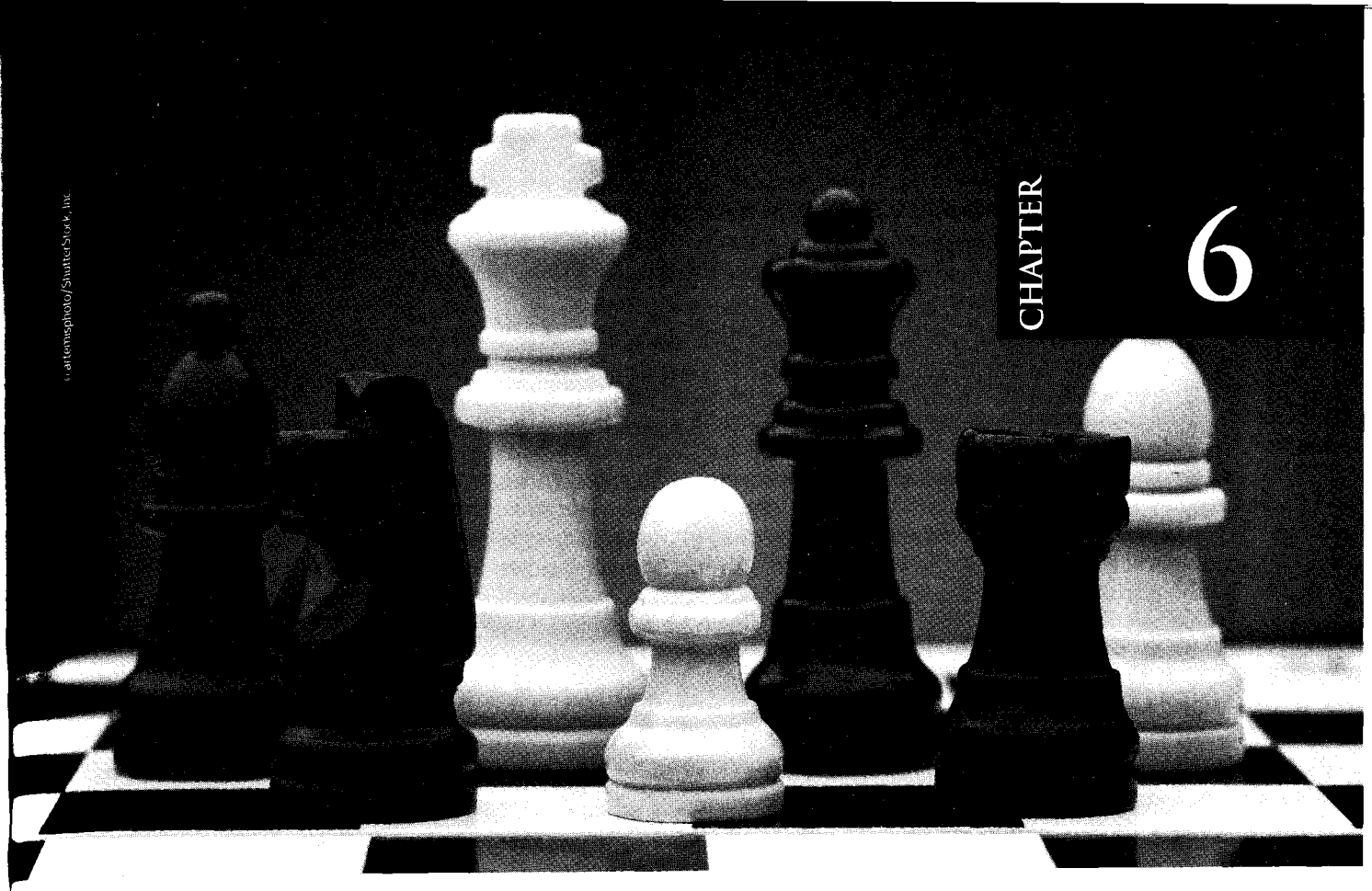
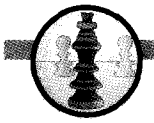


LEADERSHIP COMPETENCE II: APPLICATION OF SKILLS, TOOLS, AND ABILITIES

Thinking always ahead, thinking always of trying to do more, brings a state of mind in which nothing seems impossible.
Henry Ford

This chapter presents additional knowledge and empirically based skills and abilities (a leadership toolbox full of "tools") required for a health leader's success in organizational practice. The leader's application of these skills, tools, and abilities is valid for small groups as well as all members of an entire organization. Strategies for leaders in effecting planning and situational assessment, decision making, and training that result in positive outcomes are addressed; these strategies, in turn, result in practical leadership actions and applications based in "active" leadership.



LEARNING OBJECTIVES

1. Describe planning, decision making, and training in health organizations and provide examples of each.
2. Summarize the planning process and the decision-making process within the context of leadership.
3. Apply and relate at least two different decision-making models to a leadership situation.
4. Differentiate the levels or components of the planning process and distinguish each level or component from the others.
5. Plan and design a quality improvement program based on a system of rational decision making for a health organization.
6. Compare and contrast willful choice to garbage can models of decision making, training leaders to training staff, and cultural competence to ethics and morality.

PLANNING

Planning is an essential leadership skill that requires knowledge about planning and the ability to structure and develop a system of planning. Planning is an essential and critical component to successful leadership; effective planning and consistent leadership practice are vital to linking the clinical and administrative domains.[1] Health leaders plan at all levels of an organization. Specifically, they plan the operational actions necessary within their area of responsibility to implement the senior leadership team's strategic or operational plans. Health leaders who can understand, apply, and evaluate planning will have advantages over those who haphazardly plan or fail to plan.

Starting from the highest level of health organization strategic and operational plans, leaders at subordinate levels should (and many say must) develop strategies and operational practices that achieve the goals and objectives of the high-level plans at their subordinate level of the organization. Each level of the organization should (again, many say must) have goals and measureable objectives with time lines and accountable owners that contribute to the mission and to achieving the vision of the health organization. Wise leaders at all levels of the organization should (must) acquire the strategic and operational plans of the organization and seek counsel with their supervisory leader on how best to contribute to the organization's mission or vision at their level of leadership. Wise leaders also hold themselves accountable to fulfill goals and objectives at their level and report results regularly (monthly, quarterly, etc.) to those they lead as well as those they report to in the leadership hierarchy.

For some scholars, such as Yukl, planning is a step in decision making.[2] For others, planning is a cultural imperative and a method for leaders to guide the organization to its most effective, efficient, and efficacious outcomes.[3,4] Planning occurs formally, informally, strategically (how the organization can best serve its purpose in the external environment), and operationally (how the internal capabilities and resources of an organization can be used effectively, efficiently, and efficaciously to achieve the strategies and goals of the organization as documented in the strategic plan).

A set of basic definitions will assist in understanding the differences in the term *planning*:

- *Planning* is a process that uses macro- and micro-environmental factors and internal information to engage stakeholders to create a framework, template, and outline for section, branch, or organizational success. Planning can be strategic, operational, or a combination of both.
- *Strategic planning* is concerned with finding the best future for the organization and determining how the organization will evolve to realize that future. It is a stream of organizational decisions focused in a specific direction based on organizational values, strategies, and goals. The focus is on external considerations and how the organization can best serve the external markets' expectations, demands, and needs.
- *Operational planning* is about finding the best methods, processes, and systems to accomplish the mission/purpose, strategies, goals, and objectives of the organization in the most effective, efficient, and efficacious way possible. The focus in operational planning concerns internal resources, systems, processes, methods, and considerations.

Planning is vital to the survival of the organization. Indeed, creating a plan is an investment in improving the organization. Improvement is realized through internal change and evolution. Developing and focusing the organization to best meet the needs and demands of its customers and others (stakeholders) that affect the organization lies at the heart of planning. Because the environment, technology, information, people, financing, and governmental policies and laws are constantly changing, the organization itself must evolve to survive, succeed, and prosper. Planning is a journey—but this journey must have a destination, and it must be planned. In other words, it is a planned journey forward in time. In that light, planning includes both a process (developing and achieving goals and objectives) and an outcome (the plan itself).

> *Planning is a process.* This process involves moving an organization along a predetermined path based on its values. Similar to the decisions involved in planning a real-world trip (e.g., which road to take, which stops to make, and who will drive), the organizational planning process entails deciding which goals are important to the organization and which objectives must be met to reach those goals.
>
> *Planning has an outcome.* This outcome paves the way to a better future state based on organizational values and the external environment. Improving effectiveness, efficiency, efficacy, customer satisfaction, employee satisfaction, financial performance, and many other possible improvements are a part of moving the organization to reach a better future state.

