Effective Leadership in Long Term Care: The Need and the Opportunity

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ACHCA
American College of Health Care Administrators

AMERICAN COLLEGE OF HEALTH CARE ADMINISTRATORS POSITION PAPER

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Preface

Under the Omnibus Budget Reconciliation Act of 1987, the nursing home administrator is responsible for management of the skilled nursing facility [42 CFR 483.75 (d) (i) (ii)]. Administrators of nursing homes and a variety of other long term care settings play a central role in the quality of care and the quality of life of the people they serve. Even so, the importance of their leadership is rarely discussed or researched as a component of quality and culture transformation initiatives. The American College of Health Care Administrators (ACHCA), the professional membership association for long term care administrators, commissioned this leadership paper to document the conceptual underpinnings for competent long term care leadership. ACHCA's position is that the presence and perseverance of effective leadership is essential to the successful design, implementation, evaluation, and maintenance of quality and safety practices along with a person-centered culture transformation in the long term care setting. ACHCA, in collaboration with key long term care partners, has a primary role in the development of that leadership.

This leadership concept paper is the result of a strategy emanating from ACHCA's 2007 Strategic Plan. On behalf of the 2007 Board of Directors, Chairman of the Board Larry Slatky (CNHA, Fellow), Past Chair Lonnie Bisbano (CNHA, Fellow), and President & CEO Marianna Kern Grachek (MSN, CNHA, CALA, Fellow) provided assistance and direction for the framework of this paper. ACHCA contracted with Bernie Dana, MQM and Douglas Olson, PhD, MBA to develop this position paper. Their biographies are provided at the end of this paper.

In writing this paper, *The Need and the Opportunity*, the authors were aware that it may be shared with a variety of audiences. Many of the people who actively manage and lead long term care organizations have little time to review the broad and the focused literature on leadership. Educators in long term care may have a thorough understanding of leadership research, but may not grasp the complexity of its day-to-day application. Private and public policy makers need to understand the significant relationship between developing effective leadership and achieving and sustaining quality improvement across the profession. The breadth and depth of this paper attempts to address all of these audiences.

The authors also developed a companion paper on *The Role of ACHCA.* This paper recommends strategies for ACHCA to develop leadership programs and partnerships that will help create change. It will be used at the discretion of their Board of Directors as they develop initiatives to represent the important and valuable profession of health and aging services administration.

Acknowledgements

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Executive Summary

Consistent with its purpose and vision, the American College of Health Care Administrators (ACHCA) is exploring how it can help stimulate the changes necessary for the long term care (LTC) profession to move forward in its quest for performance excellence. This position paper provides an in-depth review of the need and opportunity for leadership development and the role that ACHCA should consider to create and provide leadership programs that are uniquely effective and beneficial to its members and the profession.

Leadership can be viewed as both a position and a process. The one common aspect of leadership across all views is that it involves purposeful influence of a group or organization. Attempts to distinguish the difference between a leader and a manager have created a misconception that the management process is less important than the leadership process. High performance organizations require a balance of both effective leaders and managers.

While all organizations have leaders, not all leaders are effective. Common ways to evaluate effectiveness are the achievement of results and the development of follower support. Leaders are expected to use their status and power to help the group solve problems. When successful, leaders gain power and status. Leaders lose power and support when they don't take action or their initiatives fail because of poor judgment or incompetence.

Recent studies on leadership have focused on behaviors rather than traits. Task, relationship, and participative skills can be learned and developed into practices that make the leader more effective. A new area of study called the "neuroscience of leadership" helps us understand why knowledge alone is not enough to improve leadership effectiveness and organizational change.

The demands on LTC administration have evolved significantly since the 1960s. Administrators have traditionally focused on management processes. The hectic, unrelenting pace of work along with frequent, unplanned interactions have encouraged and rewarded a "crisis management" style that makes it difficult for administrators to give priority to leadership processes. The LTC focus on management is also driven by entry level licensure requirements and exams, along with the intense regulatory structure. As a result, many LTC leaders view quality and performance narrowly as achieving the minimal standards set by regulations rather than meeting and exceeding the needs and expectations of the residents/patients and their families.

Studies have evolved in long term care that clearly link effective leadership practices with organizational performance. While these LTC studies support the broader research on leadership, there are some nuances that make long term care leadership unique. Among other things, these nuances can relate to the need for a compassionate perspective, the high interaction of people, the regulatory-driven environment, a predominantly non-professional work force, a flat organizational structure, the frequent change in leadership positions, and a lack of understanding and sensitivity of governing authorities.

Developing effective LTC leaders requires the dedication of resources, identification of needs, and significantly better approaches than have been used in the past to deliver training. LTC providers, trade associations, government agencies, and educational institutions have all attempted to fill this gap. The core drivers of leadership training, such as licensure and certification requirements, will have to be modified or supplemented. Opportunities to enter into the profession and the rewards for performance need to be expanded.

LTC studies have shown that organizational performance is more closely linked to leadership experience than to formal education. Experience translates knowledge into actions, applies problem solving techniques, and holds people accountable for performance. ACHCA should incorporate these same dimensions into innovative programs for advanced leadership development.

The need for effective leaders in long term care is real. The opportunity for ACHCA to focus energies and establish its position as the premier provider of leadership development in the health and aging services field is significant. The effort required to achieve this goal is daunting. Even so, the goal can be realized if appropriate resources are gathered and the right partnerships are forged to create a program that makes the administrator more marketable and adds value to the organization that he or she serves.

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Introduction

The purpose of the American College of Health Care Administrators (ACHCA) is to promote excellence in leadership among long term care (LTC) administrators. The vision for this leadership is to forge long-term health care services that are desired, meaningful, successful, and efficient. Through voluntary membership, ACHCA recruits, recognizes, and supports persons who, by training or experience, are qualified to administer a health and/or residential care facility, or who have a substantial interest in the practice of health and/or residential care administration (ACHCA By-Laws).

ACHCA has clearly established and affirmed its mission and vision. The current challenge is to stimulate the changes that will enable it to achieve its mission more effectively by: (1) making leadership recognized as a pivotal element in achieving any and all private and public initiatives for long term care excellence; (2) developing the capability to provide leadership development programs that enable long term care leaders to become more marketable through demonstrated effectiveness in a dynamic environment; and (3) influencing visionary, leading-edge change in long term care through partnerships and collaborative efforts that promote and share research and innovations in long term care leadership and management.

The objectives of this position paper commissioned by ACHCA are (1) to discuss and establish the vital need for effective leadership to deliver quality LTC services; (2) to identify the system gaps in leadership development that impede the LTC profession from achieving the level of performance excellence being demanded by all stakeholders; and (3) to propose an approach that may enable ACHCA to develop leadership training programs that produce improvements in both results and support. To achieve these objectives, the authors have reviewed existing and emerging literature and research on effective leadership and management; examined leadership development models being used by various organizations; and utilized their own extensive experience in long term care leadership and training.

Leadership and Management

In common vocabulary, leadership describes the traits and behaviors of people whom we admire because of their ability to bring people together to achieve a shared objective. Leadership is also used to identify formal positions of authority (specialized role view) and the informal influence that seems to naturally occur in any kind of social group by any one at any time (shared influence view). Attempts to create a more technical definition have created as many definitions as there are approaches used to research this subject. These various approaches include traits such as personality and values, behaviors and patterns of activities, the amount and type of power used to influence others, and how the situation and context impact leadership effectiveness. The only common link found in most research is that leadership involves purposeful influence of a group or organization.

