

EXECUTIVE COACHING IN A HEALTHCARE SETTING: AN EXPLORATION  
OF THE IMPACTS, OUTCOMES, AND CHALLENGES IN A CHANGING,  
COMPLEX ENVIRONMENT

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## ABSTRACT

Complexity is a phenomenon found in nature and science. The study of human social behavior and complexity is becoming more widely understood. Complexity science with the understanding of how individuals interact and adapt within complex systems has been studied across many business sectors. Healthcare has been identified as a complex system, however, the research and the behaviors of leaders have not taken the foothold for progress and change like it has in other business sectors. While many have identified the need for change such as the Institute of Medicine's Quality Chasm Report and the Triple Aim imperative, the amount of disruption needed for effective outcomes to occur, has not been seen in the US healthcare delivery system. This capstone addresses one area of healthcare where promising results have shown impact. The results suggest that emotional intelligence gained through executive coaching with senior leaders helps them gain perspective and understanding of themselves and others to lead the way for change; positive leadership behaviors, in turn affect the broader organization and the landscape of healthcare itself. With that, there is promise that leaders may be able to create the path forward for making the nation and the world a healthier place.

## ACKNOWLEDGEMENTS

It is hard to believe that I am finally at the point of writing this acknowledgement. I have been reminded, through the entire process of attending and completing graduate school that it is never too late to begin again. With the culmination of this capstone writing, I wish to thank the people who have helped me to through the Penn Organizational Dynamics program; I would not be here without the encouragement of many. I am filled with an immense sense of gratitude for those who have supported and challenged me over the last several years.

I would like to first thank my mother, who initially encouraged me to always do my best in whatever endeavor I chose. She was a role model for me as she was someone who showed me from an early age—always reading and curious—what a continuous learner looks like. She encouraged me to succeed, to have the faith to try new things, while always believing in me. Before her passing, she made me promise to her that one day I would fulfill my goal and wish of attending graduate school and becoming a coach. This capstone and the MSOD serves as my tribute to her love and support to complete that accomplishment.

Secondly, my immense love and gratitude goes to my husband Bill; my thanks are hard to express in words. His never-ending, steadfast support with love, laughter and encouragement have kept me going throughout this entire process, even with some personal challenges along the way. Without him, I am not sure I may have made it through.

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## CHAPTER 1

### INTRODUCTION

Healthcare is becoming ever more complex and demanding in its delivery within the United States. It is vital to have safe, efficient and quality care in a healthcare delivery system that maintains and supports the care of patients across a given health sector. Many professional and political calls-to-action and initiatives in recent years have attempted change and improvement in healthcare models (Berwick, Nolan & Whittington, 2008). As a part of healthcare organizational systems, senior leaders are positioned to be key stakeholders to influence and create change in hospitals and health systems and impact how patients receive optimal care with positive outcomes. As such, it is imperative to examine leadership behaviors of those senior leaders who are the key to driving decisions and future changes for the stability and growth of our health systems in the United States.

This Organizational Dynamics capstone explores the narratives of senior healthcare leaders through the lens of their executive coaching experience and explores how senior leaders in a large tertiary healthcare setting experience executive coaching in the context of their organization. The work includes interviews with a broad range of senior leaders within a large, dynamic and complex, multi-site pediatric tertiary healthcare setting.

Given the challenges faced by an ever more shifting and complex health care system, an original question of this capstone thesis was to explore the impact, if any, of the executive coaching experience on the leaders' team and on

the broader organization. Specifically, this work seeks to look at how the executive coaching experience for leaders in a clinical environment contributes to their leadership capabilities, mindset, and leadership behaviors; additionally, it explores how executive coaching impacts leaders' work processes, their communication, their collaboration, and the culture across formal and informal teams.

Healthcare delivery is multi-faceted and filled with complexity. It is a rapidly-changing environment, with technology and electronic health record changes, increases in patient care acuity, external regulatory pressures focused on quality and safety, and financial pressures for reimbursement. The examination of this topic warrants a look at how leadership can impact healthcare delivery systems through the benefit of executive coaching.

Patients are demanding transparency, better outcomes, and better healthcare experiences. I believe it is important to study healthcare leadership because of the current landscape of healthcare delivery which is focused on efficiency and measurable outcomes. Therefore, it is necessary to look at how individual leaders and teams contribute to and are functioning to achieve those efficient outcomes. As part of this, the key components of emotional intelligence (Goleman, 1995) among leaders will be outlined throughout this research.

### Personal Background and History

As a leader and manager of a team in a healthcare surgical setting, I am personally vested in the relevance of this topic. I have been a registered nurse

for almost thirty years in a variety of clinical and nonclinical care delivery settings. I have been both a follower and a leader, and have seen the effects, outcomes, and consequences of both effective and ineffective leadership. In my experience as a leader, I have observed that quality patient care is inconsistent across settings, and believe it begins at the top of an organization; competent leadership in all areas of the organization drive decisions for the front-line staff. When an organization is not being led by leaders making the most prudent decisions, the quality of care can be compromised.

I have found that the need for, and the demand for, excellent organizational leadership is ever-more relevant. This is in the face of the headwinds of both internal and external demands for safety, quality and efficiency in patient care, coupled with regulatory, financial and political constraints. Thus the effect of these stressors ultimately impacts the way we deliver care to individual patients as well as the way leaders navigate the challenges of change both internally and externally. The rate of burnout and stress continues to increase among healthcare providers at all levels; the current state of healthcare is evolving to where patients are becoming smarter consumers, demanding more transparency and a role in decision making.

As I am concluding my studies in the Organizational Dynamics executive coaching and organizational consulting cohort, this topic has specific relevance to me. I am passionate about creating high functioning teams with positive cultures because, unfortunately, in the hospital setting it tends to be more the exception than the norm. Over the course of my career, I have become curious

how clinical and nonclinical leaders are best able to optimally function and lead teams. I am curious how they are able to execute and communicate strategies, goals and initiatives in the context of a rapidly-growing, changing, and complex environment; and throughout the writing of this capstone it has been my goal to provide some answers to these questions.

### Focus and Purpose

I set out to ask how executive coaching impacts leaders in this setting and how coaching impacts individual leadership behavior and decision making. I furthermore questioned how that then impacts a leader's team and the broader organizational goals and strategies. Can direct clinical care be impacted when senior leaders gain the benefits of executive coaching? What makes a good leader; and a good leader in a complex, changing environment? When is the right time for coaching?

The intended audience for this capstone is anyone who is interested in exploring further the results and outcomes of coaching and those interested in leadership effectiveness of healthcare administration.

### Domain of Topic

The domain of this topic covers healthcare, executive coaching, leadership, and leadership development and competencies, including emotional intelligence and systemic and adaptive leadership. It also explores organizational complexity, complexity in healthcare, and silos within organizations. In this capstone I also explore the theories of adaptive leadership and its challenges within formal and informal networks.

## Layout of Capstone

The capstone is laid out in six chapters, each of which builds upon the next. Chapter one provides the background and context for the capstone and my personal background and interest that has led me to want to study this topic.

Chapter two provides the relevant literature reviewed for the structure of the thesis with three main topics: *the current healthcare environment, leadership, and executive coaching*. It is worth mentioning that because these three topics are quite large and comprehensive, the literature search has been distilled to that which is most relevant to my capstone topic. It begins with a look at the current healthcare landscape, including the Institute of Medicine's (2001) statement on the *Quality Chasm* in healthcare and the *Triple Aim Imperative* (Berwick, 2002). I then delve into complex adaptive systems and change theories, and how the literature relates these theories in the healthcare sector. Next, I review leadership models and competencies through a look at Daniel Goleman's work (1995, 1998) on emotional intelligence, and the systemic and transformational leader approach (Beerel, 2009). Because of the complex nature of healthcare systems, I look at complexity and adaptive theories of leadership (Uhl-Bien, 2001, 2016, 2017, 2018) and how leaders navigate through networks (Uhl-Bien Arena, 2017) to lead change, and the skills and challenges necessary to do so. And finally, I examine the literature looking at executive coaching definitions and processes and the levels of learning in coaching (The Executive Coaching Forum, 2017), such as problem solving, developing new leadership capabilities, and developing skills for sustained learning after coaching.

The literature exploration also captures the evaluation of coaching, including the benefits, outcomes, and client perceptions. Taking it a step further, I review the relevant data on executive coaching in healthcare, coaching for leadership development and behavior change, and coaching for organizational development.

Chapter three covers the methodology of the qualitative interviews and the approach I took with senior leaders of the organization. The methodology began with networking within the selected organization for garnering interest in the capstone research. I outline how this work would be of benefit to the organizational key stakeholders. I provide an overview of the timeline of qualitative interviews, how they were set up, outlining the process of garnering participants, and the importance of the confidentiality agreement.

Chapter four shows the data collection process with a look at the interview questions and why I chose them. I review the questions which asked about the coaching relationship and process, the coaching goals, evaluation of oneself on individual impact, team impact, and organizational impact after coaching.

In chapter five I delve into the heart of the data with an interpretation and analysis of the findings and a summary of the data. I identify common coaching goals and coaching themes that emerged from the interviews. I then look at the coaching impact with a review of the tools the coaches used as expressed by the interviewees, and the benefits of coaching as perceived by the coachees. The data analysis includes how behavior change and decision making resulted in greater communication, collaboration, and dealing with conflict. The analysis



illustrates the impact of executive coaching on the leader's immediate team and the larger organizational network. I explore the challenges with coaching that the coachees faced, how they worked at sustaining the changes, their satisfaction with the coaching, and how that influenced their coaching experience. I end with looking at what the data did and did not show which informs the topic of further research.

Chapter six is a summary and conclusion with an integration of the research of executive coaching and the impact to healthcare organizations based on this research. Particularly, I draw a correlation to the impact to care delivery and clinical management and the organizational impact that indirectly impacts clinical care, given the context of the complex and dynamic systems at play that were outlined earlier, along with the reasons for the demand in excellence in leadership because of these factors. Lastly, I outline the limitations of this capstone thesis with a call for potential future research opportunities.

## CHAPTER 2

### LITERATURE REVIEW

When reviewing the academic research literature and stakeholders' professional reviews on the topic of executive coaching within a healthcare setting, it is germane to provide a broad review of the information available on the current complex healthcare landscape. It is also relevant to acknowledge the challenges and barriers leaders face within that setting. As such, the literature review and research process for this capstone is outlined and based upon three major topics which seem to naturally flow and interconnect: 1) The current healthcare environment and landscape, 2) Leadership: models, complexities and competencies, and 3) Executive coaching: definitions, processes and evaluation methods. Topics that cover organizational leadership, healthcare administration, and executive coaching are very dense and broad theoretical and practical topics, and this literature review by no means serves as an exhaustive review of the vast amount of academic literature that exists on these topics. It spans a review of over one hundred articles of theoretical and empirical studies as well as commentary and debate on the state of health care, in the US and abroad.

This review is a highlight and discussion of the relevant data that pertains to the limited scope and structure of the work of this capstone that highlights a tertiary teaching hospital setting. Tertiary care is defined as, "highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities" (Merriam-Webster Dictionary, 2017). Tertiary healthcare

systems can be large, complex environments (Sturmberg & Martin, 2013), organized hierarchically and across many specialized disciplines.

### Healthcare Environment and Landscape

Currently the healthcare industry, similar to many other industries in the United States, is faced with lightning speed technological changes, combined with financial and regulatory pressures that demand a swift pace of competency and leadership for healthcare organizations (HCOs) to keep up with those demands. Leading experts and consultants weighing in on the current turbulent state of healthcare comment on how there exists both demands of internal organizational challenges as well as external regulatory, payer and consumer pressures that are influencing the healthcare system (Davis, B.J, 2019; Lerman & Jameson, 2018). This, in turn, heeds the call for leaders to get ahead of and adapt to the continual changes taking place across multiple levels of the care delivery models and systems.

As healthcare has advanced over the last half century, healthcare markets and organizations have been historically set up with the hospital as the archetype healthcare organizational structure (Begun & Thygesun, 2015). Begun & Thygesun (2015) state that within this system there sometimes lives a dichotomy between the formal organizational structures of the administrative hierarchy and the medical staff organization. This can pose issues of varying allegiances to strategic priorities. Both administrative and medical leadership usually report to the governing board, with the medical staff often having more influence over revenues and quality of care. While still true today, it is worth noting that this

same work references the thoughts of Harris (1977) from over forty years ago, noting that much has changed in the complexity of the healthcare system.