The desired future state constitutes the vision of the organization; the vision is what the combined staff of the organization strive to achieve. If you know where you are going, then planning the trip and getting commitment from your staff becomes much easier. Also, organizational resources (including your energy and time) can be devoted to reaching set goals and having a positive outcome (turning the vision of your organization into a reality).

In this light, the process comprises a journey that must be planned knowing that different ways of doing things, different stops, and different issues will be encountered along the way. The vision represents the final destination. The destination must be determined and the journey must be planned. As a health leader, you are critical in determining the vision (outcome/destination) and the process (journey/goals and objectives) that will ensure the organization reaches its intended vision.

For all health organizations, mergers, departmental restructuring, implementation of new technologies, and market changes may indicate a need for the organization to develop a strategic plan to support its overall plan. Strategic planning can be described as an organizational planning process that analyzes the current situation of an organization and forecasts how the organization will change or evolve over a specified period of time. The health leader is an integral part of a successful strategic plan. Strategic planning on the part of an organization and its leaders requires both thought and action, however. In health organizations, strategic thought includes the "ideas, reasons, and processes for changing the future state of your organization."[5] Within the component of strategic thought exists the vision, intent, and planning affecting the path that the organization takes in moving toward its future.

If the strategic plan is a road map, then the organizational vision is the final destination, describing where the organization is going. The vision depicts a perfect situation in which the future destination can be obtained. The health leader must energize his or her followers to buy into the vision so that the organization can begin its strategic journey on the correct path. The strategic vision must be tested and retested to ensure that it has won buy-in from all stakeholders (both external and internal).

A vision may require many drafts and revisions to ensure that the needs of all stakeholders are met. In the dynamic world of the health industry, leaders need to recognize that the strategic vision should be tangible. To be tangible, the vision should be stated in the form of concrete ideals rather than using generalizations, should identify a direct relationship between the organizational values and culture to the future direction of the organization, and should communicate a unique future to stakeholders.[6]

Once an organizational vision is developed, intent must be established. Intent describes how the organization will be affected if change does not occur. Organizational leaders must outline how these "impacts" or "crises" could potentially influence the viability of the organization. Examples of crises might include market changes, technological advances that cause older technology to become obsolete, personnel shortages, and decreased reimbursement from payers. From the road map perspective, the wrong intent is analogous to driving in the wrong direction without a road map.

Once the vision and intent have been established, the strategic plan needs to be developed; that is, from the road map perspective, the quickest, most efficient route must be drawn to the final destination (i.e., the vision). One can assume that a good plan will lead to an effective outcome—namely, achieving the vision.

Strategic thought is followed by the component of tactical action, which includes commitment, execution, and accountability. In the health industry, tactical

action encompasses the feelings, practices, and metrics for changing the future state of the organization.[7] If strategic thought is the plan for the journey to reach the final destination, then tactical action is the journey itself, including the mechanism for getting there. Tactical action requires commitment within the organization, execution of the plan, and accountability for this effort within organizational leadership.

Commitment, like the strategic vision, requires buy-in by the organization and its internal and external stakeholders. It involves a relationship between organizational leaders and followers; in contrast, each party has a clear understanding of the strategic vision and his or her role in reaching this vision. Without commitment on all levels, it will be impossible to achieve the strategic vision effectively and efficiently. From a leadership perspective, a leader can foster commitment within his or her team by serving as a model and demonstrating a strong commitment to the plan and vision. A leader cannot expect to achieve buy-in from followers if he or she has not fully committed to the vision.

During the execution phase of the strategic plan, each team member performs his or her assigned duty. Without a strong, unified commitment, execution of the plan will be a dismal failure. It is the leader's responsibility to enhance motivation and maintain commitment within the team, particularly when team members encounter obstacles. The health leader must be supportive of his or her team members, supporting them by providing them with the needed skills, equipment, and materials to effectively carry out their roles in the plan. In many ways, the health leader's effort in this phase echoes the precepts of House's path–goal theory.

Leaders and followers require consistent feedback about performance during execution of the plan. To ensure that they receive this information, measures must be put in place to gauge successes (or lack thereof) during this time. Successes should be acknowledged between leaders and followers. After all, employees want to know that the plan is working correctly. Lack of success should be analyzed and modified to determine inconsistencies within the execution of the plan.

THE LEADER'S ROLE IN PLANNING

Most people look for leaders who have a vision and who can direct them in the path of the mission. There can be many leaders within a single organization, and each leader will have a vision for his or her own tasks or responsibilities. The morale of the organization can sometimes depend on the attitudes espoused by visionaries of the organization. Staff members of an organization look for the visionaries to lead by example. In planning, leadership should come from within the organization; the effort should be exciting, where followers are excited to follow. Health leaders provide the structure, process, macro direction, shared outcome for all stakeholders, motivation, accountability, influence, obstacle removal, resources, and persistence in the overall effort of *directing*, *staffing*, *organizing*, *controlling*, and *rewarding*.

Planning is the fundamental function of leadership from which all other outcomes are derived. The first step in planning is establishing the organizational situational assessment; the vision, mission, strategies, goals, objectives, and action steps are then developed. Without this structure and signposts as first steps, the organization cannot move forward.

The vision provides the motivational guidance for the organization and typically is defined and promoted by senior leadership. It explains how the organization intends to achieve its goals, whereas the mission defines why the organization pursues the goals it does. Both vision and mission are "directional strategies."

The mission statement is the organization's reason for being. It provides guidance in decision making as well, ensuring that the organization stays on the track that its leaders have predetermined. From the mission statement, strategies to achieve the mission and, ultimately, the vision are devised. Goals are broad statements of direction that come from strategies. This multilevel approach focuses and narrows effort for each section within the health organization. Objectives, in pursuit of achieving goals, are very specific.

Goals further refine the strategies focused on in the mission. They are expected to be general, observable, challenging, and untimed.[8] Goals are general in nature; in contrast, objectives are highly specific. Notably, different perspectives often switch goals with objectives and objectives with goals. Whatever framework you select for your organization, try to be consistent. It is not important if goals are at a higher level than objectives, or vice versa; what matters is the process of planning—a planning and execution culture should grow and mature in your health organization. Erven promotes objective development within the "SMART" framework; to be SMART, objectives must be "specific, measurable, attainable, rewarding, and timed."[9]

The phase in which action steps or tactics are established and implemented follows all of the preceding activity. Action steps or tactics represent a fifth level of planning; they provide the most specific approach for describing the *who*, *what*, *when*, *where*, and *how* elements of the activities needed to accomplish an objective.

Planning can be described as an ongoing process of thinking and implementing at multiple levels. At each level, health leaders engage in directing, staffing, organizing, and controlling. Along the way, such leaders must remember that "what gets measured gets done"; thus all planning objectives and action steps must be measurable, assigned to an accountable and responsible person, and set within a time period. Periodic progress reviews, either monthly or quarterly, are essential to see the movement toward success.

In addition to this effort of *directing*, *staffing*, *organization*, and *controlling*, *rewarding* is important. These five elements are crucial as leaders embrace the foundations and functions of planning. Health leaders must publicly praise success and reward those who have achieved predetermined action steps, objectives, and goals.

As U.S. General and President Dwight Eisenhower once said, the plan is important but the process of planning is even more important. The team building, achievement, and success orientation that a culture of planning and implementation brings to an organization is invaluable in ensuring its success over both the short and long term. Situational assessment and environmental scanning are vital elements to establish and maintain a successful culture of planning in a health organization.

SITUATIONAL ASSESSMENT AND ENVIRONMENTAL SCANNING

All health leaders must be able to assess the situation currently facing their organization, which requires an assessment of both internal and external environments. A situational assessment must be an objective and honest look at the diverse factors that could affect the health organization's success in achieving its vision, mission, strategies, and goals. One tool commonly used for the internal assessment is SWOT analysis, which investigates internal strengths and weaknesses and external opportunities and threats.[10]

SWOT analysis offers insight into both the internal and external factors that might affect the organization's performance and success; however, every organization needs more information about the environment than just its potential opportunities and threats. Choo reports that it is important to obtain information about relationships, trends, and information in the external environment; health leaders need to know which influences are acting on the industry and even the economy.[11] A focused environmental scan concentrates on specific information, such as how many consumers bought a particular product or service in the last year. External scanning, whether focused or more general, is essential for planning and forecasting the organization's performance into the future.