In *Leadership in Organizations*, Yukl (2006) defines leadership as "the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives" (p. 8). This definition is useful because it provides for both direct and indirect influences on the preparation for future challenges as well as the current work of the group or organization. Yukl describes leadership as going well beyond the ability to direct the completion of tasks or to achieve a particular result through sheer will and determination. His definition recognizes that effective leaders achieve results by inspiring followers and by training and coaching them to develop the skills.

Much of the literature on leadership over the past decade tries to distinguish between a leader and a manager. Some suggest that these roles are qualitatively different and mutually exclusive. This literature has brought us maxims like, "Managers do things right, but leaders do the right things" (Bennis and Nanus 1985, p. 21). The manager is usually described as the dependable operational workhorse and the leader as the great organizational visionary. Unfortunately, this stereotypical approach has been widely accepted in popular literature and creates the misconception that the "manager" is less able and less valuable than the "leader" in the organization.

Kotter (1990) and others conclude that it is the processes rather than the roles of leadership and management that are distinct, and that the processes do not necessarily require different types of people. This approach says that management processes seek to produce predictability and order while leadership processes seek to produce organizational change. Kotter found that the two processes of leadership and management need to be compatible and both are necessary for an organization to be successful. Strong leadership processes alone can disrupt order and efficiency and create unrealistic demands for change. An unbalanced focus on management processes may discourage innovation and risk-taking while producing a bureaucracy without clear purpose.

Extensive research by the Gallup organization found that "the most important difference between a great manager and a great leader is one of focus" (Buckingham and Coffman 1999, p. 63). Effective managers look inside the company to see how to develop the talents and strengths of its people based on their individual differences in style, goals, needs, and motivation. The core activities of an effective leader tend to be different. Leaders look outward at the competition, at the future, and at strategies. While leadership is a critical role, it will not produce a great organization unless effective managers are there to help channel individual talents into performance. In essence, different talents will more naturally support the different processes of leadership and management. Some are blessed with the talent to be both. Even so, managers should not be criticized if they do not have the natural inclination to look outward. The focus on developing effective leaders should not be greater than the focus on developing effective managers. "Great vision without great people is irrelevant" (Collins 2001, p. 42).

In relation to developing a higher performing organization, leadership should be described more broadly to include all management level positions. The argument that not all "leaders" are in positions of leadership and that not all people in positions of leadership are "leaders" is true. It is exciting to know that there are informal leaders in the organization because those traits and skills can be developed to give the organization hope for the future.

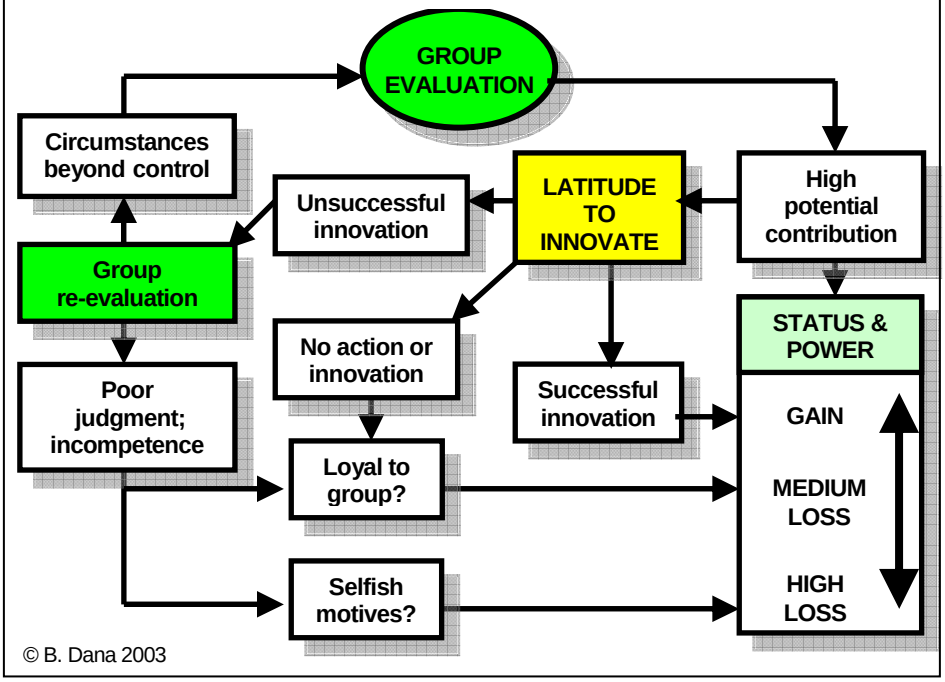
Describing leadership broadly encourages a focus on the common characteristics and processes that make leaders and managers effective rather than different. The key to optimizing success is to develop the strengths of each member of the management team in a way that contributes to the synergy of the whole team in implementing and sustaining a higher performing organization.

Evaluating Leadership Effectiveness

All organizations and groups have leaders, but not all leaders are effective. Two commonly used factors for evaluating effectiveness are follower support and goal achievement. The leader can have immediate or delayed influence on the outcomes for both factors. For instance, a policy or practice change may produce immediate results. The results from initiatives to build trusting relationships or to implement a quality management system are often realized over time.

Followers play a key role in evaluating the effectiveness of leaders. Whether in a position of authority or informally selected by a group, leaders are typically evaluated based on their potential to benefit the group or organization by controlling scarce resources, providing vital information, and resolving critical problems. As shown in Figure 1, those who are perceived to be able to make a high potential contribution are given status and power and the latitude to innovate. Followers also expect the leader to show initiative by helping solve important problems. Leaders who take no action will lose status and power. Leaders gain esteem and influence when their solutions are successful. If solutions fail, the followers evaluate the cause and the leader's motive. The group will continue to be supportive if they perceive the leader to be loyal to the group and the failure related to circumstances beyond the leader's control. However, leaders will lose significant status when the group perceives the failure to be linked to selfish or irresponsible decisions (Yukl 2006, p. 158).

Figure 1: Social Exchange Theory Map



This social exchange theory is helpful to understand why leaders may succeed or fail. A manager or leader should have effective leadership behaviors, knowledge, and processes to help a group solve

problems and make good decisions. An ineffective leader may react to losing the support of followers by using intimidation, withdrawal, and personal attacks that further estrange followers and impair his/her ability to achieve the desired goals.

The majority of leadership research has focused on differentiating the components of leadership to evaluate effectiveness. These are generally broken down into traits and behaviors (Jago 1982 and Clark 1990). Traits are characteristics such as personality, motives, values, and skills. There is considerable evidence that leadership traits are both learned and inherited as part of a person's temperament and natural talents. Some people will be more naturally inclined to develop certain leadership skills and traits while others will have to work hard at it. Some will be more task-oriented, while others will be more people-oriented. Some will enjoy change and others will prefer stability. Personality traits seem less important than skills for effective leadership (Yukl 2006, p. 444). While charisma can be beneficial, charismatic leaders are less effective over time if they yield to their tendency to become the focus of the organization and make co-workers dependent on them. Out of the 11 companies identified by Collins as making a transition from "good" to "great," only one of the leaders had charisma and few were well known by the general public (Collins 2001).