Continuing with this same idea, Anderson & McDaniel (2000) posit steps to improving the healthcare industry from both a clinical and business point of view, and observe there is tremendous tension between the *business* of healthcare and the *practice* of health care, noting that it is “a tension that is tearing at the very fabric of many health care organizations” (p.85). They also suggest that HCOs for many years have been viewed as professional organizations, with historically administrative and management practices proven effective when clinicians are involved. These professional organizations, which were historically dominated by physician groups, now usually contain more than one professional entity within the organization which makes it unique as compared to other organizations. Scott (2003) as noted by Begun & Thygeson (2015) outlines the growing complexity in healthcare delivery and indicates that,

healthcare delivery in the era from 1920 to 1960 as was ‘the least changeable, most highly institutionalized sector’ in US society, with healthcare delivery dominated by the power of physicians (Scott, 2003). (Begun & Thygeson, 2015, p. 5).

Begun & Thygeson also illustrate the work of Glouberman and Mintzberg (2001) who describe hospitals as containing four different entities as a way of organizing that are all necessary, but disconnected with potentially conflicting values: “1) care: nurses and care delivery teams, 2) cure: physicians and other medical professionals, 3) control: administrators, and 4) community: governing board” (p.3).

In addition to being historically physician-driven, healthcare organizations can be driven by individual, siloed decision making and communication, with little to no transparency of quality outcomes to consumers. Weller, Boyd, & Cumin's (2014) work discusses the challenges of the delivery of modern healthcare in multidisciplinary teams. For example, some challenges include teamwork and communication for safe patient care and reduction in unintended harm. Weller's, et al. (2014), work is a meta-synthesis of multiple studies with the research outlining the characteristics of an effective team. The peer-reviewed articles in that work focus on the steps to improve clinical information-sharing between healthcare professionals. It presents a seven-step plan to overcome barriers to team communication and information-sharing among practitioners, but notes that given the complexity of systems, no one solution is sufficient. This claim is also pointed out in the Institute of Medicine's (IOM) *To Err is Human* landmark 2000 report on the status of safety in medicine due to a fragmented, non-integrated model.

The decentralized and fragmented nature of the health care delivery system (some would say "nonsystem") also contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence (Institute of Medicine, 2000, p.3).

As several of these trends have shown improvement and have evolved over time, healthcare systems have worked on standardizing quality and improvement measures, and have shifted to a patient-centered, value-based model. Charmel and Frampton (2008) point out that a focus toward patient-centered care has now been widely embraced by many of the industry's care

providers, policy-makers, regulatory agencies, research bodies, and funders. They are also faced with regulatory compliance requirements, tightening on margins for reimbursement, and more educated consumers who demand patient-centered, value-based care; consumers now require quality, safety and better outcomes at a lower cost. While the demand for care continues to rise due to increases in medical technology and chronic conditions in the population's health, these critical factors have been on the forefront of concern for many practitioners.

#### Triple Aim/ Quality Chasm Healthcare

An assessment of the present status of our healthcare delivery systems and leadership point to several seminal expert reports from the National Academies of Sciences Institute of Medicine (2000, 2001) which changed the tide and impacted the current state of care in the U.S. Taking a look back at the history and looking forward to where the practice of healthcare delivery is today, these reports were the cornerstone for changes in safety and quality measures implemented in health systems across the nation. Beginning in 1996, healthcare leaders met over a period of two years to convene over the state of healthcare and the critical imperatives facing the U.S. Health System. In 1998, the roundtable of experts report identified a focus on patient-centered care as one of six interrelated factors constituting high-quality care (Chassin & Galvin, 1998). In 2000, as previously mentioned, the landmark report *To Err is Human: Building a Safer Health System* (Kohn, Corrigan, & Donaldson, 2000), brought awareness and change to the medical community. However, this was just one piece of the

puzzle to the solution of driving quality outcomes in improved patient experience and health.

The steady shift forward in healthcare improvement can be traced to the 2001 Institute of Medicine report entitled *Crossing the Quality Chasm: A new Health System for the 21st Century*, which came out fifteen months after the *To Err is Human* report. This landmark report began to shape the way care is delivered on the individual level, the hospital level and in the larger community setting. The report outlined not just the disparate gaps seen in the care of patients, but the immense chasm which existed (Newhouse, 2002). Despite the continuous advancements in medical science and technology, this highlighted the need for improvement in six key strategic quality areas.

As medical science and technology have advanced at a rapid pace, however, the health care delivery system has floundered in its ability to provide consistently high-quality care to all Americans. Research on the quality of care reveals a health care system that frequently falls short in its ability to translate knowledge into practice, and to apply new technology safely and appropriately (IOM, 2001, p.3)

The six aims of the report included safety, effectiveness, patient-centered focus, timeliness, efficiency, and equitable care for all. (IOM, 2001). This solidified the patient-centered care approach not only as a way of creating an improved patient experience, but also as a fundamental practice for the provision of high-quality care (Charmel & Frampton, 2008).

To accelerate the path forward, the Institute for Healthcare Improvement, led by Dr. Don Berwick (2008), who also sat on the committee for the Quality Chasm report, created the imperative known as the '*Triple Aim*,' a framework for optimizing health system performance by focusing on the health of a population,

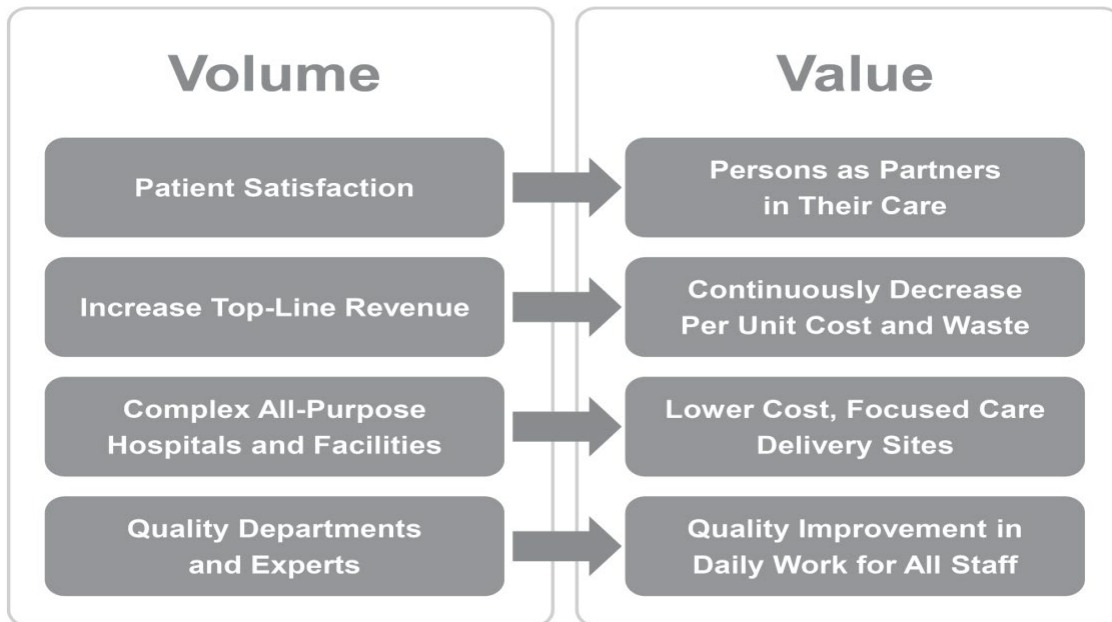
the experience of care for individuals within that population, and the per capita cost of providing that care (Berwick, Nolan, & Whittington, 2008). The triple aim imperative serves as a model and structure to move the needle on improving healthcare. The change of focus to challenge the traditional notions of localized, siloed medical care models to more multifaceted, integrated ways of thinking and problem solving paved the way to understanding health delivery on a more complex, dynamic, nonlinear system level. This, in turn, affects the way executives lead strategies and initiatives in HCOs.

A commentary ten years after *To Err is Human*, Clancy (2009) points out there is still much work to be done to safeguard patients from preventable harm, and calls for the need for a look at the next decade ahead: to form teams to address and learn from safety incidents as well as partnering with patients in an advisory capacity to enact change and create educated consumers. We are now almost twenty years past the initial IOM reports, and while healthcare has shown improvements in key areas as measured in overall safety and quality performance and patient satisfaction, there are still gaps in best practices such as poor quality, high costs, staffing shortages and lack of implementation of efficiency and innovation initiatives (Weberg, 2012). Haeusler (2010) points out that the reality of the complexity of the healthcare environment makes it imperative that thought leaders begin to look at supporting managers, executives and leaders to adapt and challenge old and outdated ways of thinking and leading; from a hierarchical, control-and-command transactional method of leading, to a more transformational, adaptive, visionary style of leadership.



Looking at further applications of the *Triple Aim* for providers and leaders in health care, Bodenheimer & Sinsky (2014) and Shanfelt & Noseworthy, (2017) have taken the *Triple Aim* imperative for health system performance and have suggested there be a quadruple aim; the care of the front line providers giving the care—who are experiencing stress and burnout—which in turn affects the triple aim goals of improved patient satisfaction and outcomes. A white paper by The Institute for Healthcare Improvement (Swensen, Pugh, McMullen, & Kabcenell, 2013) also addresses the impact leaders can have in addressing the intent of moving forward with the *Triple Aim* (Berwick. et al, 2008) to improve and integrate healthcare, and suggests a framework to address high-impact leadership behaviors with new ways of approaching and framing care delivery from one of *volume* to one of *value* (See Figure 1). This paradigm shift may help to set the context for how leaders in a hospital setting can guide the experience of transformation, particularly through the lens of executive coaching as a leadership development tool, for both clinical and nonclinical leaders.

Figure 1. From Volume to Value in Healthcare  
(Swensen, et al, 2015, p. 8)



Throughout this literature review I have discovered a connection between parallel models and frameworks, based on three levels, for how leaders operate internally within a complex healthcare system and for how care is delivered externally, as illustrated in Table 1 (See Table 1). I suggest that by looking at these models in a parallel manner, it helps to see the types of impact leaders can make on three levels.

Table 1. Parallels of Internal and External Systems Frameworks that Impact Healthcare Practice and Leadership

Level	Triple Aim Model of Healthcare Improvement	Complexity Theory Levels in Healthcare Delivery	Leadership in Healthcare IHI Framework	Executive Coaching Organizational Level Impact of Leadership Behavior
1	Individual Care	<i>Micro</i> : Individual patient-physician interaction within an organizational interdependent structure	Driven by Persons and Community	Individual
2	Cost	<i>Meso</i> : Multiple interdependencies with other organizational structures for operations and delivery of services	Organizational Culture	Team
3	Population Health	<i>Macro</i> : Network of organizations within a broader network system that dictate policies and allocation of resources for patient health	Engagement across traditional system boundaries	Organization

1) Berwick, (2008), 2) Khan et al, (2018), 3) Swensen, (2013), 4) Hompe, Capstone 2019

## Healthcare: A Complex System

Medical professionals and teams are faced not only with complexity in the medical care that they provide—as advances in medical knowledge are continually evolving—but are also part of a complex, dynamic and continuously-changing system within which they practice (Arena & Uhl-Bien, 2017; Hanson & Ford, 2010). It is recognized that medicine continues in a simplistic and “reductionist” scientific world view that appears resistant to move to a more complex, dynamic, ‘holistic’ scientific world view (Sturmberg & Martin 2013). However, health systems are often described as messy, unpredictable, and complex systems with a growing acknowledgment and need for practitioners, policy makers and academic scholars to adopt a complexity perspective (Belrhiti, et al 2018). More recently, Khan, Vandermorris, Shepherd, Begun, Lanham, Uhl-Bien, & Berta (2018) posit that complexity thinking in healthcare is increasingly being embraced as a model of understanding for transformation and change. My research of relevant literature suggests that healthcare complexity is not only limited to health systems within the U.S., but modern healthcare systems and organizations across the globe, as evidenced by thought leaders from Canada, the US, and the UK contribute to this literature.

Khan et al, (2018) describe healthcare to include patients, the delivery of health services and programs for acute and chronic conditions, public health, and long term care; a system that becomes complex because the interdependencies are dynamically flexing between states of stability and chaos in the context of hierarchical, *micro*, *meso*, and *macro* levels. These levels are described as

*micro* with individual level interactions, *meso* with interactions among other organizations for operations and resources, and the *macro* level which reaches the broader system level to impact how patient health is managed across these systems for policies, priorities and allocation of resources. These levels of complexity theory mirror the Triple Aim (Berwick, 2008) imperative of individual health (micro), group health (meso), and healthcare delivery cost (macro).