Situational assessment and continuous environmental scanning are crucial if organizations hope to survive in the dynamic health industry. A leader's and leadership team's responsibility is to remain current about and relevant to situational and environmental change that can or will affect the organization. Forces that contribute to the health industry's rapid and dynamic environment are varied but cumulative; as a consequence, they have a cumulative impact on the industry. "Technology, demography, economics and politics drive change, not only as individual factors but interacting to make the rate of change faster."[12]

Another approach is to look at the dynamic environment as comprising macro-environmental forces and health micro-environmental forces. In an approach that has been validated over the last two decades, in 1992 Rakich, Longest, and Darr outlined a series of categories that leaders can scan (environmental scanning) to keep current and relevant in the industry:

1. Macro-Environmental Forces
   - **a.** Legal, [regulatory, executive orders, and case law] and Ethical forces;
   - **b.** Political (including government policy) forces;
   - **c.** Cultural and Sociological (including values [beliefs and attitudes]) forces;
   - **d.** Public Expectations (including community, interest groups, and media);
   - **e.** Economic forces; and
   - **f.** Ecological forces.
2. Health Care Environmental Forces [also called micro-environmental forces]
   - **a.** Planning and Public Policy (regulation, licensure, and accreditation) forces;
   - **b.** Competitive forces;
   - **c.** Health Care Financing (third-party payers, public and private, and financial risk);
   - **d.** Technology (equipment, material, and supply entities) forces;
   - **e.** Health Research and Education;
   - **f.** Health Status and Health Promotion (wellness and disease); and
   - **g.** [Integration with other health disciplines and organizations] Public Health (sanitation, environmental protection, etc....) forces.[13]

The Rand Corporation has suggested that the immense pressure exerted by cost-containment efforts and the rapid speed of change are major factors that can influence the health industry.[14] Multiple forces have cumulatively contributed to change in the health industry

in recent decades. Compare the health organizations of the 1960s or 1970s to those of today: There is a vast difference between the two organizations. The speed of that change in a mere 40 to 50 years is astonishing, as are the gains in the ability of healthcare delivery systems to diagnose, treat, and rehabilitate patients who present with health needs.

For example, consider the life expectancy of people living in the 1960s compared to today. "Between 1961 and 1999, average life expectancy in the [United States] increased from 66.9 to 74.1 years for men and from 73.5 to 79.6 for women."[15] Projections for 2015 estimate life expectancy to be 76.4 years for males and 81.4 years for females, according to the U.S. Census Bureau.[16] Trends in aging are also tied to life expectancy, but have profound implications for health services.[17]

This dynamic whirlwind, often called *whitewater change*, frames a picture of the world that the health leader must navigate. Although there have been tremendous successes in this industry, health leaders must continue to recognize the dynamic nature of the industry and challenge their organizations, groups, teams, and individuals to become more efficient, effective, and efficacious, while functioning under significant cost-containment pressure. From a practical viewpoint, Kotter suggests eight steps to transform organizations in dynamic situations (italics added):

1. *Establish a Sense of Urgency* by examining market and competitive realities and identifying and discussing crises, potential crises or major opportunities;
2. *Form a Powerful Guiding Coalition* by assembling a group with enough power to lead the change effect [from any level of the organization] and encourage the group to work together as a team;
3. *Create a Vision* to help direct the change effort and develop strategies for achieving that vision;
4. *Communicate the Vision* by using every vehicle possible to communicate the new vision and strategies and by teaching new behaviors by the example of the guiding coalition [at lower levels of the organization, the leader translates the senior leadership's vision for his or her section, branch, or unit into understandable and actionable tasks for that level and situation];
5. *Empower Others to Act on the Vision* by getting rid of obstacles to change, changing systems or structures that seriously undermine the vision, and encouraging risk taking and nontraditional ideas, activities, and actions;
6. *Plan for and Create Short-Term Wins* by planning for visible performance improvements, creating those improvements, and recognizing and rewarding employees involved in the improvements;
7. *Consolidate Improvements and Produce Still More Change* by using increased credibility to change systems, structures, and policies that don't fit the vision; hiring, promoting, and developing employees who can implement the vision; and reinvigorating the process with new projects, themes, and change agents; and
8. *Institutionalize New Approaches* by articulating the connections between the new behaviors and corporate [organizational] success and developing the means to ensure leadership development and succession.[18]

Kotter's eight steps are a sequence of leader actions and are cybernetic; that is, a feedback loop goes from the last step back to the first step. Leaders of health organizations should consider the changes in the macro- and micro-environments by assessing them against the *cost*, *quality*, and *access* health assessment constructs for those community members whom they serve. This analysis, for the segment of the continuum of care (from self-care and health promotion and prevention to primary, secondary, and tertiary care to long-term care and hospice care) for which the leaders are responsible, should be integrated into the holistic aspect of health and the health infrastructure available (or needed) in the community. Leadership depends on a leader's ability to make quality and consistent decisions. The discussion here now turns to the complexity of decision making and how to develop an efficient, effective, and efficacious decision-making culture to dovetail into the organization's planning culture.

DECISION MAKING AND DECISION ALIGNMENT[19]

Decision making occurs in all organizations. Health organizations, for example, face many decisions each day. The decision-making process begins with identifying a question or problem—that is, an area needing improvement or an operational issue. Problems, issues, questions, and operational challenges come to leaders and managers from many different people, both within and outside the health organization.

Leaders and managers usually are taught to utilize the rational decision-making model, which focuses on analytical (quantitative) methods; when necessary, they may couple this approach with group methods (qualitative) such as the normative group technique (brainstorming, alternative categorization, prioritizing alternatives, and selecting an alternative based on group consensus) to triangulate the final result (using both quantitative and qualitative methods) and identify an effective decision.

In reality, decision making is not as sterile and ordered as most have been taught. Both willful choice (rational)

decision-making models and reality-based ("garbage can") models are used in organizations amid a myriad of tools and techniques. Thus there are three major domains of decision making:

- Willful choice or rational models
- Reality-based or garbage can models
- Combinations of willful choice and reality-based models

Likewise, three types of decision-making methods are used:

- *Quantitative methods:* Tools such as multiple attribute value, probability-based decision trees, analytical mathematical models, linear programming, and similar tools
- *Qualitative methods:* Tools such as focus groups, interviews (formal and informal), normative group techniques, and similar tools
- *Triangulation methods:* Combinations of quantitative and qualitative methods where, classically, qualitative methods are perceived as "theory building" and quantitative methods are described as "theory testing, validating, or confirming"

A review of bounded rationality, willful choice, and reality-based decision-making models is presented next. More time is spent on reality-based models because this decision-making method is the least well known, but may be the most applicable to health organizational leaders and managers.

Bounded Rationality in Decision Making

Decision making must occur within the bounded rationality of the environmental context in which the problem must be solved. In modern times, with the advent and availability of the Internet, the bounded rationality of information available for decision making is immense and global. The bounded rationality for any problem spans the parameters in which the rational resources are available to the decision maker to accomplish positive outcomes. Organizational culture influences decision making as well. As noted in a study of military officers published in 2009, officers with an embedded "forcefulness" and "decisiveness" culture in team leadership roles were more spontaneous and less rational in decision making than their equally ranked team members.[20] Clearly, then, bounded rationality is influenced by organizational culture.

Prior to the dawn of the Information Age and the widespread use of the Internet, information was considered to be a scarce resource that was difficult to find—a perception that has changed dramatically, to the point that we live in an age characterized by "information overload." Unfortunately, the vast amounts of information available do not always include all the information necessary or completely accurate information with which to make the best decisions. Additionally, information may not be in a form that is immediately useable by those needing it. As a result, the most the health leader can hope to achieve is the best decision possible based on the information that is known. With any decision at hand, different levels of ambiguity and uncertainty will surround the issue. Decisions made easily and with little risk tend to have less ambiguity and uncertainty associated with them, whereas complex, difficult, and more risky decisions tend to have much more ambiguity and uncertainty embedded within them.

Complicating this feature of human decision making is the fact that, although much more information is available today, decision makers may not have access to all the proper information regardless of tools available to them. Further, searching out that information may require far more time than decision makers have to arrive at a decision. Not all information or sources will be identifiable, but time will advance in any case. The decision maker will need to arrive at the best decision that can be made at the time. As a consequence, health leaders must often "satisfice" by seeking "a satisfactory reward rather than seeking the maximum reward."[21]

Willful Choice Decision-Making Models

Today's decision-making models and current understanding imply that decisions are made by rational, intentional, and willful choice. Choice is guided by four basic principles: (1) unambiguous (you know which questions to ask) knowledge of alternatives, (2) probability and knowledge of consequences, (3) a rational and consistent priority system for alternative ordering, and (4) heuristics or decision rules to choose an alternative.[22] These models assume that alternatives are selected based on greatest utility (via cost–benefit analysis, for example) for the organization, given the environmental situation (e.g., as assessed via a SWOT analysis in strategic planning), in line with its objectives, goals, and mission. The decision-making models used in engineering, operations analysis and research, management science, and decision theory represent variations on the rational and willful choice model.[23]

The six-step model of decision making[24] applies the analytic willful choice model as follows:

1. Identify the problem.
2. Collect data.

3. List all possible solutions.
4. Test possible solutions.
5. Select the best course of action.
6. Implement the solution based on the decision made.