Studies have also examined how motives affect leadership effectiveness. McClelland and his associates (1985) found that the motives fall into three categories: (1) affiliation (obtains satisfaction from being accepted and liked), (2) achievement (obtains satisfaction from successfully accomplishing a difficult task or being the first to do something), (3) power (obtains satisfaction from influencing the attitudes and behaviors of others). Various studies have determined that power can be subdivided into two groups. Leaders with a personalized power orientation satisfy their need for power by dominating others in selfish ways. Leaders with a socialized power orientation gain satisfaction by helping others develop and by influencing the group to achieve their goals. Start-up and young, growing organizations tend to have leaders who have expertise and a strong achievement orientation. Larger, more mature organizations perform best with a leader who is strongly oriented to socialized power, complimented by a moderately high need for achievement and a relatively low need for affiliation (Boyatzis 1982).

The more recent studies of leadership are less concerned with how leadership originates and more concerned about what leaders do and how the organization experiences it. Research in leadership practices has found that highly effective leaders have a high concern for both task objectives and relationships, and tend to use a behavior pattern that is appropriate for the situation they are experiencing.

Developing Effective Leadership Behaviors

Leadership behaviors are primarily learned and are often categorized as task-oriented, relations-oriented, and participative (Yukl 2006). The *task-orientation* of effective managers is focused on planning, coordinating, and providing resources rather than doing the same kind of work as their subordinates. Effective managers showed *relations-oriented* behaviors that are supportive and considerate. They initiate efforts to understand subordinates, keep them informed, listen to their ideas, recognize them, and empower them. Effective managers also practice *participative leadership*. Rather than just individual supervision, they use more group activities to facilitate and encourage

subordinates to work together and participate in decision-making (Yukl 2006, p. 54). Practicing participative leadership does not mean that effective leaders always use group decision-making processes. In fact, effective managers consider the quality, subordinate acceptance, and timeliness of the decision when deciding whether to use autocratic, consultation, or a group decision process. For instance, an autocratic decision is appropriate when time is a key factor, the leader has sufficient information to make a good choice, and subordinates share the leader's goals and are likely to accept his/her decision. Leaders are more effective when they consult with subordinates if they lack essential information or if the subordinates may not share the leader's goals or accept an autocratic decision. The leader should empower a group to make a decision when the leader and subordinates share the same goals and the group is fully informed and capable of making a quality decision. In any case, the leader remains responsible for all decisions and their results (Yukl 2006, p. 93).

Effective leaders are often described as "transformational" leaders. They practice "delegating significant authority to others, developing co-worker skills and self-confidence, creating self-managed teams, providing direct access to sensitive information, eliminating unnecessary controls, and building a strong culture to support empowerment" (Yukl 2006, p. 271). Transformational leadership is relevant at all levels of an organization and to all types of situations (Bass 1996). To be effective, these leaders have a "contextual intelligence" which gives them "an almost uncanny ability to understand the context they live in – and to seize the opportunities their times present" (Mayo and Nohria 2005). They are effective in leadership practices that guide the organization though the stages of change where people realize the inadequacy of the old way of doing things, explore and select a promising new approach, and institutionalize the new approach through changes in structure, policy, and rewards (Yukl 2006, p. 286).

Examining leadership practices provides a better link to evaluating effectiveness than do studies of traits. Two approaches that have gained credibility and support over the past decade are the works of Bass and Avolio (1997), and Kouzes and Posner (2002). These researchers have developed the most commonly used and cited instruments for evaluating leadership practices.

The Multi-Factor Leadership Questionnaire (MLQ) developed by Bass and Avolio (1997) captures the basic elements of transformational leadership. It measures practices that arouse strong follower commitment, influence the perspective that followers have of problems, encourage and support followers, communicate an appealing vision, model appropriate behaviors, and enforce rules to avoid mistakes. Numerous research studies have validated the MLQ which is largely focused on the leader practices at the level of personal influence.

Kouzes and Posner (2002) conducted extensive interviews to identify practices related to the best and most fulfilling achievements of managers. They identified five practices that were validated through ongoing surveys of middle and senior managers across the country. Their Leadership Practices Inventory (LPI) assesses: (1) challenging the process, (2) inspiring a shared vision, (3) enabling others to act, (4) modeling the way, and (5) encouraging the heart. Challenging the process has leaders searching for opportunities to change the status quo. Inspiring a shared vision is focused on envisioning a future. Enabling others to act is associated with fostering collaboration and building teams. Modeling the way focuses on behavior in pursuit of goals and treatment of people. Finally,

encouraging the heart recognizes contributions and celebrates accomplishments. The LPI seems to have a stronger focus on leader/follower relationships, which is a good comparative reference for approaches concerned with how the organization experiences leadership.

The *Good to Great* research by Collins (2001) found a unique characteristic in the leaders of organizations that had made a transition from good to excellent performance. These "Level 5" leaders had a combination of both professional will and personal humility. Their focus is on the organization's success rather than their own. They take responsibility for the organization's failures, but give credit to others for the successes. The practices of "Level 5" leaders are revealed by the embedded characteristics of the organizations they led to transformation. They bring the right people into the organization to help develop and sustain the vision. They keep the organization focused on what it is best at, passionate about, and economically successful in doing. They understand and act on their current reality while sustaining hope that they will prevail in the end. They create a culture of self-discipline and rigor that enables them to make key decisions that will accelerate rather than create their momentum.

The Baldrige National Quality Program's Criteria for Performance Excellence also provides an excellent model for effective leadership practices. Three of the categories (leadership, strategic planning, and customer and market focus) form the "leadership triad" of the Baldrige framework. These categories guide how senior leaders set organizational direction and see future opportunities for the organization. The categories of workforce focus, process management, and results form the "results triad." This triad represents the way that the organization's work is accomplished to achieve performance results. The category of measurement, analysis, and knowledge management gives the organization a fact-based, knowledge-driven, continuous improvement foundation for the performance management system. The leadership category assesses how senior leaders guide the organization through vision and values, focus on results, workforce communication and engagement, effective governance, leadership performance evaluation, and legal and ethical behavior. The program assesses both the effectiveness of the approaches used and the performance results, with emphasis on alignment and integration (NIST 2007).

The evolving neuroscience of leadership provides meaningful insights into how the brain functions in relation to developing leadership practices and creating organizational change. For instance, studies have revealed that people may resist organizational change imposed on them because it actually "provokes sensations of physiological discomfort" (Rock and Schwartz 2006) in the brain that may push people to act impulsively and emotionally. These breakthroughs in cognitive science have also revealed flaws in many of the common management practices designed to affect personal and organizational behavior. For instance, they have found that incentives and threats seldom create lasting change in core behaviors. Likewise, rapport and trust seldom reach the level of sophistication and consistency to reliably produce real "buy-in" to organizational change. On the other hand, focusing attention on something and practicing it continually can reshape the way the brain is "wired" and create lasting changes in thinking and behavior. These neuroscience studies have found that individually generated insights supported by an "attention model" (process used to repeat the insight) can dramatically change expectations and attitudes and lead to a "long-lasting change in our personal

identity" (Rock and Schwartz 2006). This understanding of neuroscience is supported by research into learning and education practices (Jensen 2005).

Leadership in the Evolution of Long Term Care

The challenges of a rapidly changing health care marketplace make it essential for long term care (LTC) organizations to be proactive in developing effective leadership practices while continuing to improve the practice of management. The nature of the LTC field has changed over the years, and the expectations placed upon administration have evolved along with the field.
The pressures were different in the 60s when the industry was growing rapidly. Regulations were minimal, demand was pent-up, and the expansion of Medicaid to cover LTC enabled those on welfare to access long term care services. Both proprietary and faith based (*e.g.,* church affiliated) organizations were helping develop and grow the facility and service base of the traditional nursing home operation. The requirements of leaders in these early days were essentially focused on motivating groups of people or agencies to finance or sponsor a new facility. The charismatic abilities of leaders were paramount to help inspire and organize people to come together to meet this need. While the emergence of the "charismatic" abilities of leaders was necessary in this era, the multi-faceted demands placed on today's leaders were not as apparent.