What is complexity? Uhl-Bien & Arena (2017) describe complexity in a workplace context as the following:

Although many are feeling and experiencing complexity in the workplace and in their lives, it is harder for them to describe exactly what it is. Despite the name, the concept of complexity itself is really quite simple: Complexity is about *rich interconnectivity*. Adding the word “rich” to interconnectivity means that when things interact, they change one another in unexpected and irreversible ways. Complexity scholars like to describe this as the distinction between ‘complexity’ and ‘complicated’ (p. 9).

The complexity theory approach stems from a holistic perspective of a system where the whole is greater than the sum of its parts. It has been defined as a phenomenon in healthcare where multiple, diverse, interdependent agents intersect and there exist differences in these agents in values and expertise (Anderson and McDaniel, 2000; Begun & Thygeson, 2015):

Interdependence among multiple diverse agents produces novel outcomes, particularly when agents and forces affecting the system are changing over time. Multiple, diverse, interdependent agents are present in healthcare organizations, most pointedly in the form of hundreds of specialized clinical healthcare professions and the administrators who attempt to help organize them into effective delivery teams and units (Begun & Thygeson, 2015, p. 1).

Complex systems theory has been well studied in the scientific world in the physical sciences, and is now being adapted to the social sciences with well-

known theorists (Uhl-Bien, 2002; Cilliers [Sturmborg, ed.], 2013) leading the way since the late 1980s. Such researchers are moving away from a linear, cause-and-effect Newtonian way of thinking, to looking at individual components as part of the whole, seen within context and interconnected within a system (Sturmborg & Martin, 2013). Traditional reductionist approaches have led to failure and problems, and Cilliers (2013) points out there are limits to the complete human understanding of complex systems; there may always be unknowns. It is this ambiguity and the unknown, that can create tension for medical practitioners and leaders whose comfort level reside in models seeking direct answers to scientific inquiry.

Complex healthcare structures lend themselves to adapt to the competencies and learnings of Complex Adaptive Systems theory (CAS). The military in the 1990s coined the term VUCA as an acronym for volatility, uncertainty, complexity, and ambiguity (Bennett & Lemoine, 2014; Gillespie, 2017; Horney, Pasmore & O'shea, 2010) in order to describe the challenges of the environment in which we live. This term has been applied to healthcare applications characterized by the rapid pace of change with technology coupled with the lack of time and tools to understand the interconnectedness of it all, suggesting that leaders take a vision, action, clarity, and agility approach.

A complex adaptive system is described as a collection of individual agents whose actions are not predictable, and whose actions are interconnected with the ability for one's actions to potentially change another in a nonlinear fashion through relationships (Anderson & McDaniel, 2000; Begun and

Thygeson, 2015; Plesk & Greenhalgh, 2001; Weberg, 2012). In this model, boundaries are loose and not rigid, actions are based on certain internalized rules, and behavior is adapted over time. Systems are embedded within other systems that evolve together. CASs are dynamic networks working in parallel that constantly act and react to other's behavior, and control is dispersed and decentralized; at every moment many decisions are being made that affect the whole (Sturmberg & Martin, 2013). While tension can exist, interactions continually emerge in an unpredictable way. Order emerges as a result of interactions among the individuals or parts of the system; hierarchical control is not needed, the system is self-organizing, similar to events found in nature (Anderson & McDaniel, 2000).

The key tenets of CAS, as outlined by Cilliers (1998) and Sturmberg & Martin (2013) and reinforced in work by Khan, et al (2018), are that there is uncertainty and ambiguity such that the system must adapt and emerge over time in response to change and pressure. CAS's are self-organizing, open systems with complex structures that contain a paradox; complex behavior is possible when the behavior of the system is constrained, and paradoxically a *fully* constrained system does not have capacity for complex behavior (Cilliers, 2013). When complexity causes strain, the natural tendency is to want to restore order which is not always the optimal solution.

Despite this, what we see in our data over and over again is that when faced with complexity, the natural proclivity of people and organizations is to respond with order—to turn to hierarchical approaches of leading and managing change top-down. Snapping back to previously successful, ordered solutions provides a sense of control that satisfies not only the needs of managers who have been trained in traditional leadership

models, but also organizational members who look to leaders to take care of them and make things “right” again. What we see in our research is that when confronted with complexity, organizations most often seek greater accountability. They demand “more from less” and instill better risk mitigation strategies. When these fail, they turn to greater regulatory control. These “order” responses can actually do more harm than good (Uhl-Bien & Arena, 2017, p.10).

Instead, the authors suggest the need for adaptive, agile leadership where organizational behavior allows for emergent and innovative solutions from networks of formal and informal connections. The nascent theory on ‘adaptive space’ in the work of Arena and Uhl-Bien (2017) explains the necessity for the intersection of both operational and entrepreneurial leadership, where the “dynamics of complexity” (p.12) allow for differences of thought to create a mutual desire for change and learning.

A review of literature on complex adaptive theory illustrates that these mental models are seen in health care organizations in the U.S., Canada, Australia, and the UK; and were first introduced in the 1980’s with most recent literature conveying recognition that healthcare leaders and practitioners need to recognize the rich complexity, ambiguity and adaptive needs of complex organizations (Khan, et al, 2018; Belrhiti, et al, 2018). While traditional healthcare improvement as seen in the Institute of Medicine work at the start of the 21st century has suggested that quality and safety be standardized through policies and procedures and sharing of best practices, the recent literature suggests practitioners and leaders explore alternative approaches depending on the level of complexity (Khan, et al., 2018).



## Leadership: Models, Competencies, and Complexities

How does this complexity backdrop influence the leaders, decision makers and those directly and indirectly impacting the care of patients and families? Leadership and the ability to have others follow has been studied for decades; theories have been debated, discussed and challenged and have evolved with the context of the time. There are many thought leaders in this area but simply put, leadership can be broadly defined as the ability to move other people to do or achieve something: “Leadership is a relational activity where individual(s) guide(s) or direct(s) others (followers) to attain an objective or goal” (Beerel, 2009, chapter 3, p.4). Beerel points out that this definition lacks context, time orientation, and the characteristics of the leader. There is a difference between leadership and authority.

Beerel points to several leadership theories from Northouse’s (2005) summative book that include the trait approach, the skills approach, the style approach, and the situational approach from the work of Hersey and Blanchard, and the contingency theory approach. Northouse’s work, Beerel also points out, touches on the psychodynamic qualities of leadership with the need for a leader’s insight on emotional responses for self and followers to affect change. Effective leadership includes understanding and gaining knowledge of the psychodynamics of the leader and of groups. This complements my observation in this capstone that leadership requires understanding of self and other, and that an executive coaching experience may add value and understanding to one’s own leadership competencies and actions.

Historically, leadership in healthcare was a task and action-oriented transactional, control-and-command hierarchical, bureaucratic approach. Transactional leadership involves some form of exchange for work (Beerel, 2009). This type of leadership still exists today, with more and more literature coming out to emphasize the need for the understanding of the application of complexity leadership to co-exist within this setting. Belrhiti, et al, (2018) describe that during the 1960s, leadership expanded from trait and personality leadership, toward theories of understanding leadership styles and behaviors.

Contingency leadership and situational leadership maintain that effective leaders have a preferred style of leading but also adapt their style to the task, the staff capacity and context of the experience. Uhl- Bien & Marion (2001), Beerel (2009), and Belrhiti, Giralt, & Marchal, (2018), all point to the evolving understanding of transformational leadership theory that began in the 1980s; which leads to complexity leadership theory as a broad, holistic view beyond the interpersonal influence of leader attributes and follower emotions, to one on the macro level where relationships are at the center and are seen emerging across many sectors and levels of the system.

Marion & Uhl-Bien (2001) illustrate how at the macro level, the executive leadership's role—or the leadership *of* the organization—is to foster and accelerate the emergence of what is known as “distributed intelligence—a function of social and human capital assets” (p.391). At the micro level, the level below the executive leadership team—or the leadership *in* the organization—

complex leadership is creating the optimal conditions for “productive, unspecified future states to take place” (p.391). Further stated, it is held that,

complex leaders cultivate largely undirected interactions among individuals, ensembles, and sets of ensembles to create uncontrolled futures (Marion & Uhl-Bien, 2001, p.394).

Transformational leadership, as opposed to transactional leadership, changes the lens from the traits of the individual leader to looking at how the leader is in relationship to the follower; how the leader can garner action and outcomes of followers to meet the needs of the larger organization. The four components of transformational leadership as in the work of Bass and Riggio in 2006 (Beerel, 2009) involve influence, inspiration and motivation, intellectual stimulation, and individualized consideration. However, the work of Uhl-Bien and Marion (2001) took this a step further to emphasize that transformational leadership is not solely the work of the leader (micro level) but that the leader creates the optimal environment for connections, interactions and leadership capacities of the group. This moves away from providing answers on the local level, yet allows for interactions to emerge where follower’s behavior produces structure and innovation (Uhl-Bien & Marion, 2002). Arena & Uhl- Bien (2017) in recent work on complexity leadership in healthcare share that:

Complexity is occurring on multiple levels, and across many sectors and contexts is especially felt more strongly in healthcare, where volatile regulatory environments, evolving pay structures, changing patient relationships, and wearable technologies are combining to create tremendous uncertainty with respect to where healthcare will go (p.10).

### Complexity Leadership

Complexity leadership is not about formal roles, but attributed to those who formulate ideas and outcomes as a result of interactions; distributive leadership is defined as being action-based and not role-based, and where leadership is a relational, social process within a group instead of an individual (Begun & Thygeson 2007; Khan, et al, 2018). In other words, it is not top down, but emerges from the bottom up. Complexity leadership involves creating the right conditions for progress, and not providing the answers or too much direction (Marion & Uhl-Bien, 2001).

The call for adaptive, agile leadership in healthcare (Haeusler, 2010; Weberg, 2012) is starting to gain traction in healthcare forums and commentaries by both physicians and nurses. Weberg (2012) suggests that leaders who understand complexity leadership will be able to guide organizations into the future, but there are currently gaps in traditional leadership models. The need for understanding innovation and change through formal and informal networks is imperative. These practitioners recognize that outdated mental models are not effective, and tackling complex realities requires new ways of thinking on collaboration and innovation for practice, research and policy.

#### Adaptive Leadership:

Heifetz (1997, 2017) and colleagues over the last several decades have outlined the challenges leaders face in adopting technical versus adaptive styles of leadership. In technical work (Heifetz 1997; Haeusler, 2010, Thygeson [Sturmberg, ed.], 2013) the challenge is simple or complicated—as opposed to complex— when a leader or expert defines or finds the solution to the problem

and the group follows. The solution does not involve learning or behavior change by those who have the problem. Often this type of leadership is seen in the healthcare setting. With adaptive challenges and change management, leaders frame the question or issue at hand and mobilize others to address the problems. The solution is unknown and is uncovered, requiring learning and behavior change by those experiencing the problem to solve the challenge. This can create conflict and pressure, but those experiencing the problems learn to overcome resistance. This dynamic may involve allowing the organization to feel pressure, allowing emergence of conflict, and may involve giving up personal values and habits to impact organizational learning and change.

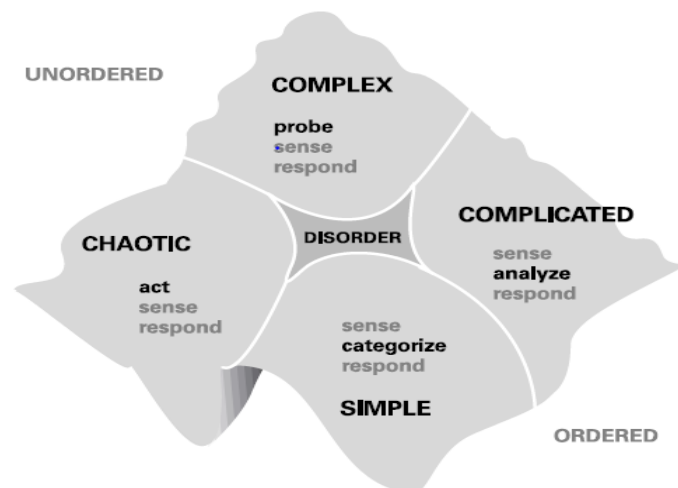
As previously mentioned, Khan, et al ( 2018) point out that many healthcare systems are still governed using traditional models of top-down hierarchical leadership that strive to eliminate chaos and reduce uncertainty. Complexity leaders, on the other hand, thrive in uncertainty and chaos. Uhl-Bien (Khan, et al, 2018) argues that these two types of leadership can co-exist, but makes the point that depending on the objective, different types of leadership may be needed. The research of Khan, et al (2018) summarizes six insights on how complexity thinking fosters understanding in a healthcare setting, and supports the notion of bridging leadership in the adaptive space, by creating the ability to have both entrepreneurial and innovative work operationalized by the traditional leaders to formalize change. This is accomplished through intersections of formal and informal networks and created as the result of pressures on a system (Uhl-Bien & Arena, 2016). They also outline adaptive

principles and practices that they have seen in their studies of adaptive work in thirty complex organizations over a period of eight years. Those practices and principles will not be outlined as part of this literature review.