This practical model assumes that time and information are abundant, energy is available, and goal congruence of participants (everyone is focused on the same set of goals) has been achieved.

Criticism of Willful Choice Models

Well-known leadership and management concepts consider preplanning (short- and long-term) as the method to solve ambiguity (not knowing what to do) in business. As task complexity increases and time availability decreases, however, the challenge of planning and problem solving becomes increasingly more difficult.[25] The rapid pace of operations and change in health care today makes traditionally based organizations less adaptive and flexible in complex environments.[26] Information and time are assumed to be abundant and relatively free resources in rational and willful choice models; moreover, organizational participants in the decision-making process are assumed to have similar (if not the same) goals.[27] Perhaps not surprisingly, these assumptions are the basis of criticisms of the willful choice model. Theories of agency (for conflict management) and economics (scarce resources—namely, time and information) have proposed to resolve contradictory issues associated with willful choice as an explanatory model. Both the theories of agency and economics depend on rational participants to validate the models.[28] The reality of the healthcare industry suggests that individual and group preferences change as underlying variables associated with the decision vary, environmental factors evolve, and other organizational decisions are made.[29,30] In addition, preferences of participants in the decision-making process often vary in illogical and emotionally dependent ways. Although accounted for in the willful choice models, time and information are not considered to be as valuable or scarce in these models as reality actually suggests they are.

Neoclassical economic theory suggests that the greatest good occurs when individuals are free to pursue self-serving interests.[31] This relationship further confounds the willful choice decision-making models' underlying assumptions. It is unreasonable to assume that each participant in a decision-making process will have similar self-serving goals and similar joint organizational goals most of the time. These contradictions add further credence to the view that willful choice models should be used when participants' goals are similar, time and information are available in sufficient quantities, and participants are well trained in the use of the model.

We do not mean to suggest that one should not use willful choice models, but rather that these models should be used in *appropriate* situations. This leaves the leader and manager in a tough situation: Which model should be used when the willful choice model conditions cannot be met? Other options include reality-based models. In the discussion that follows, the garbage can model is highlighted as an extension of rational decision-making models. It adds to the available methods of decision making for the leader and manager in health organizations.

Reality-Based Decision-Making Models

Reality-based models, such as the garbage can model, are intended to extend the understanding of organizational decision making by emphasizing a temporal context (the situation at one point in time) and accepting chaos as reality. Rational (willful choice) decision-making models are a subset of reality-based models. In ambiguous (do not know what to ask or do) situations where time and information are limited or constrained and "perfect information" is impossible to acquire, where organization structure/hierarchy is loosely coupled, and where the organizational persona seems to embody organized anarchy (chaos), analytical decision-making models do not fit reality. The garbage can model, what was originally designed to reflect decision making in universities, has been cited to explain decision-making processes in various organizations and situations. This kind of model also has been introduced as a possible method for understanding processes such as how an organization learns.[32] For the past two decades, researchers have observed that willful choice models of decision making underestimate the chaotic nature and complexity regarding actual decision-making situations; a large percentage of decisions are made by default, when decision-making processes are followed without actually solving anything.[33]

Garbage Can Model Concepts

Organized anarchy, *chaos*, and *bedlam* are terms that describe organizational decision making. "Garbage can decisions can occur in any organization but are more likely to be found in 'organized anarchies,' where decisions are made under ambiguity and fluid involvement of participants."[34] Garbage can models represent attempts to find logic and order in the midst of decision-making chaos. In this model, garbage—defined as sets of problems, solutions, energy, and participants—is dumped into a can as it is produced (streams of "garbage" in time); when the can is full, a decision is made and removed from the scenario.[35]

> Numerous empirical observations of organizations have confirmed a relatively confusing picture of decision making. Many things seem to be happening at once, technologies are changing and poorly understood; alliances, preferences, and perceptions are changing; solutions, opportunities, ideas, people, and outcomes are mixed together in ways that make interpretation uncertain and leave connections unclear.[36]

In management arenas (and specifically in acquisition decisions), the decision-making load, speed required in decision making, uncertainty, and equivocality (i.e., ambiguity—not knowing which questions to ask or what to do) are commonly encountered factors that influence the decision-making process.[37] Thus the temporal nature of decision-making processes, if taken as "snapshots" in time, would show a sequential arrival of problems, solutions, and information in a complex mix of participants, environmental factors, and consequences of prior decisions as reality in the "organized chaos" of decision making in organizations. Recognizing that time is not static and multidimensionality is ever present, the garbage can model depicts the chaotic nature of decision making through the jumbled mixture of elements in the garbage can.

Concepts are grounded in the ambiguous and uncertain states of nature for the garbage can model. Originally, three states of nature contributed to the model. All three states are immersed in ambiguity and, to a lesser degree, in uncertainty: (1) The greater the ambiguity of technology, (2) the more diverse the preferences of participants (the fewer preferences that are known, the greater the level of uncertainty) and of the organization, and (3) the greater the level of participation (in more specific terms, attention of participants), the more prevalent the garbage can processes in organizational decision making.

Ambiguity is defined as ignorance. Not only does this definition imply lack of knowledge, but it also indicates a lack of understanding of which questions to ask, which information is available, and which kind of connectivity exists between problem and solution sets and the consequences of implementing solutions. Ambiguity of participation exists when participants in the decision-making process have competing time demands that battle for attention that would otherwise be necessary to solve a problem (make a decision). Because measurement of participation ambiguity depends on many extraneous variables in a sea of limitless situational factors, it is difficult to quantify. Yet, attention and energy variations among participants are considered a "given" phenomenon in decision-making processes.

Extending the original concepts in the three-factor model, Takahashi proposed three additional state-of-nature ambiguities to the model: (1) fluid participation, (2) divorce of solutions from discussion, and (3) job performance rather than subjective assessments.[38] Regarding individual preference, Pablo and Sitkin suggest that the more risk adverse a decision maker is, the less tolerant of ambiguity he or she is.[39]

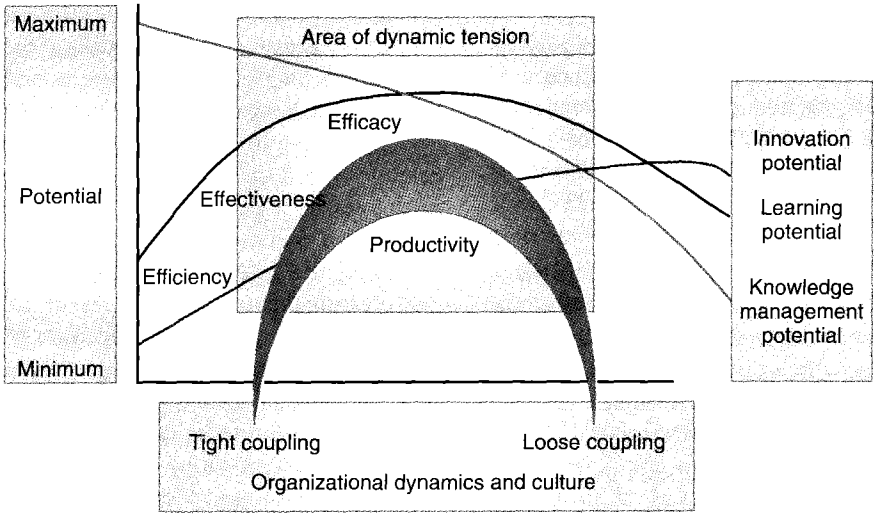
Loose coupling in organizations fosters adoption of the garbage can decision-making approach. Loose coupling, in this sense, is defined as a more informal, differentiated focus, such that members of the organization focus less on following the rules, yet structured connectivity of intra-organizational entities is still present. Loose coupling tends to allow a more flexible organization.[40] Organizations that are loosely coupled can more readily adapt to change and shifts in environmental factors.[41-43] The strength of the feedback loops present determines organizational coupling: Stronger feedback loops imply tighter coupling, whereas weaker loops suggest loose coupling.[44] Four criteria[45] are measured to determine the coupling status in organizations:

- *Formal rules:* The more closely the rules are followed, the more tightly coupled the organization. (In entrepreneurial organizations, formal rules are not as important.)
- *Agreement on rules:* The greater the employee congruence, the tighter the coupling. (Entrepreneurial firms agree on social norms rather than formal rules.)
- *Feedback:* The closer the feedback in time, the tighter the coupling.
- *Attention:* Empowered individuals allocate energy and time to prioritized projects in their "area." (Participation, competence, and empowerment foster focused attention to areas of responsibility.)