In the 70s and 80s the industry began to see the need for an efficient and organized approach to respond to the growth in complexity of financing and regulatory systems. Financial results were emphasized as changes in Medicaid reimbursement and Certificate of Need laws limited competition and gave focus to efficiency through larger homes and acquisitions. Publicly traded multi-facility groups grew rapidly through acquisitions. The short-term "bottom line" focus, absence of standards, lack of consequences for poor performance, and the lack of competition often resulted in poor quality and the promulgation of standards through laws and regulations. The ability to manage well and maintain an organized approach to delivering care and services was the trademark of a successful organization and administration. This time in the industry was often referred to as the "business era." The culture of management was prevalent in many organizations, and the corporate chains began to invest time and resources in systems that enhanced efficiency and control.

Events beginning in the 90s and extending to the present signal the need for a change in the approach to leadership. Changes in consumer preferences, growing quality expectations, human resource limitations, stressed finances, and competitive marketplaces have raised the bar for the profession of health and aging services administration. The margin for error in maintaining optimal operations has become slimmer, and boards and owners of health care organizations demand effective management. Furthermore, change in the field is constant and leadership is now required to continuously look for ways to maintain or bolster organizational creativity and innovation while at the same time making sure that the basics of clinical care and other essential practices are achieved. Trends today include nursing home transformation, "rightsizing," and expanding the array of service options available to baby boomers and their parents. Proficiency in both management and leadership are required for organizations to survive and thrive.

The Management Focus of Long Term Care Administration

Over the past 30 years, researchers have given a great deal of attention to identifying the differences between leaders and managers. In the reality of long term care administration, those differences are often clouded by the hectic, unrelenting pace of work; frequent, unplanned interactions with others; many reactive activities that are brief and unconnected; and varied work content that covers everything from building maintenance to clinical performance. What the health care manager may have proactively planned to do is seldom accomplished in the normal course of a workday. Most days bring more problems than a manager can handle at one time and only a few of the issues will get immediate attention. Crisis management becomes the accepted approach where decision processes are "characterized more by confusion, disorder, and emotionality than by rationality" (Yukl 2006, p.26). In this reactive environment, managers tend to focus on the most urgent issues even when they may not be the most important. Under pressure, they frequently make decisions based on assumptions rather than fact. Administrators should reconcile both the demands and constraints of their position when making difficult choices between what often seems to be two "rights" rather than "right and wrong." Sometimes the constraints include "political" factors such as the approval of others or the justification of resources. Even when they rationally know that these should be priorities, it is difficult for LTC managers in this "crisis management culture" to find long periods of uninterrupted time to dedicate to leadership processes such as visionary planning, team building, searching for best practices, and developing subordinates. Instead, the administrator is often recognized, even praised, for his/her ability to deal with the crisis rather than prevent it.

According to a model developed by Haimann (1989), administration consists of planning (long and short range); organizing (grouping of people and activities); directing (getting work done through others); controlling (measuring performance and outcomes against plans); and coordinating (optimizing the efficient use of time and resources). While functions of leadership are implied in this model (*e.g.*, long-range planning, directing) it primarily defines the administrator as a manager. Such a model still has applicability, but it is important to begin recognizing the need to develop the administrator's effectiveness as a leader as well as a manager.

The perception of the administrator as being primarily a manager is exemplified in the formal definitions found in statutory and/or licensure requirements for nursing home administrators as well as in the accreditation and certification standards in education and industry. Wisconsin statutes state that the "Practice of nursing home administration means the planning, organizing, directing and control of the operation of a nursing home" (Wisconsin Statue Chap. 456, 1995). Further, it outlines that a licensed administrator shall supervise a nursing facility. Supervision shall include, but not be limited to, taking all reasonable steps to provide qualified personnel to assure the health, safety and rights of the residents. Minnesota rules emphasize the administrative licensee shall be responsible for the facility's management, control and operation (Minnesota Rule 4655.1200, 1996). Both of these examples have an emphasis on management, which is the norm in state licensing codes.

The National Association of Boards of Examiners of Long Term Care Administrators (NAB) identifies the domains of practice that define the knowledge and skills expected of new nursing home administrators and assisted living facilities (Table 1). While recent versions have begun to incorporate leadership and quality questions, the emphasis remains primarily on management and technical

functions. While there is some similarity in the descriptions of the subject areas, they clearly fail to recognize that these two domains should be based on a common core of knowledge with some variation to acknowledge the different levels of care and regulatory requirements. Indeed, it may be possible to create a core exam for everyone entering the field of health care administration with supplemental exams for specific services. Creating this kind of alignment in future changes will promote the development of effective management and leadership practices in a broad spectrum of long term care services.

Table 1: Subject Matter Areas for Licensing Examination (with % of questions applicable)

Nursing Home Administrator	Residential Care/ Assisted Living Administrator
1. Resident Care and Quality of Life (35%)	1. Resident Care Management (30%)
2. Human Resources (15%)	2. Human Resource Management (18%)
3. Finance (14%)	5. Business/Financial Management (18%)
4. Physical Environment and Atmosphere (13%)	4. Physical Environment Management (13%)
5. Leadership and Management (23%)	3. Organizational Management (21%)

Source: NAB Information for Candidates, 2006. The subject matter for residential care has been rearranged to align the categories.

ACHCA could serve as a valued partner for NAB in the current and future dialogue and policy discussions about expanding the subject matter to embrace the greater variety of aging services that are available now and developing in the future. Technological advances, diversity issues, and marketing expertise are becoming more important. Even so, the basics of managing complex systems to support the well-being and the happiness of residents must remain a key focus at the entry level.

The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) has recently released a draft of their revisions to the leadership chapter of the 2008 *Accreditation Standards for Long Term Care Facilities* (Joint Commission 2007). The chapter has four sections: Leadership Structure, Leadership Relationships, Organization Culture and System Performance Expectations, and Operations. The premise is that leaders help shape the culture of an organization and the culture affects the organization's various systems. The leadership standards appear to focus on a checklist of important managerial tasks and practices, but they do not align fully with key leadership practices.

The description of the administrator's role by the Association of University Programs in Health Administration (AUPHA) is an exception to this management emphasis. AUPHA states, in part, "The administrator must have a firm commitment to a philosophy of care and service to the patient/resident population. His/Her primary professional role is as a shaper and designer of an institutional or service environment, the ultimate purpose of which is quality patient care" (AUPHA 2000).

Unfortunately, many long term care administrators view quality as the management of satisfactory levels of clinical outcomes and regulatory compliance. In his book, *Juran on Leadership for Quality*, Joseph Juran (1989) uses "Big Q" and "little q" to describe the difference in perspectives on quality. "Little q" thinking is narrowly focused on specific outcomes or tasks such as clinical measures and survey deficiencies. "Big Q" requires visionary thinking to develop systems that align all functions of the organization to contribute to performance excellence and customer satisfaction (a leadership

process). Visionary thinking does not replace the need for knowledge of geriatric principles and practices, or the knowledge of what constitutes excellent care and services, or the ability to discern reality from expectations. Rather, visionary thinking connects the best care standards to the resident's expectations, productivity to satisfied employees, and person-centered culture change to the rigor of managing effective processes and systems.