Key leadership decision making as outlined by the work of Snowden and Boone (2007) in the Cynefin Model (See Figure 2) allows for the understanding of decision making by leaders in complex *known* and *unknown* situations. It outlines a framework for managing in the context of complexity,

which allows executives to see things from new viewpoints, assimilate complex concepts, and address real-world problems and opportunities. (*Cynefin*, pronounced ku-*nev*-in, is a Welsh word that signifies the multiple factors in our environment and our experience that influence us in ways we can never understand.) Using this approach, leaders learn to define the framework with examples from their own organization's history and scenarios of its possible future. This enhances communication and helps executives rapidly understand the context in which they are operating (Snowden & Bone, 2007, p.1-2).

Figure 2. The Cynefin Model (Snowden & Boone, 2007)



Based on a graphic by Debera Johnson

This model serves as a guide to leadership decision making in the context of a problem they may face. There are five options from which to choose and act, the first four—namely simple, complicated, complex, and chaotic—require a leader to diagnose and then act, and the fifth domain occurs when any of the four contexts are unclear. In a complex environment, leaders need to communicate well, not dictate a predetermined solution; leaders need to allow for patterns to emerge to allow for next steps to become evident, through what Snowden and Boone (2007) call “probe, sense, and respond” (p.5). This is different than coming up with a solution to a problem and asking others to act.

### Systemic Leadership

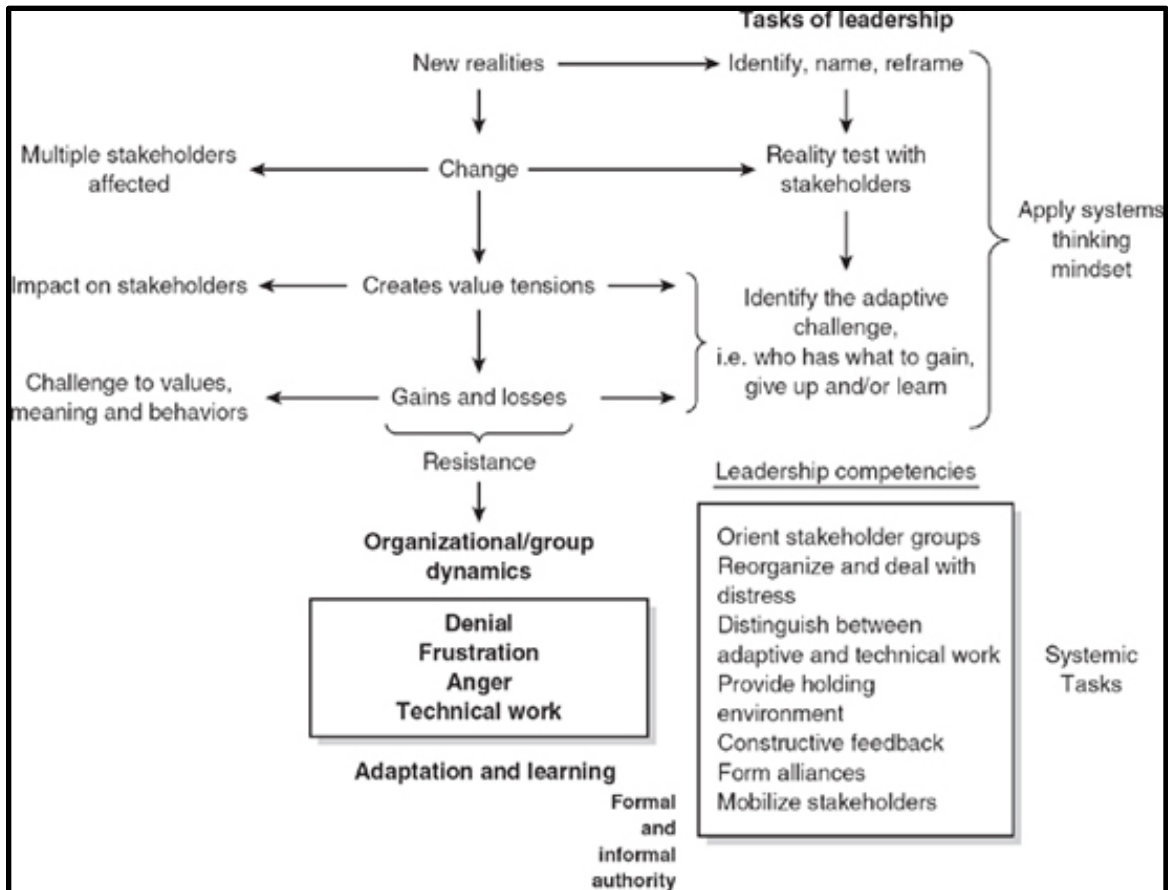
Systemic Leadership theory as outlined by Beerel (2009) is the approach to leadership in which leaders facilitate the response to change and new realities of an organizational environment. She opines that,

true leadership is primarily and fundamentally concerned with identifying and responding to ever-changing realities. There is nothing more important, compelling or urgent than the existence of changing realities and wrestling with what that implies for the healthy survival of a system or organization (Beerel, 2009, chapter 3, p. 11).

This ties in with complex adaptive theories in that Beerel further states that the capabilities of leaders in this approach do not attribute to any one character trait, but require being open, attentive, curious and mindful about the reality of change with the ability to see patterns and relationships and have strength in systems thinking. Systemic leaders identify adaptive challenges with an awareness of new realities and tensions created or implied in the system, and act accordingly, with

the ability to have emotional maturity and intelligence to navigate choppy waters  
(See Figure 3).

Figure 3. Leadership Competencies in Systemic Leadership Theory Approach (Beerel, 2009)



### Pluralized Leadership

Whereas Uhl-Bien's work characterizes complex leadership as relational leadership, pluralized leadership is described by White, Currie, & Lockett (2016) when he credits the work of Denis, et al (2012), as characterizing this type of leadership as an entity where multiple leaders exert influence through 'formal and informal means' and which naturally occurs in complex organizations on a continuous basis collectively (p. 280).



This work is a rigorous scientific empirical study that looks at how leaders influence networks through relationships. The research highlights that while most research acknowledges pluralized leadership within complex settings, there is not adequate research on how leadership is spread in complex organizations, thus verifying the need for the research. Social network analysis theory was applied, and while this may serve as a jumping off point for further research on the impacts of leadership relationships and behavior, it is limited in its application to this capstone, but relevant to touch upon as an emerging leadership theory that may have relevance in future studies in healthcare.

Recent research by Belrhiti, et al (2018) outlines key literature entities covering complex leadership in healthcare with a scoping review of thirty seven relevant conceptual, empirical and advocacy papers. This work concludes that there is a gap in the current literature with complexity science theory and actual application in a healthcare setting. They found the majority of researchers defined complex leadership in a healthcare setting in a homogeneous manner, with evidence of the need for further empirical research studies on how understanding of complexity can contribute to better outcomes within health systems. This research did not identify how better healthcare is actually defined, furthering the need for additional research in complexity science in the healthcare arena.

### Emotional Intelligence and Leadership

Leadership competencies and success hinge on the ability to be able to manage oneself and manage relationships with others. Psychologists have been

researching theories in intelligence and emotions for the greater part of the early 20<sup>th</sup> century (Salovey & Mayer, 1998). Historically, when psychologists began to write and think about intelligence, they focused on cognitive aspects, such as problem solving. Emotional intelligence- abbreviated to EI- also referred to as emotional quotient or EQ, emerged from the theory that emotions impact many aspects of the human experience. In 1990, the concept and construct of emotional intelligence was formally introduced by Professors Peter Salovey of Yale University and John Mayer of the University of New Hampshire. In their seminal article, Salovey and Mayer (1990) proposed that cognition and emotion are interconnected and not distinct; individuals have the power to identify, leverage, and regulate their emotional states to achieve desired outcomes.

In 1995 Daniel Goleman, a psychologist and science journalist, popularized the term emotional intelligence in the title of his book, *Emotional Intelligence: Why it can matter more than IQ*. He popularized the construct of the experience of emotions as a domain of intelligence. Goleman then wrote a now-classic Harvard Business Review article “*What Makes a Leader*” (1998) that first outlined how emotional intelligence impacts leaders and how it applies to business. Goleman tapped into the growing business interest in this area and its connection to personal and professional success (1998), and the term Emotional Intelligence (EI) became very popular throughout organizations. Goleman noted that traits of intellectual intelligence are not enough to determine success in leadership, and posited that effective leaders also have a high degree of emotional intelligence. Leaders with high EI are proposed to be better able to

develop and manage relationships (Beerel, 2013). Goleman found ties with EI and measurable business results. Goleman later expanded the theory to include a number of specific social and communication skills influenced by emotions, which many leaders have adopted. Mayer and Salovey (1997) created a revised model of EI emphasizing the cognitive components of emotional intelligence and conceptualized the potential for personal growth.

Most elements of every emotional intelligence model can be summarized in four domains: self-awareness, self-management, social awareness, and relationship management. Emotional intelligence is about what one sees and emotional competence is what one does. It is about awareness of one's own actions and how one relates to others. The emotionally intelligent person is not only able to be aware of and handle one's own emotions, but able to relate to others in an individual, team or group setting through empathy and with the ability to handle conflict or difficult conversations. Without having strong EI traits, Goleman theorizes that it is challenging for leaders to motivate and influence individuals and teams for a desired outcome (Beerel, 2009).

Two studies found positive relationships between the ability to manage emotions and the quality of social interactions, supporting the predictive validity of an ability measure of emotional intelligence, the Mayer-Salovey-Caruso Emotional Intelligence Test (Lopes, et al. 2004). There is a growing body of research suggesting that EI abilities are important for success in many areas of life and has been described as the key to both personal and professional success. Recent research highlights the importance of EI as a predictor of

success in important domains such as academic performance, job performance, leadership, trust, conflict, and stress. Many researchers in the field of EI claim its application positively impacts overall well-being. However, some argue that there is a middle ground, and those who measure EI say there may be downsides: some traits can be overused or taken to an extreme which leaves room for further study. In other words, despite its apparent significance, one could argue that EI or EQ is not the panacea for all leadership success.

Though definitions vary, EQ always comprises intrapersonal and interpersonal skills — in particular high adjustment, sociability, sensitivity, and prudence. Thousands of scientific studies have tested the importance of EQ in various domains of life, providing compelling evidence for the benefits of higher EQ with regards to work, health, and relationships. For example, EQ is positively correlated with leadership, job performance, job satisfaction, happiness, and well-being (both physical and emotional). Moreover, EQ is negatively correlated with counterproductive work behaviors, psychopathy, and stress proclivity. But is higher EQ always beneficial? Although the downside of higher EQ remains largely unexplored, there are many reasons for being cautious about a one-size-fits-all or higher-is-always-better take on EQ. Most things are better in moderation, and there is a downside to every human trait (Chamorro-Premuzic & Yearsley, 2017).

### Executive Coaching: Definitions, Processes and Evaluation Methods

Executive coaching is defined by the Executive Coaching Forum as:

Executive coaching is a one-on-one individualized process to benefit the leader and his/her organization. Working with goals defined by both the leader and the organization, a qualified and trusted coach uses various coaching methods and feedback data to develop the leader's capacity for current and future leadership. This coaching is guided by a coaching partnership to achieve maximum impact and the highest level of learning (Ennis & Otto, eds., 2015, p.8).

There are three key stakeholders identified in executive coaching: the executive, the coach, and the organization—which may include a supervisor and HR contact of the executive for the purpose of serving the goals and interests of the

organization. Ely, et al (2010), taking from the works of multiple researchers, broadly define leadership coaching in terms of a relationship between a client and a coach that facilitates the client becoming a more effective leader.

The definition of executive coaching, also known as leadership coaching, has evolved over the years with Ely, et al (2010) summing up the definition taken from the Center for Creative Leadership as a formal one-on-one relationship. In this relationship, the parties collaborate, in an accountable and supportive environment, to assess and understand the leadership and developmental tasks of the coachee while challenging their constraints, and exploring new possibilities to reach goals and sustain development (Ely, et al, 2010; Ting & Riddle, 2006). The progression of the above definition has been defined over the years by Kilburg (1996), Witherspoon & White (1997), Peterson and Hicks (1997), and Douglas and Marley (2000) as summarized by Ely, et al.'s (2010) comprehensive review. The overall goal of coaching is to improve a leader's effectiveness at work to enhance the organization's business strategy (Barner & Higgins, 2007) and is the mechanism to provide leaders with tools, knowledge, and opportunities to develop in their effectiveness (Feldman & Lankau, 2005).