In the garbage can model, the concept of loose coupling is required to understand decision making. As a thinking exercise, consider where a health leader should establish the level of coupling in a health organization; refer to **Figure 6-1** when contemplating this question.

Temporal order replaces sequential order. Time is spatial in that a multitude of issues, problems, information flows, and sensing mechanisms can bombard decision makers in short or long time blocks. How problems and information to resolve the problems arrive in time has relatively equal priority with the evaluation of their importance. Arrival time and sequence in the current context both influence how much attention the decision maker pays to the situation:

> The process is thoroughly and generally sensitive to load. An increase in the number of problems, relative to the energy available to work on them, makes problems less likely to be solved, decision makers more likely to shift from one arena to another more frequently, and choices longer to make and less likely to resolve problems.[46]



Innovation, learning and knowledge management and organizational coupling
Tension: efficiency, effectiveness, efficacy, productivity.
Where should health organizations focus? Consider mission, vision, strategies, goals, and external (e.g., error-free delivery of care) and internal (capabilities) assessments.

FIGURE 6-1 The Ledlow and Johnson model (Revised by Ledlow): Coupling and the tension of innovation, learning, and knowledge management.

Source: Reproduced from Johnson, J., Ledlow, G., & Kerr, B. (2005). Organizational development, training and knowledge management. In B. Fried, J. Johnson, & M. Fottler (Eds.), *Human resources in healthcare: Managing for success* (2nd ed.). Chicago: Health Administration Press.

Individuals in the decision-making process, directly and indirectly, are interconnected and influence the context of the decision at hand.

Obviously, attention demands influence decision making. Time and energy must be allocated to understand, evaluate, and formulate a problem; then to synthesize relevant information; next to evaluate options; and finally to choose an alternative to counter or terminate the problem. Individuals focus on some things and do not attend to others in the same space of time. Corporate actions, outcomes, and responsiveness are the results of dynamic organizational processes, not heuristics of individual choice.[47] Time and energy combine to form "attention." Attention is a dynamic concept that is highly dependent on load (i.e., the number of decisions that need to be made).

Lending support to the garbage can concept, rational choice in organizational decision making can be skewed by rituals and symbolism. Symbolic rituals associated with decision-making processes, at times, may derail rational attempts to understand the process. Decision making is a process that reassures the organization that values, norms, and logic are upheld; in this light, decision making is a ritual.

Lastly, decision making as a process focuses on showing control and logic in a world of complexity and rapid change. Saying, "We made a decision" and "We own the process" implies control of human existence by logical choice. However the choice ritual makes one feel, decision making is not rational. For this reason, a depiction of organized chaos rationalized by imperfect participants among a myriad of complex and synergized variables is more appropriate, as shown in **Figure 6-2**.

Decision possibilities in the garbage can run the gamut from willful choice models to garbage can–based models. Decisions by "flight," "resolution," and "oversight" are prominent categories in the latter model. *Flight* is defined as a decision maker's intentional movement (attention shift) to another area of concern (problem). *Resolution* comprises a decision that uses classical decision-making processes such as willful choice models.[48] *Oversight* is defined as decision makers activating a process or procedure before a problem becomes apparent, such as development of a standard operating procedure or use of an established and documented process. Much of the research shows that flight is a significant result of many decision-making processes; in essence, decisions were "overcome by events" or were not made, but rather allowed to either resolve or escalate themselves. So, what does a leader or manager do to deal with the reality of decision making?

OPTIMIZATION OF DECISION MAKING

If a health organization has decision-making processes that resemble the garbage can environment, understanding the issues and proactively creating an environment that

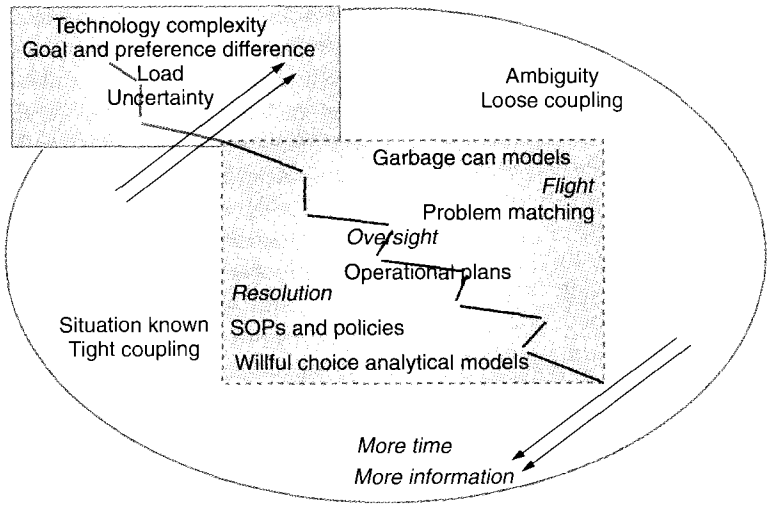


FIGURE 6-2 Conceptual garbage can decision-making model.

improves decision making can benefit the organization as a whole. Simulation results as part of garbage can studies revealed that decision making by resolution is not the most likely result of decision-making processes unless flight results are greatly constrained or decision load is light. Instead, flight and oversight[49] are more likely to occur—that is, either decisions are not made or predetermined and established processes (such as standard operating procedures) are used to a greater degree than might be noted with willful choice models. Given these findings, why not reengineer organizations to foster decision making based on the goals of the organization, where clearly defined yet challenging goals are set and managers direct subordinates to focus, persist, and provide effort in achieving the goals,[50] comprehend technology, and logically apply rational decision-making processes? The answer is simple: Organizations do not exist to make decisions, but rather to serve the external environment. An organization structured to make decisions will not serve its customers well and eventually will be eliminated from the marketplace.

Imperfect decision making can be expected. In light of the ambiguous reality of information, preference, differences, incongruent goals, and sporadically occurring problems coupled with information bombardment of the temporally "exposed" decision maker, the garbage can model represents a reasonable extension of willful choice theories. Humans strive for processes of willful choice, yet, as the garbage can model proposes, fail to achieve rationality in decision making due to time, energy, attention, uncertainty, ambiguous information, and decision-making load issues. Leaders who can grasp the dynamics of the garbage can are better prepared to position their organizations to make good decisions amid organized chaos and competition.

Given this understanding, it seems clear that leaders and managers in health organizations should develop an organizationally sensitive *system of decision making* with the understanding that decision making is not always orderly. To do so, they should focus on the following tasks:

- Evaluating the situation and decisions that need to be made across the organization (or within your area of responsibility) and categorizing decisions by quantity, urgency, information needed to make the decision, and variance in decision outcomes
- Developing readily available information concerning core business functions
- Standardizing, documenting, and training team members on decisions that need to be made routinely, where the same or similar decision outcome is required, and "pushing" those decisions to the lowest levels of the organization as possible but requiring feedback loops
- Determining decision-making load (quantity in a set time frame) and information available to make decisions for the existing decisions (those not standardized)
- Determining the importance of a decision to the organization by creating a system of risk determination, prioritization (urgency), and technological requirements for nonstandardized decisions
- Training team members on the decision-making system and processes

When a decision or decisions need to be made, a health organization leader should take the following steps:

1. Evaluate the priority and risk of the decision to be made, and determine whether this is a standardized decision or a decision that needs to be worked through.
2. Evaluate time available, resources available, participant attention, goals, and incentives.
3. Determine which decision making method to use: oversight, based on established documented processes such as standard operating procedures; resolution, using a willful choice model; or by pushing the decision to the appropriate level, individual, or group. It is also important to know when you do not need to make a decision (flight), based on the importance and risk level of the decision at hand.

To develop a reality-based decision-making system, the leader and manager must understand that decision making is not a sterile and orderly process in most cases. Importantly, organizational decision making *should be aligned* (decisions should be in accordance) with the organization's *mission* and *vision* statements and *strategic planning–based goals and objectives*.

TOOLS OF DECISION MAKING

Early careerists need to be aware of the various tools of decision making for future leadership study and practice. Study (e.g., taking a course) and practice of both quantitative and qualitative decision-making tools are highly recommended. This section highlights both methods and triangulation, which represents a combination of both quantitative and qualitative methods. It is recommended that each tool mentioned here (and those not mentioned) be researched (perhaps on the Internet), discussed, practiced, and role-played with others in the class, group, or organization. Facilitating the decision-making process in a group or organization is an essential skill of leaders and managers, and a working familiarity with decision-making tools is a prerequisite to such a skill.