LTC Leadership Studies and Perspectives

While a great deal of research has been done to describe various approaches to leadership, little work has been done in long term care to correlate effective leadership with desired outcomes. One study looked at the correlation between leadership and nursing facility survey citations. This study found that administrators with a gerontological nursing background had significantly fewer citations. The limitations of this study are that it looked only at administrator demographic information and used simple correlation tests (Singh, Amidon, Shi, and Samuels 1996). Dimant's study (1991) found that improvements were driven primarily by effective internal management processes that involved residents and families, developed a team approach to care, and improved the motivation and satisfaction of nursing assistants through changes in human resource management and development. This study found that data turned into information was an important building block for measuring performance, but it was not the driver of improvements.

The Pioneer Network provides a review of literature related to their mission and values at their website (www.pioneernetwork.net/research/OrgStructure.php). This review focuses on organizational structure and turnover impact, and offers little to address the impact of or need for effective leadership. A model by Grant and Norton (2003) suggests that leadership is one of the contributing factors in the stages of organizational evolution towards a more resident centered environment. Another resident centered model, the Eden Alternative, discusses that there is no substitute for wise leadership as the lifeblood of any struggle against loneliness, boredom, and helplessness that plague residents in many long term care settings. A popular resource for organizations involved in culture change is Gilster's leadership model focusing on seven components derived from a literature review and case study approach in an Alzheimer's Center (2005). The staff and resident empowerment principles embedded in the person-centered culture change movement should be one of the elements addressed in any leadership program (Action Pact 2007).

In a National Science Foundation study, Potthof (1998) used the framework of the Baldrige National Quality Award Program to customize quality practices to the senior service setting. Olson (2000) used the study to explore how leadership practices impacted the participating nursing homes. The leadership practices were developed using a thorough review of the leadership and quality literature and expert interviews, focus groups, and pilot testing to refine the scale. Using employee satisfaction as the dependent variable, Olson found that three fundamental leadership practices were correlated to higher facility performance (2000):

1) Focused visionary is the practice of setting a clear future for the organization and is connected to the planning function.

2) Supporting change is the practice of encouraging growth and innovation at both an organizational and individual level, and has a strong influence on the operations of an organization, and

3) Effective communication practices, the creation of a climate of sharing information, had the only direct relationship with employee satisfaction. Being an effective communicator is critical to the success of an administrator.

A visible presence of leaders was important to these organizations, but not empirically significant in the model. Lastly, understanding quality was not used in the final revised model of leadership influence.

Table 2 shows comparisons and levels of agreement between the LTC leadership practices identified in the Olson study and the broader studies identified earlier. It is clear from the literature that visionary and change skills are universal needs of effective leaders.

TABLE 2: Leadership Practice Models

General Leadership (LPI by Kouzes & Posner)	Transformational Leadership (MQL by Bass & Avolio)	Quality LTC Leadership (Olson)
Challenging the Process	Intellectual Stimulation	Understanding the Quality
Inspiring a Shared Vision	Charisma	Focused Visionary
Enabling Others to Act	Individualized Consideration	Supporting Change
Modeling the Way		Visible Presence
Encouraging the Heart	Inspirational Leadership	Effective Communication

Olson, Dana, and Ojibway (2005) examined the applications and interviewed the leaders of the nine 2004 recipients of the American Health Care Association's criteria-based Step 2 and Step 3 quality awards. The extensive interviews focused on the leadership practices and culture changes that the administrators led during the transition to high performance results. Seven common themes emerged: (1) they choose to act on a vision for what can be; (2) leaders and managers lead by example; (3) customer expectations define their quality standard; (4) the employees are "engaged"; (5) an effective quality management system sustains their focus on performance; (6) they developed a structure to fulfill their quality journey; and (7) they are committed to continuous learning and growth. These results are also supported by the broader studies on leadership practices.

MyInnerView (Grant, Gulsvig, and Call 2006) used its extensive data base of customer (resident and family) and employee satisfaction surveys to examine the attributes of facilities with high resident and family satisfaction ratings. They found that leadership and organizational culture are the key drivers of excellence. They used employee satisfaction surveys to determine the leadership practices of the "best in class": (1) understand your customers, (2) keep score, (3) review results, (4) align processes and systems, (5) engage employees, (6) focus on strategic priorities, and (7) develop leaders. These practices are similar to the themes in the Olson, Dana, Ojibway study.

Numerous articles about leadership and leadership practices have been published in industry related magazines and journals. Many of these reflect personal observations or provide limited evidence to support their conclusions. This does not mean that they are not valid. Indeed, much of what is written on this subject is similar to the conclusions found in the limited research that

has been done. Colloquiums sponsored by the Academy of Health have taken on broader policy issues such as the infusion of technology, which probably should be included in basic administrative competence training.

The person-centered culture change assessment released in 2006 called "Artifacts of Change" reflects the developing interest of the Center for Medicaid/Medicare Services (CMS) in changing organizational culture. Unfortunately the literature is rather scant when it comes to presenting the role of leadership in making these changes effectively. The good news is that the principles of adopting a resident-centered care philosophy is nothing new for the best of quality leadership, which has at its core a customer-driven focus. However, changing the culture of this reactive, regulatory-driven profession may take some extra effort and perseverance. Both CMS and the Quality Improvement Organizations (QIOs) have associated the high turnover of administrators and directors of nursing services and the failure to effectively utilize medical directors with the slow development of a quality service environment in long term care facilities. These problems reflect the need for more effective leadership to allocate the necessary time and energy commitment to achieve change (Kotter and Cohen 2002).

While limited, research provides strong evidence that effective leadership and management practices have a significant influence on organizational performance in long term care settings. The potential for developing additional empirical studies in these areas is growing as LTC organizations confront the fact that "business as usual" is no longer acceptable.

The Uniqueness and Complexity of Long Term Care Leadership

A plethora of different types of senior services create potentially differing demands and opportunities for leadership and management. Service settings range from the more formal to informal types of services. Services of the traditional skilled nursing facility have increasingly become medically complex and specialized (American Health Care Association 2001). Assisted living has emerged as an alternative to the nursing home, offering care and services in a less institutional setting with an emphasis on greater privacy and flexibility. Senior housing services continue to serve a less frail population, but many are making health and support services more readily available to their tenants. Community-based services, including home care, are often the preferred choice of frail older adults who desire to stay in their own homes.

Without credible research, one can only conjecture what might be the impact on leadership of different long term care settings. Educational programs for administrators are largely driven by licensure requirements, which have historically emphasized the differences rather than similarities across settings. Practical observations and some limited research of the senior service field reveal some of the unique challenges that effective leaders are able to address.

- Nursing facility administrators and management staff should be able to proactively understand, plan, and execute person-centered change. Administrators should learn to overcome the barriers that drive them to evaluate their effectiveness through a limited focus on regulatory compliance and personal control.

- Assisted living administrators and management staff should balance their focus on marketing and customer service with the need to develop and institutionalize effective quality management systems that consistently meet and exceed the expectations of the customers. This is essential to minimize the need for more and more regulatory requirements. The current pattern reflects what happened to nursing homes more than 30 years ago because of ineffective leadership.
- Both senior housing and community-based service administrators should create and communicate a shared vision that is supported by effective systems and training. These are essential to effectively lead a complexity of services with more empowered staff in a community rather than single building.