With those definitions in mind, coaching as a learning development tool has become more commonplace within organizations over the last several decades in both the U.S. and internationally, and has emerged as an intervention for behavior change for middle and senior level managers (Barner & Higgins, 2007; Ely, et al. 2010; Ennis & Otto, 2015; Feldman & Lankau, 2005; Korotov, 2016). With an overall increase in demand for executive coaching, organizations

are looking to have more data around effectiveness and coach competencies outlining the need for more standardized ways of measurement (Riddle, et al. 2015).

With the swift pace of rapid global change in markets, not just in business but also in healthcare, one can make the case there is an ever-growing need for leaders to perform at their peak, with talent being a key factor for driving results and success. Many organizations have adopted leadership development programs to improve business outcomes, with coaching as a segment of this development (Riddle, Hoole & Gullette, eds., 2015; Boyatzis, 2013).

As markets and businesses become more complex and global, the need to develop leaders who can adapt rapidly changing business realities will continue to grow. Executive coaching, especially internal coaching, is emerging as an effective response to this environment, but there remains a need to formalize its processes and structures (Riddle, et al, 2015, p 26).

Executive coaching is most often used by organizations to assist leaders in a new role, to help with specific performance challenges, to develop leadership skills for high-potential employees, and serving as an objective confidante to senior executives to assist with strategic and organizational decisions (Axmith, 2004).

### Evaluating Coaching

While coaching and leadership development are not new concepts or constructs, the evaluation methods and outcomes research based on empirical studies for executive coaching is, with both empirical and theoretical work, lagging behind other disciplines (Feldman & Lankau, 2005; Bono, et al., 2009;

Ely, 2010; Riddle et al, 2015). Bono (2009) provides a survey of executive coaching practices and states, “there are numerous case studies, best practices, and individual perspectives on coaching” (p.362), and includes a 2005 literature review that ascertains that more attention has been paid to executive coaching by practitioners than by academics; this is also seen in related illustrations by Ely & Riddle (Bono, et al, 2009; Ely, 2010; Riddle, 2015). The amount of coaching-specific research has grown over the past several decades with Grant (2017) highlighting the number of citations since 2015 as just over 2,100, and notes a noticeable increase in recent publications broadening considerably in scope, content and complexity.

The research suggests that the ways to standardize practice and evaluate good coaching are inherently challenging, because it is based on biased, non-uniform, self-reported ways of measurement, based on the context of the coaching experience, the context of the organization, the coaching approach, and the goals and experience of both the coach and coachee. Grant (2017) in looking at coaching as evidenced- based practice, states:

“Similarly, the empirical support for coaching spans a broad range from rigorous coaching-specific research (both quantitative and qualitative) to basic research in disciplines not specifically related to coaching. Further complicating the situation is the fact that coaching research itself is focused on many different facets of coaching, ranging from research focused on the effectiveness of coaching interventions to produce specific outcomes, through to the nature of coach-coachee relationships, to explorations of how the effects of coaching impact on and reverberate through human and organisational systems” (Grant, 2017, p.2).

However, Habig and Hoole in their Center for Creative Leadership book chapter (Riddle et al, 2015) contend that the success of EC is more easily

defined in that the goal is essentially always the same regardless of context, namely to impart substantial behavior change in critical behaviors to directly or indirectly affect the strategic goals of the organization. They further contend that behaviors and outcomes are unique to each leader, but evaluation should be geared to the achievement and attainment of the goals of the leader set during the coaching engagement.

The definitions of executive coaching are direct and clear, however the research on coaching evaluation- while it has grown over the years- still contains gaps in measurement of the effects of coaching. Meta-analysis of research seems to capture the most comprehensive view of studies throughout the years. Ely, et al. (2010), in addition to the Center for Creative Leadership (Riddle, et al., 2015), propose an integrative framework with which to work to evaluate effective leadership coaching and affirm the importance of empirically advancing coaching practice knowledge. This idea is outlined as two frameworks, the *summative* evaluation framework (see Table 2), which assesses the outcomes of the leadership development intervention; and the *formative* evaluation framework (see Table 3), which looks at the improvement of program development and implementation.



Table 2. Summative Evaluation Framework (Ely, et al. 2010)

	<b>Focus of assessment</b>	<b>Relevant data sources</b>
<b>Reactions</b>	<ul style="list-style-type: none"> <li>• Client's perception of coaching effectiveness</li> <li>• Client's perception of coach (e.g., competence)</li> <li>• Client's satisfaction with coach–client relationship (e.g., trust)</li> <li>• Client's satisfaction with the coaching process (e.g., frequency of meetings)</li> </ul>	<ul style="list-style-type: none"> <li>• Self-report satisfaction (client)</li> <li>• Behaviorally anchored rating scales (client)</li> </ul>
<b>Learning</b>	<ul style="list-style-type: none"> <li>• Self-awareness</li> <li>• Cognitive flexibility</li> <li>• Self-efficacy</li> <li>• Job attitudes (e.g., job satisfaction, organizational commitment)</li> </ul>	<ul style="list-style-type: none"> <li>• Pre and post self-assessments (client)</li> <li>• Self-report cognitive flexibility, self-efficacy, and job attitudes (client)</li> </ul>
<b>Behavior</b>	<ul style="list-style-type: none"> <li>• Change in client's leadership behaviors (e.g., managing personnel resources)</li> <li>• Client's achievement of coaching goals</li> </ul>	<ul style="list-style-type: none"> <li>• Pre and post 360-degree assessments of leadership behaviors (client, subordinates, and superior)</li> <li>• Ratings of goal achievement (self and relevant others)</li> </ul>
<b>Results</b>	<ul style="list-style-type: none"> <li>• Employee retention (client and client's subordinates)</li> <li>• Adequate pipeline to fill senior leadership positions</li> <li>• Changes in subordinates (e.g., job satisfaction and performance)</li> <li>• Changes in customers' satisfaction</li> <li>• Customer satisfaction survey</li> <li>• Return on investment</li> </ul>	<ul style="list-style-type: none"> <li>• Organizational records</li> <li>• Succession planning</li> <li>• Satisfaction and commitment (client's subordinates)</li> </ul>

Table 3. Formative Evaluation Framework (Ely, et al. 2010)

	<b>Focus of assessment</b>	<b>Relevant data sources</b>
Client	<ul style="list-style-type: none"> <li>• Client readiness</li> <li>• Expectations about coaching</li> <li>• Organizational support, goals, and climate</li> </ul>	<ul style="list-style-type: none"> <li>• Attitude and skill assessment (client)</li> <li>• Expectations (client)</li> <li>• Organizational representatives</li> </ul>
Coach	<ul style="list-style-type: none"> <li>• Coaching competencies</li> <li>• Expertise in coaching certain skills or in certain industries</li> </ul>	<ul style="list-style-type: none"> <li>• Experience, certification (coach)</li> <li>• Background (coach)</li> </ul>
Client-Coach relationship	<ul style="list-style-type: none"> <li>• Rapport</li> <li>• Collaboration (e.g., degree of collaboration between client and coach in formulating development goals)</li> <li>• Commitment (e.g., client effort toward goal achievement)</li> <li>• Trust and confidentiality</li> </ul>	<ul style="list-style-type: none"> <li>• Self-report (coach, client)</li> </ul>
Coaching Process	<ul style="list-style-type: none"> <li>• Assessment (e.g., client's receptivity to assessment results)</li> <li>• Challenge (e.g., number and quality of development goals)</li> <li>• Support (e.g., provide client resources to facilitate goal achievement)</li> </ul>	<ul style="list-style-type: none"> <li>• Ratings of client's receptivity (coach)</li> <li>• Learning development plan (coach)</li> <li>• Behaviorally anchored rating scales (client)</li> </ul>

The framework noted above is the cornerstone model of this capstone used for the evaluation of the qualitative responses which will be highlighted in proceeding chapters of this thesis.

### Executive Coaching Benefits and Outcomes

There are benefits to creating a coaching program and culture in an organization; in the context of Peter Senge's theory (1990), as outlined in Riddle, et al (2015), a powerful way to foster organizational learning is by approaching the evaluation of coaching in organizations with the combination of the development of a coaching culture and evaluative thinking. Traditionally, outcomes in coaching have been measured using the four-part Kirkpatrick model of evaluating training and learning: *reaction, learning, behavior and results* (Bates, 2004; Ely, et al. 2010; Falletta, 1998; Greif, 2016; Riddle, 2015). This model has been used over the past forty plus years, with the research showing limitations to this model. There have been augmentations to include the implementation of cognitive dimensions of behavior change in executive coaching with the evaluation of multiple dimensions within each category as outlined in the summative evaluation framework (Ely et al, 2010) (see Table 2).

The presumed outcomes of coaching include changes in managerial behaviors with presumed increases in managerial effectiveness. (Feldman & Lankau, 2005). Greif (2016) illustrates that the outcomes and results of coaching are varied, and evaluation is difficult due to the complexity and nature of the relationship. Each coaching experience is unique and individual, depending on the client and the subject of the coaching. Many executive coaching outcomes are intangible and individual results vary; the interventional output is a situational process and not a tangible product (Grief, 2016, p.2).

### Coaching in Healthcare

Wolever, et al (2016) point out the timely nature of the need for coaching in healthcare as they indicate the dire need for improvement, illustrated by the many external forces impacting multiple shifts in the industry. The issues of cost, volume-based care, and siloed models mirror the content revealed earlier in this literature review. Wolever, et al address three applications in healthcare, of which leadership coaching is one. They posit that coaching in healthcare may be a mechanism to help support the critical reinvention and disruption of this industry to impact change; it will help equip individuals with the personal resources necessary to accomplish the goals and challenges they face. The case for executive coaching in healthcare is paramount; healthcare systems are in need of highly competent leaders who foster cultures of innovation and well-being. They point out that leadership coaching in healthcare lags behind other industries, partly because of the lack of research in this sector attributed to the sector's demand for rigorous peer-reviewed evidence and the specialized knowledge required of the complex, rapidly changing healthcare sector. The case is made for the need for executive coaching illustrated through the point that organizations that will prosper in the environment of disruption and massive change require resilient and adaptive cultures. This includes the staff who work within that culture. However, they point out that over the last decade, there remains a limited amount of peer-reviewed papers on the value of coaching in healthcare, with a survey of 583 healthcare CEOs perceiving coaching as having only moderate value. A systems perspective is necessary in healthcare and executive coaching as leadership capacity develops.

### Executive Coaching Process/Models

Most research that looks at coaching agrees on the generic process of executive coaching in three to seven phases and may include various assessment techniques and instruments, including assessment, challenge and support, known as the ACS model (Ely, et al, 2010). *The Center for Creative Leadership* (CCL) (Riddle, et al, 2015) and the *Executive Coaching Forum* (2017) expand upon this and outline a comprehensive process that includes pre-coaching analysis, contracting, data gathering and evaluation, goal setting and development of coaching plan, implementation of plan, measuring results, and transition to long-term development (Ennis & Otto, 2015). Barner and Higgins (2007) outline four theoretical coaching models, each offering distinct perspectives and advantages toward improving an individual's effectiveness to improve business outcomes. The models include a clinical model, a behavioral model, a systems model, and a social constructionist model. This same article is geared toward the coach as a scholar- practitioner to inform practice.

As part of the coaching process, the Executive Coaching Forum (Ennis & Otto, eds, 2015) outlines three levels of individual learning in the coaching process for sustained learning after coaching: problem solving, developing leadership capabilities, and developing new behaviors which involve thinking, acting, and self-reflection, also defined as 'learning how to learn' (p.11). Individual learning can be assumed to translate to collective organizational learning through executive coaching (Swart & Harcup, 2010), as shown in a study of two law firms where empirical evidence demonstrated the

interconnectedness of the two, through individuals thinking and behaving differently to impact the collective.

### Partnership, Relationship and Client Perceptions

De Haan, et al (2013), Eggers & Clark (2000) and Ennis & Otto (2016) emphasize the importance of the partnership and of the coach-coachee relationship for successful coaching. Good coaching that succeeds empowers employees, and happens when the coach does not provide answers, but when the coach asks key questions for the client to discover the answers themselves to accelerate the process of behavior change; the coach creates an open environment of unconditional positive regard and acceptance (Eggers & Clark, 2000; Rogers, 1995). The results of the work by de Haan, et al, (2013) in studying 156 client-coach pairs, showed that,

the client perceptions of the coaching outcome were significantly related to their perceptions of the working alliance, client self-efficacy, and to client perceptions of the range of techniques of the coach. The client-coach relationship mediated the impact of self-efficacy and range of techniques on coaching outcomes, suggesting that this relationship is the key factor in determining how clients perceive the outcome of coaching”.