Quantitative Methods

Quantitative methods include mathematical and computational analytical models to help leaders understand the decision-making situation (data turned into information, which is then turned into knowledge) and produce mathematical outcomes of solutions. Some models are rather simple; others are highly complex. Quantitative models assist in assigning a "number" to uncertainty. Models include multiple-attribute value and multiple-utility methods, linear programming, probability, and decision trees based on Bayes' theorem, and can be as complex as discrete and dynamic simulation. In general, simulation uses theoretical distributions and probabilities to "model" the real-world situation on the computer. From this computer model, response variables produce "outcomes" that can be evaluated.

Quantitative models take time and understanding of the important elements (also known as factors or variables) associated with the decision that needs to be made. In most health organizations, quantitative models are gaining momentum, though qualified (highly trained and well-practiced) analysts who understand health processes and can perform a range of quantitative analyses remain difficult to find and hire. Even with quantitative analyses in hand, many times leaders and managers skew decisions toward the qualitative side of decision making.

Six Sigma is a methodology that is growing in prominence in the health industry. Quantitative methods are critical to Six Sigma, which is a fact-based, data-driven philosophy of quality improvement that values defect prevention over detection. The Six Sigma technique drives customer satisfaction and bottom-line results by reducing variation and waste. It can be applied anywhere variation and waste exist, and every employee should be involved in its implementation. Six Sigma is used by many business organizations; health organizations are now using this philosophy as well to improve the work processes in their facilities.

Six Sigma is used to evaluate the capability of a process to perform defect free, where a *defect* is defined as anything that results in customer dissatisfaction.[51] The higher the Sigma level, the lower the number of defects. At the Six Sigma level, there are approximately 3.4 errors per 1 million opportunities, a virtually error-free rate.[52] Among early adopters of this approach are some of the most highly regarded health systems in the country—the Cleveland Clinic, the Mayo Clinic, and Johns Hopkins Medical Center, to name a few. These facilities consistently rank among the best hospitals in the world.[53]

Six Sigma is most successful when senior leadership makes a strong commitment to change, and in institutions where patient satisfaction and error-free care are the driving forces. Health organization staff must be trained by professional Six Sigma trainers. The training includes a "lean" thinking that seeks to drive employees toward perfection. It comprises a set of tools of varying degrees of sophistication that can be helpful for a leader to improve the health organization.[54]

A complementary approach to Six Sigma is Lean Sigma. Lean Sigma focuses on fixing the broken systems and processes that hinder medical professionals from

doing what they do best, empowering employees to make improvements, reducing time and costs, synchronizing processes, and improving quality and the patient experience.[55] This practice helps to create efficient processes and decrease wasted time in a health facility. Lean Sigma provides the road map for fast and sustainable improvement while creating a work environment that strengthens and sustains the patient experience and increases the effectiveness of the health service and the provider of care.

Qualitative Methods

Qualitative methods include a variety of tools, ranging from personal intuition, discussions with team members, informal interviews, formal interviews, focus groups, nominal group techniques, and even voting. These methods are very useful in the decision-making process, because experience, intuition, and common sense can all be used by individuals as well as by groups.

Study and practice of qualitative methods are essential for leaders to facilitate decision making for themselves, groups, and organizations. The most notable leader decision-making tools of a qualitative nature are intuition, consensus, and coalition-based counsel.

Triangulation

The combination of quantitative and qualitative methods results in triangulation, a more thorough (albeit more time-consuming) method with which to make decisions. For example, a group may use nominal group techniques to develop a small set of possible solutions, then analyze each solution quantitatively. From there the leader can make a decision.

Training the group or organization to use triangulation is a good practice for resolving ("resolution" in reality-based models) decisions. Triangulation can also be used to develop standard operating procedures ("oversight" in reality-based models). Lastly, triangulation can be used to make improvements to processes within the organization. Kaizen theory (discussed later in this chapter) utilizes triangulation in the context of continuous quality improvement.

Decision Making in Quality Improvement

Extending the discussion on decision making, quality improvement integrates well into the overall schema of decision systems. In essence, quality improvement is a distinct system characterized by seven phases: (1) decision making (identification of improvement areas), (2) situational assessment, (3) information gathering, (4) decision making (what to do with assessment and information to improve), (5) planning, (6) implementation, and (7) feedback. Quality improvement, as a system, is an organizational culture "flag" found in many excellent health organizations. The connection in this arena is simple: Where quality improvement systems exist, decision-making systems are embedded throughout the system of continuous quality improvement. Total quality management (TQM), Kaizen theory, and the Shewhart cycle are all quality improvement strategies; they are profiled in the remainder of this section.

Total Quality Management

The TQM principles were initially brought to Japan by W. Edwards Deming after World War II. Consequently, Japanese businesses have been practicing TQM for more than 50 years, with remarkable results: Japan was able to rebuild its war-torn economy and innovate so that it became one of the strongest economies in the world in the latter part of the twentieth century. Despite this proof that TQM can be used over the long term with successful results, many health leaders feel an urgency to adopt new management philosophies every few years.[56,57]

The key with TQM for any leader is to strive for documented and incremental decreases in variation and redundancy. This is a 14-step process:

1. Constantly strive to improve products and services.
2. Adopt a total quality philosophy.
3. Correct defects as they happen, rather than relying on inspection of end products.
4. Award business on factors other than price.
5. Continually improve the systems of production and service.
6. Institute training.
7. Drive out fear.
8. Break down barriers among staff areas.
9. Eliminate superficial slogans and goals.
10. Eliminate standard quotas.
11. Remove barriers to pride of workmanship.
12. Institute vigorous education and retraining.
13. Require that management take action to achieve the transformation.
14. Engage in proactive management.

The prudent health leader will meet in collaboration with fellow leaders in the organization. Working through a facilitator, write down each of Deming's tenets and outline those current organizational policies, practices, and procedures that have an impact on improving or impeding practices in the organization. When all the information has been collected, the leader will then be ready to establish new guidelines and break down barriers as appropriate.

Kaizen Theory

Kaizen theory is another approach with ties to Deming's work but is a Japanese-originated philosophy that focuses on continuous improvement throughout a system. Because health leaders are ultimately responsible for all aspects of organizational dynamics within the health enterprise, this approach is noteworthy. Kaizen theory is as much of an organizational culture (how things are done here) as a system that can be taught.

Kaizen originated in Japan in 1950 when business management and government acknowledged that there were problems in the then-current confrontational management system, given the pending labor shortage in Japan. This theory considers the initial quality of a project as well as the incremental improvement of quality when planning for quality improvements. Researchers defined Kaizen theory as a strategy to include concepts, systems, and tools within the bigger picture of leadership. This approach involves people (subordinates) and organizational culture, all driven by the customer. Japanese business leaders then involved the workforce in the solution of the problem. A key idea behind this theory is the need to practice reactive problem solving to promote continuous adherence to quality standards.[58]

Kaizen focuses on continuous improvement (CI) in performance, cost, and quality. In fact, some sources use the terms *Kaizen* and *continuous improvement* interchangeably, reflecting the nature of the theory. Ellife described Kaizen, or continuous improvement, as a method that intensively focuses on improving every small detail of a process, recognizing that lots of small improvements, when executed continuously and embedded in the culture of an organization, can yield much more benefit than a few "big" programs.[59] The goal when implementing the concepts of this theory in an organization is to promote a culture of consistent standards and quality by addressing small problems or tasks. In other words, *Kaizen* signifies a series of small improvements that have been made in the status quo as a result of ongoing efforts.[60] Others suggest that CI can be generated and sustained through the promotion of a good improvement model and management support.[61]

A *Kaizen event* is a focused and structured improvement project, using a dedicated cross-functional team to improve a targeted work area, with specific goals and objectives, in an accelerated time frame. It is a complex organizational phenomenon, with the potential for altering both a technical system (i.e., work area performance) and a social system (i.e., participating employees and work area employees).[62] Kaizen events are usually short-term projects, sometimes lasting only 1 week.