LTC leadership is affected by the leadership history, the established organizational culture, customer differences, and ultimately the distinct goals and market forces for the individual setting. Some of the more universal nuances of LTC that affect leadership approaches include:

- The importance of creating an organizational culture that portrays a sense of caring.
- The need to personally model a compassionate perspective for the needs of others.
- The high touch, labor intensive nature of providing long term care and services.
- The highly "regulatory-driven" and reactive environment.
- The predominately non-professional labor force with high employee turnover rates.
- The fairly "flat" organizational structure that makes it desired and beneficial for management to build relationships with as many staff as possible (Leader-Member Exchange Theory, Yukl 2006, ch. 5).
- The frequent changes in administrator, director of nursing services, and other key positions.
- The governing boards, owners, and corporate level managers often lack an understanding or sensitivity to the complexity of daily operations and the changing environment.

Greenleaf's concept of servant leadership (Spears 1995) addresses many of the nuances of long term care. The servant leadership model emphasizes the practices of vision (conceptualization, foresight, building community); change (persuasion, commitment to the growth of people); communication (listening); visible presence (empathy, awareness, healing) and technical (stewardship). Block (1996) supports similar views in proposing "stewardship" as an alternative to leadership. Block contends that positive culture change is impaired when leadership becomes "the act of a few, in charge, defining the future, controlling the path, and knowing what is best for others" (1996, p. 22). Stewardship is operating in service rather than control of others for the betterment of the entire organization. Block calls for everyone's participation in defining the organization's purpose and culture with an equitable distribution of rewards. These elements could be incorporated into the spirit of any program.

Effective LTC managers and leaders develop and align their quality management system with doing the right thing rather than with some extrinsic requirement or incentive. They have a passion for providing superior customer value that takes them well beyond the need to comply with regulations or their own internal standards. They continuously learn and develop effective leadership traits and

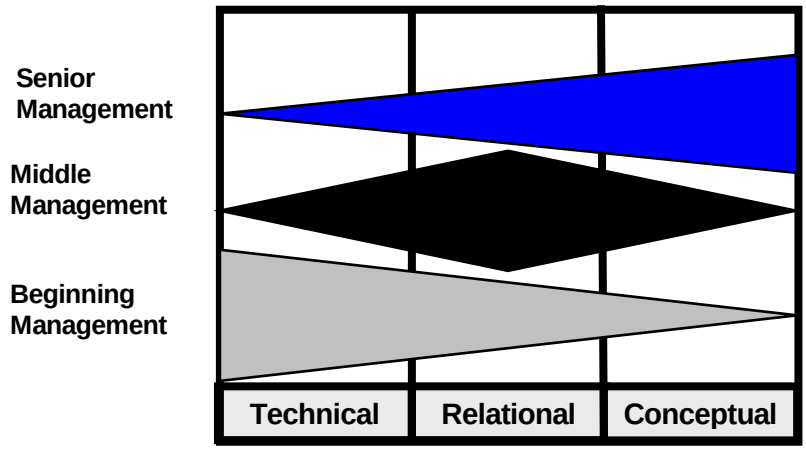
competencies. They communicate a quality-focused mission and influence positive change. They contribute to a culture of empowerment, innovation, agility, and results. Effective LTC leaders are never satisfied with just good quality (Olson, Dana, Ojibway 2006).

The health and aging services field needs to identify the leadership and management skills that are common across all settings. For instance, the need for the organization to focus on understanding and meeting the needs and expectations of its customers should transcend settings. On the other hand, setting differences should influence the identification of unique leadership practices and requirements.

Developing Effective LTC Leaders

LTC providers should allocate resources to develop a systematic and objective leadership development process. The best way to start is by identifying what skills are most needed by managers. As shown in Figure 2 (Dana 2005), the importance of three basic types of skills will shift as a manager assumes greater responsibilities. Technical skills are important for the beginning manager, but less important for the senior manager. The need for effective relational skills (human resource and communication) becomes more important as the manager has an increased span of control, negotiates for resources, and attempts to influence results. Conceptual skills are essential for senior managers. Conceptual skills include good judgment, foresight, intuition, creativity, effective planning, problem solving, and coordination of the various organizational functions (Yukl 2006, p. 198-199).

Figure 2: Shift in Importance of Management Skills



This developmental shift in management skills is a very important concept for LTC providers to understand as they look at the development of department, unit, and shift supervisors. Most long term care facilities promote people to management from the ranks. They are often promoted because they are loyal, perform their job well, and never cause any problems. As a result, many managers are ineffective because they have never received management or leadership training and cope by simply imitating what someone else did before them (Dana 2005). On an academic level, this developmental approach is already being incorporated into the applied field coursework of some university-based educational programs (Olson, Decker, Johs-Artisensi 2006).

Basic management skills should be developed if not already present. Training for long term care managers and supervisors should include work design, conflict resolution, performance evaluation, communication styles, problem-solving methodologies, and coaching. Leaders and managers should

also learn to use idea generating tools, consensus building tools, effective meeting techniques, and quality improvement tools (Dana 2005).

While everyone may not be in a position to lead an organization, department, or work unit, every willing member of the organization should have the opportunity to prepare to lead in a particular circumstance or at a particular time. Some people have no idea that they can lead until they learn how and have the opportunity. Many individuals can develop the traits of effective leadership by: (1) developing new habits to guide their behavior; (2) learning the principles, skills, and techniques related to leadership; and (3) translating new knowledge into meaningful activities and actions.

Relevant LTC Leadership Training Programs

The historical role of ACHCA as the preeminent professional association focused on leadership development has been diminished by increasing initiatives by trade and other professional associations. The American Health Care Association (AHCA) and the American Association of Homes and Services for the Aged (AAHSA) have each developed leadership programs for their members. These efforts are heavily dependent on utilizing national conference tracks, exploring new leadership literature, customized training (AHCA), best practice site visits (AAHSA) and some elements of distance networking within cohort models. AHCA provides a limited interactive leadership program to develop volunteer leaders for the association from its membership. This program mixes interactive training, assessments, reading and discussion, and peer-to-peer accountability. The American Medical Directors Association (AMDA), the National Association of Directors of Nursing Administration/Long Term Care (NADONA), the Assisted Living Federation of America (ALFA), and the National Center for Assisted Living (NCAL) have also initiated various levels of leadership programs for their members. The American College of Healthcare Executives (ACHE) provides leadership programs and certifications that are more traditionally focused on acute care facility executives.

State affiliates for these associations are also beginning to build leadership and quality management into their education offerings. The California Health Facilities Association (CHFA) has developed an interesting model for a 2 year, cohort-based leadership academy. The program begins with an intensive retreat facilitated by professional leadership consultants. Participants are required to do independent study for six hours a month, network with other participants, conduct annual customer and employee satisfaction surveys, set performance improvement goals for their facilities, and complete an individual improvement project under the guidance of a mentor. Another example is the training initiative by New York's Long Term Care Leadership Institute sponsored by the Foundation for Quality Care (FQC). FQC recently received nearly $600,000 from the New York Departments of Health and Labor to support 17 leadership training programs for 300 LTC nurse leaders and 40 nursing home administrators from 43 counties. The training includes modules called First Line Manager Course, Nurse Educator Course, Director of Nursing Course, and an Administrator Leadership Course offering basic management and technical skills. For the most part, state affiliates focus much more attention on their members' current issues. Among the various LTC associations, ACHCA is uniquely able to focus on LTC leadership development because of its position as the professional association for LTC administrators.