### Summary

For purposes of this capstone, my literature review has encompassed a look into the current state of healthcare, with a look back at key research and initiatives and external forces that are driving the dynamic changes and complexity of delivering care in a multi-faceted system. In the review I have looked at key tenets of complex systems theory and complex adaptive systems, and how the research highlights healthcare within this context. Furthermore, the application of agility, adaptability, and systems thinking among leaders allows for

a paradigm shift in the way they operate to acknowledge, create and sustain change. The review moves on to discuss the tenets of executive coaching. The development of leadership capabilities within the realm of executive coaching in a healthcare setting highlights the need for this qualitative analysis as well as the need for further study. Looking through the lens of this capstone, the questions I have proposed emphasize the necessity to further assess the impact of leadership experiences with executive coaching and the relationship to improving the healthcare system.

## CHAPTER 3

### METHODOLOGY

Since the focus of this capstone is exploring executive coaching in a healthcare setting, it was important to interview a broad range of leaders who have experienced executive coaching in a high-level leadership role in a hospital or outpatient setting; as well as executives who lead or have led teams of people who support the work of the clinical teams. I initially sought to compare leaders who have had executive coaching for an extended period of time with physician leaders who had participated in a yearlong leadership program, of which coaching was a small component. Ultimately, I chose to narrow the focus to leaders who have experienced executive coaching for six months or longer and with a contracted professional coach outside of the organization.

Because of the nature of the confidentiality in the coaching relationship, it was necessary to assure that confidentiality in the capstone work with whomever I was to partner with would be maintained within the organization for this research. I began by brainstorming ways to best reach out to my network of contacts from both the University of Pennsylvania Organizational Dynamic program, and from there, to hospital contacts to propose the capstone ideas while also garnering assurance of the benefits and the confidentiality of the work.

#### Working with Key Organizational Stakeholders

April-May 2018: I began the early work of the capstone by exploring the resources I had available within my professional network. I reached out to the Human Resources (HR) contact at the healthcare organization where the



qualitative interviews took place to discuss a high-level overview of the potential capstone research I was interested in exploring. This organization had a robust coaching program, had a large bench of coaches, and had many leaders who had gone through coaching. This meeting was an exploratory meeting to see if it would be a good fit for the organization and for me.

Additionally, during this time period, I met with a physician leader who coordinated the physician leadership course to outline my intentions for the capstone research and learn about the structure and content of the physician leadership course. Prior to that meeting, I drafted a capstone overview for review ahead of the meeting (See Appendix A). That initial discussion generated positive ideas from which to potentially work and we agreed to meet again.

June 2018: I met again with the physician leader, and joining us at that meeting was an executive coach who had coached inside the organization. His role was in coordinating the abbreviated coaching sessions that were a subsection of the physician leadership program. I shared the drafted capstone overview and proposal for their review ahead of the meeting. At that meeting we discussed the intentions of the research and the potential outcomes. A concern was expressed that physician leaders would not have enough time to set aside to speak with me about this research. A few days later after that meeting, in a phone conversation with the physician leader contact, we came to the conclusion that due to other organizational factors and influences at that time, it may be best to study only the one group of executives for the research and not include the physician groups.

I concluded later, that the idea to interview the physician groups was not well received following my mentioning the potential to look at the impact of coaching on physician burnout. I assessed that it became an uncomfortable topic, and one that may have been too sensitive to elicit in a published capstone research study. I believe this may be common in healthcare institutions that have only recently in the last several years been coming to grips with the impact of provider stress and burnout and how it may impact patient care and outcomes (Bodenheimer, 2014). It remains to be seen how willing healthcare organizations will be to share information widely and transparently.

July 2018: I again met with the Human Resource contact person and she provided me with a number of professional resources for the benefits of executive coaching and I agreed to obtain additional research on executive coaching as we continued to explore the topic together. Due to changing priorities of the organization, the HR person asked that we set up a meeting with the senior HR Director. It was necessary to have him approve and confirm that this work was in alignment with the organizational goals.

August 2019: Due to scheduling conflicts I met with the HR contact only one time. We outlined a potential process and expectations for the next steps and I agreed to plan to refine the capstone overview for the senior HR director based on her feedback.

#### Agreement to Work with the Organization

September 2019: The HR lead ultimately agreed to partner with me for the work, and the senior HR leader approved moving forward with the work. The

HR person became the liaison for the organizational leaders with whom she had coordinated their executive coaching. This human resource contact was key to the senior leaders participation in the qualitative interviews, and the facilitator for teeing up the background of my research in communications to them. She helped assist with establishing interest in this research, and because she already had established credibility with the senior leaders, she helped to maximize their participation.

### Confidentiality

I drafted a letter of the overview of my research for potential participants. In addition, while working with my capstone advisor, I drafted the consent form (See Appendix B) based on a standard template and previous consent forms found on Penn's Scholarly Commons website. I sent the research overview with the draft consent to the chair of the Organizational Dynamics program for review and approval. It was determined that this research did not qualify for IRB review. At this time I drafted the 6-8 interview questions (See Appendix C) and revised and reviewed with my capstone advisor to assure the content was on track with the research intentions.

### Process of Garnering Qualitative Interview Participants

October 2018: The HR contact sent individual emails to senior leaders who had experienced executive coaching at this organization, asking them for willingness to participate in the qualitative interviews. If a person showed interest, the HR lead connected me via email. I then sent an email with an overview of the project and the consent form to participate. I worked mostly through

administrative assistants to set up the interview meetings and three of the fourteen participants set up their meeting directly with me. The response was overwhelmingly positive and ultimately fourteen leaders were interviewed over the course of the month of October. The leaders came from varying areas of the organization including marketing, strategy, scientific research and innovation, information systems and health information management, the charitable foundation and development, quality and safety, medical operations, nursing, and government and external public affairs.

October-December 2018: Capstone project was put on hold.

#### Steps for Data Analysis

January 2018: With the completion of the qualitative interviews, the transcripts were downloaded to a confidential web-based transcription application. From there, I was able to undergo a detailed editing process for correcting the wording while also listening to the transcripts. This enabled me to listen again to the interviews and pull out key themes and ideas emerging from the data.

February-March 2019: Data analysis and research continued and after the audio edits were made. I was then able to print the edited transcripts and further distill the key data elements of the research on paper. As a result, I refocused and augmented the literature research process to support the themes that were emerging from the interview process.

## CHAPTER 4

### DATA COLLECTION

#### Demographics

My data collection includes the results of qualitative interviews with fourteen executive leaders in the healthcare organization chosen specifically for this capstone study. After informed consents were signed and secured, fourteen executive interviews were conducted over the course of a one-month period, each lasting, at minimum, one-half hour and maximum, one hour; with one interview as an outlier lasting one and a half hours.

The demographics (See Table 4) for the leadership group included eight males and six females, all with a range of tenure in their position from one year to more than ten. Over half- 57 percent- of the interviewees have been in their position for two to five years, and range in level from Director to Senior Vice President, with three interviewees holding dual titles of Chief Officer positions. The interview participants had areas of oversight in departments across the healthcare organization including marketing, strategy, research and innovation, information systems, health information management, foundational giving and development, quality and safety, medical operations, nursing, and government and public affairs. Just over one quarter of the participants oversee clinical areas or have teams that oversee clinical operations. The remaining participants did not have direct clinical frontline impact in their oversight. Over half had one to five direct reports, with only one having up to twenty. The size of the leaders' overall

teams ranged from fifteen to over fifty, with half of participants having large teams of over fifty.

Table 4. Demographics and Background of Interview Participants

GENDER	NUMBER	OVERSIGHT AREA	NUMBER
MALE	8	CLINICAL **	4
FEMALE	6	NONCLINICAL	10
YEARS IN POSITION	NUMBER	LEVEL IN ORGANIZATION	NUMBER *
1-2	4	SENIOR VICE PRESIDENT	2
2-5	8	VICE PRESIDENT	3
5-10	1	ASSOCIATE VICE PRESIDENT	3
10+	1	SENIOR DIRECTOR	5
		DIRECTOR	1
DIRECT REPORTS	NUMBER	SIZE OF TOTAL TEAM	NUMBER
1-5	8	15-20	1
6-10	5	20-30	3
11-20	1	31-50	3

		50+	7
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\* 3 Chief Officer Positions as part of total number of participants

\*\*Clinical - as defined by oversight of clinical care area for operations, analysis or improvement

### Coaching Process

The coaching engagements experienced by the participants lasted an average of six months, with a quarter being under six months, and three quarters over six months, with one participant still actively engaged (See Table 4). One participant had initial coaching and then re-contracted with the same coach several years later for a second engagement. Over half of coachees have had informal, one-time or sporadic spot check-ins with the coach after the engagement was completed.

Every interviewee who participated in the executive coaching process reported that they were able to choose their coach from an average of three potential coaches. They had the ability to work with the internal Human Resource team, who vetted the coaches for each leader and forwarded a list of coaches for them to contact, either in person or via phone. The leader received information on the coach's background and experience, and had the autonomy to choose their coach after they spoke with them. One person I interviewed asked HR for additional candidates, as the options presented to her did not seem like a match. Most others reported they chose their coach based on how they felt—which I inferred as intuition—after speaking to the coach, as well as based on the

coach's knowledge of their particular business segment and ways to deal with their leadership challenges.

All fourteen of the leaders reported participating in a 360 Feedback (Thach, 2002) process as part of their coaching engagement, and over half report that they continue to use the feedback report as a reference tool. Just over half of those I interviewed (57%) mentioned taking additional supplemental psychological behavioral assessment and personality tools such as DISC, the Hogan Assessment, and the Myers-Briggs Type Indicator test.

Table 5. Coaching Process of Interview Participants

Time since coaching	Number	Length of coaching	Number
Still coaching	1	Less than 6 months	2
6 months or less	4	6 months	10
6 months to 1 year	2	6 months to 1 year	1
Over 1 year	5	Greater than 1 year	1
Over 2 years	2		

*\*Mentioned ongoing spot check or 1x check-in with coach (informal) = 8*

### Coaching Relationship

All fourteen—one hundred percent—of the leaders who participated in executive coaching reported having satisfaction with their coaching experience,



with some more enthusiastic and descriptive than others. They mentioned the ability to interview their potential coach as a key driver to a positive match.

#### Organizational Support for Executive Coaching

Eight of the fourteen participants expressed that they engaged in coaching because their senior leader or the CEO recommend they commit to the process. A majority expressed that the CEO and the executive leadership team of the organization have expressed their belief in the benefits of coaching and support a coaching culture. Two leaders actively sought coaching and three were offered it by the HR department. Reasons for initiating coaching included being a new leader, transitioning to a new leadership level, a change in leadership above the person being coached, and transitioning out of a role with a life change.

#### Deliverables at the End of Coaching

About one-third of the respondents outlined specific deliverables as part of their coaching process. These deliverables included the creation of a 5-10 year strategic plan for the business segment, a two-year transition strategy for a team as part of the leader's retirement plan, the creation of a leadership philosophy and a leadership plan, and a stakeholder analysis of client's needs.

#### Interview Questions

The interview questions asked of the leaders who participated in executive coaching were based on the premise outlined by the Center for Creative Leadership's (CCL) *Handbook of Coaching in Organizations* (Riddle, et al. 2015, p.94) comprehensive approach to executive coaching evaluation. Habig & Hoole (Riddle, 2015) in their book chapter outline seven key elements to consider when

evaluating coaching, each of which is covered in the capstone interview questions asked of the participants (See Appendix B).

Table 6. Comprehensive Approach to the Evaluation of Executive Coaching (Riddle. Et al, 2015 p.94)

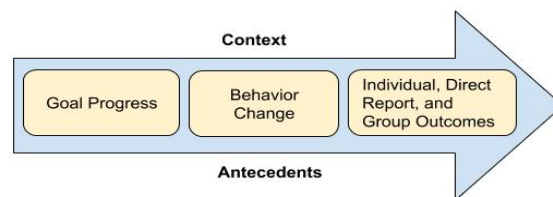
EVALUATION ELEMENTS	FEATURES
1. Context	<ul style="list-style-type: none"> <li>➤ Organizational context, boss support, coachee commitment, recent job or organizational changes, other developmental activities</li> <li>➤</li> </ul>
2. Antecedents	<ul style="list-style-type: none"> <li>➤ Coachee, coach, and rater demographics, reason for engaging in the coaching process, commitment, readiness</li> </ul>
3. Process	<ul style="list-style-type: none"> <li>➤ Coaching Process, frequency and duration goal support, satisfaction with the coach</li> </ul>
4. Coach behaviors	<ul style="list-style-type: none"> <li>➤ Coachee perception of the coach's behaviors during the process</li> </ul>
5. Goal progress	<ul style="list-style-type: none"> <li>➤</li> </ul>
6. Behavior change	<ul style="list-style-type: none"> <li>➤</li> </ul>
7. Outcomes	<ul style="list-style-type: none"> <li>➤ Individual, Direct report, Group</li> </ul>

## Executive Coaching Evaluation

Executive coaching evaluation in the seven elements is illustrated in the visual diagram of the framework outlined by Center for Creative Leadership (Riddle et al. 2015, p.95). This figure looks at coaching as a continuum of the entire process throughout a coaching engagement.