The introduction of a Kaizen event in the health setting may be problematic, given that leaders could face multiple barriers to the proposed change from the start. For example, some have suggested that demarcations are traditionally more stringent in hospital settings; subordinates in different units in the health organization protect "their" territory. It is, therefore, necessary to have personnel from the different groups involved in patient care represented on a Kaizen team. The structure and composition of this team is crucial to the success of a health organization Kaizen event. Kaizen events typically use a semi-autonomous team (a social system) to apply a specific set of technical problem-solving tools.[63]

In the healthcare arena, a Kaizen team should be composed of people from multiple disciplines to accurately address and manage events. Its members may, for example, consist of a physician, nurse, social worker, and physical therapist, depending on the event being addressed. Working as an interdisciplinary team ensures the sustainability of the improvements. Another positive side effect is that the group members can analyze one another's work processes to see how many steps each process actually includes and how much time is spent doing them. Kaizen covers many techniques and processes of CI; one that may be used in the health setting is the Shewhart cycle.[64]

Shewhart Cycle

The Shewhart cycle is also referred to as the Deming model and the plan–do–check–act (PDCA) cycle. This continuous quality improvement model consists of a logical sequence of these four repetitive steps for CI and learning.[65] The Shewhart cycle is a continuous feedback loop that seeks to identify and change process elements so as to reduce variation. The objective of this process is to plan to do something, do it, check for met requirements, and correct the process to achieve acceptable output performance. Performance improvement teams (PITs) are often developed in health organizations to address specific issues and work on problem solving by implementing the Shewhart cycle.

A PIT, which is a multidisciplinary group, may apply a model such as the Shewhart cycle to concentrate on quality improvement issues. Evidence-based data are used to analyze information within a PIT. Evidence-based practice in clinical performance, as well as administrative components, may help to reduce unnecessary tasks and procedures. The PIT can use the Shewhart cycle to tackle issues that affect the quality of care.

TRAINING

Training is a responsibility of leadership. Usually housed in the human resources department, it is the main vehicle for human resource development (HRD). Training functions as a key role of HRD by working to improve

BENCHMARKS IN QUALITATIVE DECISION MAKING FOR LEADERS

1775: Adam Smith, author of *The Wealth of Nations*, observed a pin factory in 1775 and concluded that the process of making a pin could be separated into 14 different steps and processes. After observing the process for a period of time, Smith defined the sentinel events of pin making and assigned these tasks to the personnel who showed expertise in each specific stage. The result: The factory went from producing hundreds of pins a week to thousands! However, Smith found that if certain elements of this fledgling assembly line suffered slowdowns, the entire output could be hindered or halted.

1920: Dr. Walter Shewhart of Bell Telephone developed one of the first true control charts. In a paradigm shift from management philosophies, instead of inspecting outcomes, Shewhart began inspecting the process. He developed some of the first process-control methodologies used in the United States. His primary data methods were statistics (outcomes), sampling (convenience), and control charts that could be supplied to management to measure events as they happened.

1950: Kaizen theory resulted in the increase in productivity in Japan after World War II. Before World War II, Japanese products were seen as low quality and cheap; after the war, when Japanese factories and management philosophies were reestablished, Kaizen principles helped the country establish dominance in the global marketplace. Eventually, the word *Japanese* became synonymous with the word *quality* in regard to factory-made items.

1950–Present: W. Edwards Deming applied Shewhart's principles of quality control in his role as a consultant to several organizations while visiting Japan after World War II. From 1950 onward, he often visited Japan as lecturer and consultant (the Japanese honored him by naming the highest Japanese quality award after him). In spite of this popularity in Japan, Deming's principles were not adopted in the United States until the latter part of the 1980s. Today, the demonstration of TQM, Kaizen theory, and Shewhart principles are staples of many accreditation site visits for health leaders.

the organization's effectiveness, efficiency, and efficacy by providing employees with the learning needed to improve their current or future job performance based on the mission, vision, strategies, and goals of the organization.[66]

Training comprises a planned set of activities that proceeds through health organizational needs assessment, gap analysis (Do current employees lack certain capabilities?), training module development, trainer identification, logistics of training, the training itself, and training evaluation and refinement. Training in organizations should focus on the organizationally required knowledge, skills, and abilities (KSAs). Training of staff and subordinates is, of course, essential for the long-term success of the health organization. Usually employees who work at the highest levels (leadership) and the lowest levels (e.g., receptionists) receive the least amount of ongoing training in a health organization; this is a problem that needs to be rectified (considering that the lowest levels in a health organization usually welcome and often talk with patients). Leader training is often subsumed in the HRD training structure, when, in fact, it needs to be an ongoing effort that is just as prevalent as staff training.

Why should it be that some people develop into "take charge" types who organize everything around them, whereas others remain more laissez-faire in their approach to life? Maltby asks the basic question, noting that the "question continues to dominate the study of leadership today. Volumes of research have been written."[67] Many definitions of leadership exist, and Maltby offers one taken from the writing of Jay Conger: This definition holds that leaders establish direction, gain commitment, and motivate members of the group.[68]

Developing some clarity about the "Born or made?" debate is essential to any discussion of leadership training. The current consensus is that the answer to this question is "both": Leaders are born and made. Most authors agree that although the elements of leadership certainly can be taught to others, such training is far more effective among those persons with a predisposition to leadership. To be successful, training must be designed to (1) develop and refine certain of the teachable skills; (2) improve conceptual abilities; (3) tap individuals' personal needs, interests, and self-esteem; and (4) help leaders see and move beyond their interpersonal blocks.[69] Two of the more important health organization training efforts, for leaders and all subordinates, are cultural and moral competencies.

Cultural and Moral Competencies

Health leaders must work together as partners to increase general awareness and improve culturally diverse organizations. The U.S. Department of Health and Human Services defines *cultural competence* as behaviors, attitudes, and policies that come together on a continuum to work in

an adverse cultural setting. The Robins Group defines it as a way of being that enables people and organizations to engage effectively in a variety of cross-cultural environments.[70] Because every organization is different, what constitutes appropriate cultural competence in one organization may be seen as being wholly inadequate in another organization. Thus cultural competence is "an approach that starts with the core values and cultural expectations of the specific organization."[71] It can also be defined as an understanding of the importance of social and cultural influences on patients' health beliefs and behaviors and a consideration of how these factors interact at multiple levels of the health delivery system (e.g., at the level of structural processes of care or clinical decision making). Clearly, it is important to devise interventions that take these issues into account to assure quality healthcare delivery to diverse patient populations.[72,73]

Cultural competence provides the knowledge, skills, and abilities that allow health leaders to increase their understanding and appreciation of cultural differences among groups of people. It focuses on behaviors, attitudes, and policies. This foundation facilitates exploration of different cultures, learning about cultural heritages, and appreciation of the effects of diversity on health care and the health industry. Culture and language have powerful effects in terms of how patients access and respond to all health services received from a health provider; leaders need to be aware of these issues.[74,75]

The Joint Commission suggests that all health leaders should be culturally competent. The U.S. government has presented a series of recommendations for national standards and outcomes-focused research to assure cultural competence in health care.[76,77] When cultural competency is lacking, patients and subordinates may mistrust both the leader and the health organization. For leaders, cultural competency is a learning process that will allow them to grow and expand their knowledge, sensitivity, and respect for those in the organization and for those whom the health organization serves. Cultural competency is expressed in the healthcare approaches used with patients of diverse ethnicities, races, national origins, and languages. Leaders need to be culturally competent to succeed.[78,79]

In a global community, the value of cultural competence is clear, particularly as ethnic, racial, and national diversity increases over time. These points of diversity further contribute to the mélange that is the organizational culture. Power can be used to block something from happening, or it can be used to ensure that something does happen. Power is essential if the organization hopes to ever accomplish something: Someone or some group must have the power to make things work. "Power is the basis of the ability to get things done in organizations, and is therefore an essential element of organization and leadership."[80] Cultural competence, in turn, is a capability that adds to a leader's power.

All of these factors combine to form and influence leadership. Planning, decision making, and training can and do take place within organizations that serve and employ a variety of culture types, but only cultural and moral competency can produce an organizational culture that encourages and allows employees to fully respond to leadership.

ETHICS AND MORALITY

Ethics can be defined as a theory of moral values.[81] There is a perception that all organizations are expected to work to the highest standards of integrity and ethics. Ethical standards and values are not created by laws or regulations, but rather by the board and trustees of an organization; they are then implemented by the leadership. Ethics is a framework for decision making and action, whereas morality is the level to which the ethical framework is applied. In many university programs, ethics is embedded in a health law or legal course. Ethics and morality are health leader responsibilities—a statement that holds true at all levels of the health organization. In simple terms, ethics relates to doing what is right; it is about using good and fair judgment; it is about responsible fiduciary use and distribution of resources. Ethical and moral behavior, personally and organizationally, is the leader's responsibility.

Health leaders must be ethical and moral agents of the organization. The success of the organization may rise and fall on the perception of the community regarding the morals of the organization. Staff members and the community expect the leaders to use their best judgment; leaders are held accountable for doing what is right. If a slip in morality occurs, unfavorable publicity might obscure all of the health organization's other positive efforts and smear the good name of the organizational "brand." Unfavorable publicity can have a dramatic effect on an initiative already in progress.[82] Although other leadership distinctions may depend on the execution of a skill set (such as planning) or a trait (such as charisma), the distinction of authentic leadership rests heavily on perceptions of morality. To gain support from both internal and external stakeholders, the health organization must display the sincerity of its mission and act consistently with its espoused values.