Providers and educational institutions have traditionally been reactive rather than proactive in leadership development. Some multi-facility providers have developed their own educational programs for administrators and supervisors in response to needs they have identified. More often, they depend on the training required for licensure and the continuing education programs provided by trade and professional associations. Without extensive participation and partnerships with providers or associations, universities seldom invest significantly in keeping their LTC administration educational programs in step with changing needs and current trends. Consequently, the educational field is very fragile with only a handful of viable, healthy programs. A few graduate programs (*e.g.,* Erickson and George Washington) are nationally recognized. AAHSA has recently attempted to align itself with these and other educational programs across the country. NAB is the association with the most focused effort in making sure that the undergraduate university programs are available with five recognized accredited programs at Ohio University, Saint Joseph's College, Southern Adventist University, University of Scranton, and the University of Wisconsin-Eau Claire listed on their website as available for networking purposes. Only recently has AUPHA focused more effort in accrediting programs with an emphasis in long term care.

Private consulting companies are venturing into this area. MyInnerView recently formed a partnership with Focus & Execute (www.focusandexecute.com) to create the Center for Applied Leadership which offers web-based tools and consulting services. Executive Learning, Inc. (www.elinc.com) has developed user-friendly training handbooks and a series of video training materials related to team meeting skills, quality improvement tools, and customer service processes for health care providers. LTC 100 (www.LTC100.com) is a national educational conference for the senior leaders of LTC organizations that focuses on leadership issues. Many of these resources focus on achieving outcomes through awareness and measurement. ACHCA may find opportunities to partner with some of these organizations in ways that benefit the development of the ACHCA model. The number of web-based, distance learning companies that offer long term care training programs is growing rapidly, and some of them are developing content in the leadership area.

On the horizon are some other initiatives focused on individuals at an early stage of their professional development: (1) the development of a Health and Aging Services Administration assessment tool endorsed by ACHCA to be used within university settings, and (2) a planned Young Leadership Summit in the summer of 2007 to solicit the views directly from individuals early in their careers about what they want from employers in health and aging service organizations (Center for Health and Aging Services Excellence, UW- Eau Claire, 2006/07). These are examples of the needed investment in leadership recruitment and retention programs, and also relate to the leadership responsibility of finding and developing future talent.

The importance and value of licensure in education and training is debated across the profession with the nursing home administrator licensure requirements as the model for discussion. One strength of this model is that it identifies the baseline knowledge needed by administrators beginning their careers. Many advocate that most leaders develop sound management skills early

in their careers as they are "cutting their teeth" and advancing. This premise is based on the fact that many entry level roles in this field require a strong set of management skills to survive in the operation-oriented jobs. An important weakness of this licensure model is that those who create, evaluate, and revise the knowledge and skills base are hard pressed to keep up with the needs of administrators in a rapidly changing industry, and are still less able to anticipate the needs of tomorrow. This problem is exacerbated when the existing licensed professionals become more interested in preserving their status than they are with meeting the dynamic needs of a changing field and profession. Sometimes unknowingly, they set professional standards and rules that bureaucratically discourage entry to those coming from other professions and those who have limited access to the educational programs required. NAB is to be commended for its recent efforts to move forward a national reciprocity agreement. Even so, 50 states have different educational and licensing standards. Some states do recognize ACHCA certification in determining an applicant's eligibility for reciprocity, endorsement, or some other reduction in requirements for licensure. ACHCA should be proactive in advocating for common sense enhancements for NAB (the occupational licensing agency) and its state affiliates.

The two educational models that exist today are the provider-driven administrator-in-training (AIT) programs and the more formal university-based programs. Both of these models have their own set of strengths. The advantage of AIT programs is that they are usually very current and cover a solid operational battery of skills deemed necessary by the respective corporations. The disadvantage of the AIT programs is that the corporations are often tempted to use the AIT to fill company vacancies before the person has actually completed the full program. University programs have a broader and fuller educational experience to complement their practical internship requirements. They do suffer from the challenges of keeping up with changing industry needs and trends. Many AIT programs comply with a state licensure requirement by having the AIT assist with daily activities while shadowing the preceptor. They often lack a disciplined approach that actually shapes and assesses the learning process. The field experience requirement also creates a difficult financial burden for the candidate. In the future, blending the strengths of both of these worlds could entail the creation of solid university and provider relationships. This partnership model is already beginning to surface across the country. Additionally, some programs are experimenting with the incorporation of adult learning approaches in the educational design and assessment methods of their field experience. The influence of the preceptor's or mentor's abilities and skills on the learning environment and the student's successful learning experience cannot be overemphasized.

While creating alternative administrator training models is an educator's challenge, new models need to be supported by licensure rules to assure access for potential candidates who cannot easily utilize traditionally structured education programs. This is especially true for persons embarking on a second or third career who require flexibility to complete an educational program. Regardless of any debate, the goal of ensuring that well-trained, competent people are leading organizations that care for seniors is admirable. Enhanced professional leadership certification has been asserted to have some positive correlation with overall care (Castle and Fogle 1999).

Studies show that a long term care administrator's years of practice are more likely than level of education to affect his/her facility's compliance with regulatory standards. A study published in 1992 found that years of experience in long term care administration have a direct effect on the perception of both performance and preparedness while level of education does not directly affect job preparedness (Al-Assaf et al 1992). Another preliminary study found no significant correlation between the administrator's level of education and the number of deficiencies cited in their nursing home, but concluded that controls needed to be set for resident and organizational characteristics to make the study meaningful. Another study in Alabama found no measurable relationship between repeat deficiencies and the administrator's years of formal education, years licensed, and hours of continuing education (Loescher, 1994). Recommended changes in educational content may influence some of the results of these studies. Likewise, some new approaches to the educational process, for instance the principles of change in the neuroscience of leadership, may also shed some understanding on these findings. Educational and training programs designed to simply transfer knowledge to a passive receiver create no lasting change on their own. Experience helps bring together the process of self-discovery (sometimes through mistakes) and repeated application, both of which create change in concepts and practices. Bridging the gap of knowledge and experience in the delivery of training and education holds great promise.

When applicable, the licensure requirements for the state and the content of the federal and state exams are the primary focus for the knowledge that must be gained by a potential LTC administrator. The continuing education requirements are usually met by completing a certain number of credits with little or no requirements regarding content. Some limited approaches to directed educational attention currently include ACHCA's Ideal Administrator and state licensing boards' authority to require content-specific education for remedial purposes for disciplined administrators. Regardless of its value, the impact of the content-focused education on the actual practices of the manager may be more effective when those practices are reinforced by coaching and accountability.

The overall health and aging services field wrestles with multiple type settings (*e.g.*, skilled nursing facility, assisted living, senior housing, home care), their respective knowledge requirements, and the necessity for focused educational programs such as certification. LTC leaders should first be trained in a core set of leadership practices and management skills that apply to all disciplines. Service specific training (*e.g.*, regulations, client needs) would optimally complement the basic units of learning in the development of any program. This broader approach to education would supply the field with more leaders and managers who have greater opportunities to move throughout the system with confidence and competence. Putting people together in educational programs with interests in slightly different disciplines would potentially provide a rich model benefiting from diverse perspectives. All of these points lead us to suggest a non-specific setting for a health and aging services leadership program.

Effective LTC leadership and management practices require significantly more than building knowledge to perform business tasks and meet regulatory requirements. Instead, it is about

achieving superior results by knowing what should be going on in the facility, knowing and communicating relevant and important information, asking the right questions, translating knowledge into meaningful actions, making decision and problem solving processes transferable throughout the organization, creating personal and team accountability for measurable process and organizational results, and developing a culture of sound, knowledge-based practice combined with empowerment and innovation that engages people to continuously learn and use their talents to benefit those whom they serve. How do you do that in a dynamic, complex, and demanding environment? It requires tremendous focus, discipline, and intrinsic motivation based in values that are linked to the success of others rather than on self-achievement.