Figure 4: Executive Coaching Evaluation Framework

*(Riddle, Et al. 2015, p.95)*



The evaluation of the interviewees coaching process not only took into account the emergent themes of the data, but also deliberately considered the relevance of systems thinking in the interview questions and data gathering (Beerel, (2009) p.3). This was completed through interview questions that approached the questions through a holistic, integrative lens of the impact of the executive coaching process on three levels (See Appendix B); individual impact (*Micro level*), team impact (*Meso level*), and the organizational impact (*Macro level*). Beerel (2015) reviews that,

In order to understand the behavior of the organization under pressure of change, systems thinking is best applied at three levels: the organization as a whole, the groups that make up the organization, i.e. each group as a whole; and the individual as a whole (Chapter 6, p. 3).

### Data collection process

For the data collection process, the interviews were recorded via digital audio tape as well as hand written notes gathered. Each participant agreed to the recording with assurance of confidentiality and security protection of the data. The audio content was downloaded to a web-based application for audio transcription. I then reviewed the audio data files and corrected for errors and coded the interviewee and my information. Once the data was corrected, I again listened to each audio file to begin to hear patterns and themes in the data. I then printed the transcripts and highlighted key words and sentences. From those keywords, I coded into key words and themes using the qualitative data coding method of assigning a, “summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldana, 2015, p.3). I coded for similar and frequent patterns and from there themes emerged that will be covered in the interpretation and analysis section of the capstone.

## CHAPTER 5

### DATA INTERPRETATION AND ANALYSIS

The data that emerged from the qualitative interview process with the fourteen executive healthcare leaders revealed many themes; these themes mirror the coaching processes and benefits commonly outlined in the literature I reviewed. The analysis of the data reveals and complements the many tenets of leadership and healthcare complexity challenges that have been outlined in previous chapters of this capstone.

The standard for the assessment of organizational learning for many decades rests on the application of the Kirkpatrick's framework model of evaluation (Feldman & Lankau, 2005; Greif, 2016; Ely et al, 2010; Bates, 2004) which can be applied to the evaluation of the coaching experience. This model includes four tenets: reactions, learning, behavior, and results. Broken down further, by definition, *reaction* means the learner's reaction to the intervention, *learning* means what knowledge the learner has gained, *behavior* means how one changed as a result of the learning, and *results* means how the learner demonstrated outcomes as a result. For this capstone, this same framework is used, but takes it a step further, as illustrated in the Summative Evaluation Framework (See Table 2). There are two ways of looking at the evaluation of coaching: the 'Formative' and the 'Summative' approach (Ely, et al, 2010; Riddle, et al, 2015). The Formative approach looks at the impact for ongoing change and improvement in the learning program, and the Summative approach evaluates the experience and outcomes of the learning or coaching intervention. For

purposes of this capstone, I used the Summative approach as it serves as a comprehensive model for how the executive coaching experience can be summarized (See Table 2). This evaluation model of reactions, learning, behavior, and results was the model used for creating the interview questions and subsequent data (See Appendix C). The 'relevant data source,' as outlined in this framework, is the self-reported coaching experience from the qualitative interviews and the interviewees' reports of learnings, behaviors and results. This model's reliance on self-reporting illustrates the need to gather information from multiple data sources to better evaluate executive coaching; the limitations of this capstone thesis are similarly revealed as the evaluation is based solely on one-sided subjective data from those coachees that were interviewed.

"The value of coaching should be based on the outcomes achieved for the individual and organization, not an evaluation of the process elements or self-reported satisfaction". (Riddle 2015, p.98)

A comprehensive evaluation should ideally include measures of evaluation throughout several periods of the coaching process - pre, during, and post coaching—via self-reporting as well as with multiple stakeholder input along the spectrum of the coaching process (Riddle, et al, 2015). This capstone measures solely the post-coaching results as experienced by the coachees, however there is merit in evaluating the coaching effect of leaders in the context of their broader teams and healthcare organization, even if it is one-sided self-reported data. Furthermore, as discussed earlier, there is limited outcome data available on the effects of coaching in a complex healthcare organization, and the data from my capstone contributes to additional knowledge on this topic.

Both leadership and executive coaching involve the concept of *relationship*. Leadership encompasses relationship to oneself (intrapersonal), relationship to direct reports and teams, and relationship to the broader mission of the organization (interpersonal). The executive coach, through individual relationship with the coachee, helps the leader develop and helps to influence those other relationships within the organizational context. Both the intrapersonal and interpersonal aspects will be discussed below.

The qualitative interviews of this capstone approached the context aspect of the coach and coachee relationship (See Figure 4), but was not a primary focus to the data collection. In discussions with each interviewee regarding goals and coaching impact, the nature of the coaching relationship and the coach's actions were revealed. De Haan, et al (2011) found the following related to clients' perception of coaching in a study of 71 executive coaching clients:

"The findings support the idea that common factors are at work in executive coaching, so that helpfulness is much less predicted by technique or approach than by common factors common to all f coaching, such as the relationship, empathetic understanding, positive expectations, etc."(De Haan, et al. 2011, p.24)

The interviewees reported the skills used by the coach helped them see things from a different perspective. The data showed that the coach used tactics and questions to help the coachee see another point of view, they reframed and refocused the perceptions of the coachee, and they 'held a mirror' for them to see their own behaviors. These qualities were mentioned by more than half of the participants. The coach acted as a sounding board, and was able to convey unconditional positive regard (Rogers, 1995; Wildflower & Brennan, 2011),

helping the person amplify their strengths while also pushing back and holding them accountable to help change behavior and address challenges and problems.

Additionally, the executive coaching process assisted the executive leader in understanding one's *relationship* to self, to others and to the larger healthcare organizational context. When coding and interpreting the data from the interview process, it became evident there were three levels of impact from the coaching experience: the effect on oneself in relationship to others, the effect of relationships with others, and the effect on relationship to the organizational network. "Although an individual intervention, [executive coaching] can have an impact on direct reports, teams, groups, departments, the organization" (Riddle, 2015, p. 85).

Utilizing the comprehensive approach to evaluating executive coaching, (Riddle. Et al, 2015 p.94) the data interpretation focuses on the steps five through seven as seen in Figure 4 (See Figure 4): the goal progress, the behavior change, and the outcomes of the coaching. The demographic antecedents and the context for the individuals interviewed have been covered in the previous chapter four of this capstone.

It is pertinent to mention, however, that beyond the demographics and the reasons for coaching, the overwhelming theme that emerged in the data was that of change. Each leader expressed that they were faced with the challenges and pressures of leading a team and the larger organization through immense growth



and change, a feature common to many healthcare organizations that face mergers, acquisitions and other care delivery shifts.

“...the US and global healthcare industry is amidst a perfect storm of formidable challenges...these challenges are driving much-needed disruption through models of organization, care delivery, payments, and insurance. Industry disruption and uncertainty promise to be immense, complex, and overwhelming. Fortunately, coaching in healthcare may offer some mechanisms to support the reinvention of this critical industry by bolstering healthcare leaders, providers and patients” (Wolever, et al. 2017, p.2-3)

The changes expressed by the leaders were felt because they either were new to the organization or were brought in to help turn around a team, or they had come from another role to their current position. Other leaders were faced with a change with their own direct leader, and began the executive coaching program to help navigate those areas of relationship complexity.

Riddle’s Executive Coaching Outcomes framework (Riddle, et al., 2015, p.100-102) relates coaching outcomes that impact the individual, the direct reports, the team or group, and the broader organization. This is categorized into five outcomes that include: performance, development, attitudes, interpersonal, and business, all of which were seen in the data coding.

### Findings and Summary of Data

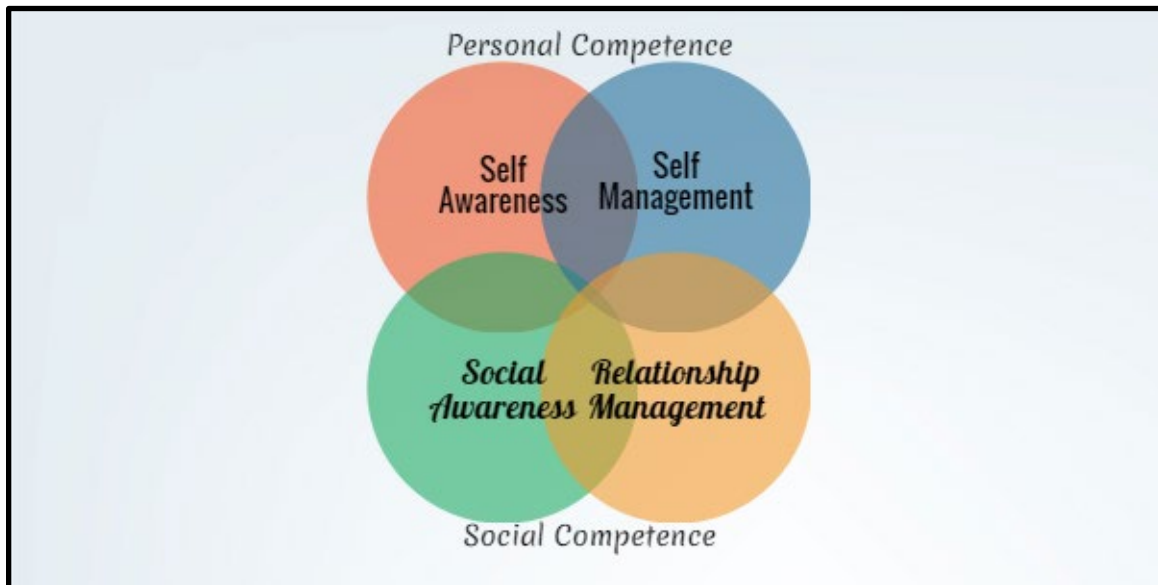
#### Goals

The coachees’ goals were reported by the interview participants as having a focus on three levels: individual, team and the larger organization. Four of the 14 who were coached expressed that they had individual leadership goals, and three of the 14 coachees’ goals focused on their own teams and other interdepartmental teams throughout the organization. Seven of the 14—half the

participants—focused their goals on all three levels: their individual leadership and competencies, their groups and teams, and the broader integrated network of the organization.

These coaching results mirror the framework of the emotional intelligence model by Goleman (1998), showing both intrapersonal and interpersonal impact. The intrapersonal competencies are connected to self-awareness of oneself and self-management of relating to others. The interpersonal social competencies are about awareness of social interactions through empathy with others and about managing those relationships (See Figure 5).

Figure 5. Illustration of Emotional Intelligence Quadrants



(Google Images, 2018)

### Behavior Change and Outcomes

The identified coded coaching themes in Table 7 are outlined on the same three levels: individual, team and organization. The executive coaching process with the leaders of this organization seemed to impact and improve one's (self-

reported) emotional intelligence or emotional quotient abilities. The qualitative analysis of the data point to a high number (almost all) interviewees reporting an increase in their own self-awareness, especially after receiving the 360 feedback and learning how their behavior is observed and experienced by others. They became aware of their own blind spots and learned what makes them 'tick.' This in turn, allowed the leaders to self-reflect with the help of the coach, and redirect and be more intentional with their behaviors. Several coachees focused on their executive presence and communication skills, by either speaking up more or speaking up less, and many gained self-awareness of how their active listening seemed to impact others.

In relating to their team and group, the participants, through coaching, focused on managing constructive debate, difficult conversations, and feedback with those in positions below, across, and above them in the organization. Most reported that the coach helped give tools to have productive conversations. The participants reported learning how their own self-dialogue plays a role in the outcome; one must manage oneself first to relate well to others.

The themes identified in the executive coaching, as they related to the impact on the organization, were mainly around managing merging and changing teams, role transitions, and succession planning for organizational success. What was more nuanced in the data was the awareness leaders gained to navigate their relationships across siloed networks to accomplish goals. Most people reported becoming more adept at understanding stakeholder needs, more adept and intentional in meetings to both get the point across to advance the

direction of the conversation, and more adept at understanding the nonverbal cues of others when outright, candid feedback is not a cultural norm in the organization.