In nonprofit health organizations, losses due to fraudulent activities are particularly troublesome because they directly reduce the amount of resources available to address tax-exempt purposes.[83] Negative publicity for a health organization may also reduce contributions and lead to loss of grants. Some organizations have publicly indicated their commitment to ethics, whereas others have done little

to prevent ethical dilemmas from arising. It is important to read your health organization's ethical statements to see where it stands on these issues.

Over the years, various reports have appeared in the literature on the need for healthcare organizations to develop and implement organizational ethics programs. Health organizations should institute visible and effective leadership training programs in these areas. These programs should promote and inspire the ethical behavior of employees and executives alike. In 2009, Fine suggested that a moral discourse in the health leadership context is important; adding purpose and context to leadership model constructs should be based in ethical considerations and possibly adopt a feminist ethic of care perspective.[84]

In recent decades, several ethical scandals have adversely affected the health industry. Health leaders should be aware of these episodes and take steps to prevent them in their own organizations. Some of the more widely publicized scandals involved embezzlement by the president of the United Way of America,[85] improper use of funds by the head of the National Association for the Advancement of Colored People (NAACP),[86] and investment fraud by the head of the Foundation for New Era Philanthropy.[87] These examples show that ineffective leadership can have a huge impact on health organizations and the industry as a whole. The success of health organizations is sometimes rated by the quality of their charitable and beneficent activities; when these activities are associated with immoral behavior, the negative effects can be devastating.

The leaders of the health organization must demonstrate that they can operate in a consistently ethical and moral manner. Consistent, ongoing, and frequent training in cultural and moral competencies is imperative; this training should begin with new employee orientation and continue throughout the tenure of that employee regardless of position or status.

CONTINUING HEALTH EDUCATION: COMPETENCY ATTAINMENT

As we close out this chapter, we offer a perspective of knowledge, skills, and abilities (KSAs) in regard to continuing health education (CHE). For the purpose of this summary, we suggest that *knowledge* is recalling information with familiarity gained through education, experience, or association, whereas *comprehension* is understanding the meaning of the information. A *skill* is the effective and timely utilization of knowledge, and finally, an *ability* is the physical, cognitive, or legal power to competently perform and achieve positive outcomes. Many of the competencies needed to start a career may be learned in degree programs; however, once an individual moves away from traditional education and enters into professional practice, most, if not all, of these capabilities are learned through CHE. As early careerists will see, whether you are aware or not, you are constantly being evaluated and assessed on a combination of your skills, knowledge, and abilities in any professional practice setting entered.

The health workforce consists of a complex assortment of individuals with different backgrounds, educational experiences, certifications, specialties, and work locations. Approximately 12% of the entire U.S. workforce works in the health professions.[88] As a result, health leaders must continue to understand the dynamic nature of the industry to lead very diverse members of the health care team, which will require them to challenge themselves and their organizations to become more competent under significant external pressures.

WHAT IS CONTINUING HEALTH EDUCATION?

Continuing health education (CHE) involves activities, learning events, or individual efforts that result in a combination of recognized (and/or credentialed) and unrecognized (uncredentialed) knowledge. Formal CHE includes those activities sponsored through professional organizations or organizations of higher education that award credit towards certification, licensure, or accreditation, or apply to annual requirements for practice. These include:

- Formalized continuing health and/or medical education (CHE/CME)
- Certificate, graduate, and doctoral education
- Recognized didactic instruction

Informal CHE includes those activities, events, and efforts individuals engage in to maintain proficiency or fill personal gaps in knowledge in personal practice. These may include:

- Mentoring (or being a mentee)
- Heuristics (a "Rule of Thumb" or organizing rubric)
- Community volunteerism
- Professional organizations (networking)

Table 6-1 provide a snapshot of the advantages and disadvantages of each type of CHE. An adroit health professional should keep him- or herself abreast of several different and ongoing types of CHE in his or her career to maintain appropriate competency within the profession.

Table 6-1 Advantages and Disadvantages of Formal and Informal Continuing Health Education

	Type	Description	Advantages	Disadvantages
Formal continuing education	Continuing health and/or medical education (CHE/CME)	Those didactic activities that are generally sponsored by professional organizations	• Recognized • Easily transferable • Peer reviewed • Panel of experts • Relevant to today's environment	• High cost • Geography • Seasonal times and opportunities for attendance • Limited focus to the profession • Often requires meeting face-to-face
	Certificate, graduate, and doctoral education	Those activities that are sponsored or take place in institutions of higher learning or education *Example:* Texas Tech University Health Sciences Center, Central Michigan University	• Results in a focused set of transferable competencies across the profession • Permanent and often without expiration • May be conducted via distance learning	• Skills become dated and may lack relevancy over time • Quality may vary between degree-granting institutions
	Recognized didactic instruction	Those activities that are sponsored by or take place in peer professional organizations or educational organizations *Example:* ACHE, MGMA, AMA, ANA, trade schools, colleges, and universities	• Credits often transferable across professions • Permanent and often without expiration • Provides a different point of view • Often relevant and necessary to profession	• Skills may become dated and may lack relevancy over time • Quality may vary between degree-granting institutions • May take months to years to learn skill • Costs may be prohibitive
Informal continuing education	Mentoring	The close and personal relationship established between a senior and a junior professional—often in similar career fields *Example:* The CEO mentoring a new hire or junior employee	• Little to no cost • Creates loyalty and decreases turnover • Reaffirms leadership principles • Transfer of knowledge and skills specific to organization	• Skills learned in one organization may not be specific to another • Can create perception of favoritism
	Heuristics	Knowledge gained through experimentation and practice *Example:* A mid-level executive volunteering to do his or her first CBA (cost–benefit analysis)	• Heuristic opportunities surround us daily • Personal challenge • Demonstration of leadership to peers, superiors, and subordinates • Provides valuable set of marketable skills	• Skills are difficult to quantify and measure • May not be valued across organizations

SUMMARY

This chapter identified knowledge and empirically based skills and abilities (a leadership toolbox full of "tools") required for a health leader's success in organizational practice. Strategies for leaders in effecting planning, decision making, and training that result in positive outcomes will ideally result in practical leadership actions and applications based in "active" leadership.

Planning, decision making, and training are integrated processes that are embedded in health organizations. Leaders can consciously make these processes better, more efficient, effective, and efficacious while reducing organizational stress. Understanding the nature of planning and decision making and becoming competent as a decision maker, facilitator, analyst, or decision-making assistant (a person who helps the primary decision makers) are critical for success as a leader and a manager; they are also necessary for success as a team member who is not filling a leadership or management role. Developing a system of planning, decision making, and training, within the organizational context, and becoming a competent user of these systems are vital to achieving and maintaining excellence in health organizations.

DISCUSSION QUESTIONS

1. Discuss the importance and use of planning, decision making, and training in health organizations and provide examples of each. How can planning, decision making, and training aid in developing organizational culture in health organizations?
2. Explain the planning process within the context of leadership. Explain the decision-making processes used by health organizations. Predict how successful leaders can be when they master these tools of leadership. What might happen if they do not master these tools?
3. Use examples to apply and relate at least two different decision-making models to a leadership situation in a health organization. How are the models different? When should each model be used in health organizations?
4. Illustrate the levels or components of the planning process and distinguish each level or component from the others. How does this structure help in planning and in progress review?
5. Relate how a quality improvement program is based on a system of willful choice decision making in a health organization. Can a reality-based decision-making model work in quality improvement? Why or why not?
6. Compare and contrast willful choice to garbage can models of decision making, training leaders to training staff, and cultural competence to ethics and morality. Justify your positions.

EXERCISES

1. Define the overall concepts of planning, decision making, and training; give examples of each as part of your definitions.
2. Generalize how a successful health leader prepares for (a) planning in a health organization, (b) developing a decision-making system in a health organization, and (c) ensuring that all employees are culturally competent in a health organization. Complete this exercise in two pages or less.
3. Prepare a list of internal and external stakeholders for a health organization in preparation for strategic planning; categorize each group.
4. In a two-page paper, compare and contrast the willful choice and garbage can models of decision making within a health organization context.
5. Organize a planning effort in preparation for a Kaizen theory or Shewhart cycle quality improvement project within a unit (keep it small) of a health organization. Describe this plan in three pages or less.
6. In a two- to three-page paper, appraise the concept of "coupling" within the context of decision making and ethics/morality in a health organization.