The Need for Change – The Need for Effective Leaders and Managers

The need for the entire long term care profession to meet high levels of performance excellence is unchallenged. Consumers, employees, owners, providers of supporting services, and government representatives want more than "satisfactory" ratings most of the time. These stakeholders want access to care and services that meet and exceed their expectations all of the time. Having an overall average of 83% of the families of nursing home residents rate facilities as "good" or "excellent" seems good compared to what is commonly perceived about nursing homes (AHCA Press Release 2006). However, having the remaining 17% rate facilities as "fair" or "poor" is not acceptable, especially when the variation around the average is considered.

Over the past two decades, various public and provider initiatives on a national scale have been launched to drive quality improvement in long term care. At the request of Congress, the Institute of Medicine published a report in 1986 titled Improving the Quality of Care in Nursing Homes. To address concerns about quality of life as well as care, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) was passed, creating in 1991 the first significant changes in the minimum standards for operation of nursing homes since 1965. In November 2002, the Center for Medicaid and Medicare Services (CMS) launched the Nursing Home Quality Initiative (NHQI). The goals of NHQI were to provide consumers with access to quality measures for nursing homes and to help providers improve the quality of care with the assistance and resources of Quality Improvement Organizations (QIOs) in every state. Quality First is a program launched in 2002 as a collaboration of the long term care trade associations to promote performance excellence through a core set of principles and expected outcomes related to various types of facilities providing health and aging services. In September 2006, a coalition of long term care stakeholders launched a 2-year, outcome-oriented, Advancing Excellence in America's Nursing Homes campaign to reinvigorate efforts to improve quality of care and quality of life in nursing homes. The coalition includes consumers, providers, caregivers, medical and quality improvement experts, and government agencies. The campaign seeks nursing homes to voluntarily participate and strive to achieve at least one of the four clinical goals and one of the four process goals. National improvement targets have been set for each of the 8 goals.

Evidence shows that the OBRA 87 regulatory changes produced some significant improvements in various clinical outcomes, but formal assessments on quality of life are not yet available.

Regulatory problems continue, both with the ability of nursing facilities to meet the minimum requirements and disparities in the way that the agencies are reviewing and citing deficiencies. The NHQI quality measures are based on clinical care outcomes and have produced some incremental improvements. While quick to agree on the concepts of Quality First, the collaborating trade associations found it more difficult to agree on improvement targets. This voluntary effort has turned to the outcomes of the "Advancing Excellence" campaign as its primary way to measure change. The Advancing Excellence campaign has set goals to improve process outcomes as well as clinical outcomes. Other than the regulatory change, all of these efforts are similar to public policy initiatives in their focus on outcomes.

These quality improvement initiatives assume that facilities have effective leaders and managers who can create the internal process changes needed to achieve and sustain the desired external outcomes. When the initiatives produce only minimal results, new and better programs are launched. The NHQI goal of providing QIOs as a facility resource is the only program that, on its limited scale, is actually helping leaders and managers adopt more effective practices.

The slow improvement in quality is not an indictment of long term care administrators and managers. Most LTC leaders have both the heart and desire to achieve high levels of performance. Unfortunately, they often lack the training and support systems that will help them to escape from crisis management, develop a vision for excellence, and create the culture changes and disciplines needed for the vision to be realized. To help fill this gap, ACHCA should create leadership and management training programs that embrace the principles of the neuroscience of leadership as one of the cornerstones for their learning model. The model should focus on gaining knowledge, utilizing processes, and practicing effective behaviors during content-focused and application (case study) stages of learning. The educational programs should use "a solution-focused questioning approach that facilitates self-insight" (Rock and Schwartz). Proven rational thinking processes that can be understood and utilized throughout the organization should support the new leadership approaches. The program should develop and use coaches to support learning and change. An entry level certification program could be built on broad-based management education programs accredited by NAB and endorsed by ACHCA. Additional levels of certification should be added that include independent assessment and demonstration of leadership effectiveness. These innovative approaches will add significant value to the members of ACHCA and to the organizations they serve.

If the long term care profession truly wants to see change, it will need to commit the substantial resources necessary to develop effective leaders and managers in all settings of service delivery. As the primary occupational representative of leaders and managers in this profession, ACHCA is ideally positioned to take the lead in creating and providing innovative training programs, partnerships, and expertise that truly make leaders and managers more effective and their skills more marketable. This process can be greatly enhanced and expedited with the collaboration and financial support of the trade associations, provider organizations, educational institutions, and related professional associations and licensing agencies.

The best way to predict the future of long term care is to have effective leaders create it.

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About the Authors

Bernie Dana is an assistant professor of business at Evangel University (EU) in Springfield, Missouri, where he teaches management and leadership courses in both the undergraduate and graduate programs. He holds a Masters Degree in Quality Management (MQM) from Loyola University – New Orleans. Prior to becoming a full-time educator in 2001, Bernie spent 14 years as Executive Vice President and Director of Administrative Support Services with Vetter Health Services, Inc. (VHS), Omaha, Nebraska. He was responsible for strategic planning, resource development, and Total Quality Management. He had direct oversight for the human resources, marketing, management information systems, and financial support services for their 32 facilities. During Bernie's tenure, four of the VHS facilities were recipients of Nebraska's Edgerton Award, the state quality award modeled after the Baldrige National Quality Award. In addition to VHS, Bernie's 28 years in long term care includes having his own management consulting business, serving as president of a retirement center management company, and serving as corporate controller for a non-profit nursing home group.

Bernie chaired the American Health Care Association's (AHCA) Quality Improvement Committee from 2001-2003. He was presented AHCA's prestigious "Friend of AHCA Quality Award" at the national convention in 2003. AHCA engaged Bernie to develop a definition of LTC quality that was published in the August 2004 issue of *Provider*. He is the author of a book released by AHCA in January 2005 on how to develop a quality management system. The April 2005 *Provider* published his collaborative research with Dr. Douglas Olson from the University of Wisconsin – Eau Claire on the common practices of high performance long term care facilities. He is also the editor of AHCA's *Guide to Facility Performance Measures* released in 2006. In 2007, he was appointed chair of the newly formed Board of Overseers for the AHCA/NCAL Quality Award Program. He frequently presents quality management seminars at state and national conferences.

Dr. Douglas M. Olson is an associate professor in the Health Care Administration program at the University of Wisconsin in Eau Claire. Douglas received his degree in health services administration from UW-Eau Claire, and his MBA from the University of St. Thomas. In 2000, he received his Ph.D. from the University of Minnesota in Health Services Research, Policy and Administration with a dual minor in Management and Aging Studies. Douglas has given numerous national and regional presentations and been published in a variety of publications. He is currently involved in applied research efforts focusing on leadership, organizational roles and best practices in leadership development in the health and aging services field.

As coordinator of the Health Care Administration program at UW-Eau Claire, Douglas has overseen the development of the Center for Health and Aging Services Excellence, which has been instrumental in promoting improvements in health and aging service administration. Before joining the UWEC faculty, he was the community administrator responsible for day-to-day operations at Martin Luther Manor/Meadow Woods, a long-term care campus in Bloomington, Minnesota. He has 15 years of direct experience working and consulting with various types of health care organizations. Douglas also serves as a Senior Advisor for Pathway Health Services, a health and aging services management consulting firm, where he consults in the area of leadership and participates in product and service enhancement.