Table 7. Coaching Outcomes Identified by the Interview Data

Individual Relationship	Team/ group Relationships	Organizational Relationships
<ul style="list-style-type: none"> <li>● Self-Awareness</li> <li>● Intentional behaviors in interactions with others</li> <li>● Reflection</li> <li>● Resilience</li> </ul>	<ul style="list-style-type: none"> <li>● Leading Teams</li> <li>● Managing change</li> <li>● Decision making</li> <li>● Delegation &amp; leading from ground up</li> <li>● Communication</li> <li>● Feedback/ difficult conversations</li> </ul>	<ul style="list-style-type: none"> <li>● Culture Changes</li> <li>● Creating the culture</li> <li>● Adjusting to culture as new leader</li> <li>● Navigating Politics</li> <li>● Interdepartmental collaboration</li> </ul>

### Challenges with Coaching

The challenges most frequently noted with reaching coaching outcomes was the lack of time; time to work on the goals and progress between coaching sessions due to shifting organizational priorities, the ability to stay on task, and the lack of built-in time to reflect on the impact of one's leadership behavioral change. The ability to sustain change and complete short-term outcomes was reported by the coachees as successful, but the longer term outcomes were more difficult for the recipients of coaching to elucidate, as half of those interviewed had completed coaching in the past year.

### Factors Influencing Coaching Experience and Outcomes

For this capstone, it is essential not only to look at how the relationship of the coaching experience affects the perception of the coaching, and the resulting behavior changes and outcomes, but it is important to put the data into context of the healthcare environment. The senior leaders that were interviewed are part of a large multi-system, delivery system with many levels of care and provide leadership for multiple sites delivering that care. In systems thinking, the whole entire system is taken into account and considered, as opposed to the smaller parts making up the whole. It is recognized that these smaller systems that make up the whole are always in relationship to each other (Beerel, 2009). In systems leadership, one must account for how the actions of one affect many. A leader in the context of a complex adaptive system exhibit complex systems behavior through formal and informal networking relationships and provide team autonomy for decision making. Leaders understand and integrate their decision making into the whole.

The data analysis of the 14 participants who were interviewed demonstrated that their executive coaching experience helped them integrate complexity leadership through deliberate and intentional actions into their relationships and communications with others across the organization. It helped them gain the awareness and skills to translate awareness into action; because of their coaching experience they were able to more adeptly interact across siloes and other organizational networks and navigate the complexities of those relationships by understanding how the implications of their own leadership skills impacted others. Four of the participants took deliberate action to be more

physically present with their teams and in every-day interactions. One coachee stated that coaching helped to understand, “the expectations of others tangentially” (Interviewee #2), and that “one’s personal goals make me a better leader and colleague” (Interviewee #4), and ‘a better understanding of other’s perspective with a sharper focus on key discussions with the team.” Most leaders (over half) expressed the goal of coaching was to influence stakeholders to navigate politics of newly-created departments within their growing and changing organization.

A key feature of complexity leadership is allowing for emergence to happen in relationships rather than taking a top-down approach. The executive coaching experience of these leaders helped them enhance stakeholder relationships, not only to “mine the politics” (interviewee #8), but communicate and message agile thinking to their teams for autonomous decision-making, emergence, and growth to occur. Given the reality expressed by many that they are leading in a stressful, complex environment where constant pressures and change are inevitable, they were able to recognize, rather than ignore, not all relationships and team dynamics are straightforward and easy. It was shown that complicated solutions are often required and leaders learned that by getting ahead of and addressing the issues, they are, as one participant stated, doing, “not only themselves, but the hospital a favor. My most valuable thing I learned from coaching is that my most important job is making sure I have the best team supporting me” (Interviewee #7). One senior leader said, as echoed in the reflections of most participants, “Coaching is the best gift I ever got in my career.

## CHAPTER 6

### SUMMARY AND CONCLUSIONS

The complexities and changing dynamic of internal and external pressures within the healthcare environment are outlined in this work, as well as the need for leadership to understand and adapt to these changes. The demonstrated need and the time for change and disruption in healthcare is now. Taking a look at how organizations, and the players within those organizations, interact on the individual, team and broader organizational level, helps to better determine the current landscape of challenges and the interventions that may create a path forward for positive change. This capstone illustrates one such intervention, executive coaching, as a leadership development tool for organizational impact. While this is a small segment of data looking through the lens of a qualitative analysis, one can infer that the findings of these interventions can be applied more broadly in the healthcare sector.

Imperatives for change are a call to action, such as those recommended by the Institute of Medicine and outlined by other leading experts in the need for improvement in healthcare quality and safety, cost containment, and population health improvement. The leaders who strategically create these system changes require the intrapersonal and interpersonal, emotionally intelligent, capabilities to carry out those key initiatives.

Recognizing that the organizational impact of positive leaders indirectly impacts clinical care, executive coaching has the potential to impact healthcare organizations through changes in its care delivery and clinical management

models. Complex adaptive leaders in a complex HCO require leadership behaviors to be flexible, open, with tolerance for ambiguity to reach innovative goals. I believe this capstone research aligns with the notion of complexity theory that individuals, teams and group behavior and actions impact the larger organization and the broader whole, and that they are all interchangeably affected by each. Complex organizational structures are organized with groups and entities layered and embedded among each; actions and behaviors affect the whole. Emergence of new ideas and constructs are created through connected formal and informal networks of decision making and integrative thinking.

The integration of executive coaching as a positive influence on leadership behaviors in a healthcare setting is seen here in this qualitative study. One must understand the nature of complex adaptive systems and the tenets of complexity leadership to relate how changes in behavior and actions can affect and impact on the level of those above, across and below a leader in the organization. Formal leadership structures can be impacted, but complexity leadership dictates that we also understand the power of informal networks to understand the impact coaching has on leadership capacities.

Looking at the organizational impact of coaching, Drake & Pritchard, (2016) noted that:

Coaching can be used as a systemic and scalable tool for enhancing capabilities, culture and change in organisations. The few studies that have been done on the impact of coaching in organisations are largely related to the behaviors of executives who have been coached. What is less understood are questions related to if, and how coaching contributes to broader benefits for organisations as a whole (p. 2).



Drake and Pritchard also point out that the positive gains achieved through coaching “will have the greatest effect in organisations if they can be tied to larger initiatives and processes in the system” (p.14), and indicate a future need for studies looking at the secondary benefits from coaching to organizations.

Executive coaching is one component of leadership development. This capstone data, findings and analysis serve as a small example of the beneficial effect of coaching on a leader’s self-reported emotional intelligence skills of self-awareness, empathy of others, social skills, and reflective behavior of relating to others after coaching. The interview data from the executive coaching experience, while context specific, helped leaders with the ability to communicate across teams, accept and manage change and ambiguity, and with managing, to be adaptable and flexible—all hallmarks of complex adaptive leadership capabilities.

Analogies can be drawn from the capstone data to larger healthcare leadership contexts, and it should be recognized that these are loose assumptions drawn from theories of what the data revealed to impact organizational change. Limitations of this data show that not all aspects of complexity science and leadership in healthcare have been addressed here. What has not been covered is social network theory, looking at the leader interactions within the organization as a result of coaching. Additional limitations include the views of externally-involved parties in the organizational executive coaching process, and the team and supervisor post-coaching perspective. Nor does this data analysis address the coach’s perspective, the coaching

interventions, approaches and methods as described by the coach, nor does it address the competencies and expertise of the external coaches themselves.

There are certainly future research opportunities in the use of executive coaching in healthcare settings. The sampling size and data methodology for this capstone pose limitations to the conclusions drawn, and there is ample opportunity for further study of the impact in this sector. True evidenced-based causality of the impacts of executive coaching to an individual, teams and to an organization can be studied over time and in an empirical—rather than theoretical—fashion with double-blinded research studies. More scientific, evidenced-based double-blinded studies looking at the long term impacts of coaching, not just self-reported data, are needed.

Executive coaching is not only about an individual seeing things through a different lens, but about creating a change in the vision of the broader organizational healthcare context for valuable, long-term improvement for healthcare delivery and society at large. This capstone illustrates that there is a positive way forward for healthcare leaders to move beyond mental models of siloed healthcare delivery concepts, to one where recognition of the complexity of the whole reflects the advantages and opportunities that await the future for the creation of systemic and innovative change.

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## APPENDIX A

### INITIAL CAPSTONE OVERVIEW TO ORGANIZATION



### **Penn MSOD Capstone Overview**

**Lisa Hompe**

#### **Capstone Overview & Requirements**

#### **Master's Degree in Organizational Dynamics (MSOD)**

Submitting a capstone is one of the academic requirements for the Master of Science Degree (MSOD) and the Master of Philosophy (MPhil) degree in Organizational Dynamics at the University of Pennsylvania. The capstone represents a way for graduate students to apply their multi-disciplinary learning from the program to a specific organizational issue or problem. The capstone is a rigorous written document that illustrates a graduate student's ability to pick a focused topic to examine in-depth, conduct research, think critically, examine the research literature related to their focused topic, and build a coherent and evidence-based argument and document.

The MSOD/MPhil capstone is above all an applied master's thesis. The word *applied* is central to the development and writing of the capstone. Applied means that graduate students will use and incorporate their knowledge and understandings from their work experiences as well as their course work from their graduate studies in Organizational Dynamics. The word applied also connotes that Organizational Dynamics values and recognizes graduate students' experience and knowledge developed over their working life and wants them to build on, refine, and expand this knowledge. (SOURCE: Penn Organizational Dynamics Course Book, Canvas site)

#### **Topic Selection and Format**

The topic and focus of a capstone are best determined through conversations and written exchanges with faculty. The *Research Paper* format investigates a topic, problem, or issue

using qualitative and/or quantitative research methods. The research method must fit the topic under examination as well as be a methodology that the graduate student is proficient in or is willing to gain proficiency in during the capstone process. Graduate students are especially encouraged to take an interdisciplinary and systemic approach to their research. A research capstone must conform to standards set by the American Psychological Association in terms of ethics, style, and format.

### **Role of Capstone Advisor**

A Capstone Advisor is chosen because she or he has expertise in the topic being addressed or expertise in the research methodology being used. The Capstone Advisor serves as a guide throughout the capstone process and it is the advisor's job to provide guidance and rigorous, thorough feedback and constructive criticism. The advisor must be a member of the Organizational Dynamics faculty. The advisor reviews the student's capstone proposal and provides feedback about the topic chosen, and the capstone format chosen. The advisor helps the student narrow and focus their topic as needed, and reviews the capstone as it progresses. (SOURCE: Penn Organizational Dynamics Course Book, Canvas site)

### **Proposed [REDACTED] Capstone Research**

I intend to research and study executive and leadership coaching in a healthcare setting for both clinical and nonclinical participants. This complements my work in completing studies in the Organizational Dynamics Organizational Consulting and Executive Coaching cohort program.

I look to partner with the Physician Leadership Program and the organization's own Leadership Institute to examine the current existing coaching and leadership programs and research how and in what ways executive coaching has impacted individuals in context with their larger organization. This research can benefit [REDACTED] as well as potentially highlighting best practices for other healthcare institutions.

I plan to explore the return on investment (ROI) of executive coaching through qualitative analysis methods by researching previous coaching participants and exploring emerging themes. These themes may include results such as:

- Employee/ Physician Satisfaction
- Employee/ Physician Engagement
- Individual and Team Performance
- Leadership growth

- Promotion
- Retention
- Patient and family satisfaction/impact
- Impact on organizational culture
- Manager satisfaction data
- Other as appropriate

I will perform a review of related research and literature including relevant topics such as:

- Importance of physicians and other healthcare team members as adaptive and transformational leaders to lead and influence others in a complex and ambiguous healthcare environment
- Physician satisfaction is decreasing and burnout is on the rise
- Need for leadership skills in communication, collaboration, feedback and self-knowledge
- Skills in managing and relating to others
- Related topics as appropriate

#### **Full Disclosure and Protection of Information**

All capstone research study participant information will remain confidential and those participating will do so on a volunteer basis.

Lisa Hompe

June 26, 2018

APPENDIX B

INFORMED CONSENT FORM

**University of Pennsylvania**

**Capstone Research Informed Consent Form**

You have been asked to participate in a research study conducted by Lisa Hompe, a Master of Science Candidate in the Organizational Dynamics Program at the University of Pennsylvania.

The following is a consent form for a research project. This research involves the study of Executive Coaching in a healthcare setting carried out by the Principal Investigator (PI) of this project from the University of Pennsylvania. You have been asked to participate in this study because of your previous experience as a leader who has experienced executive coaching.

Before you agree to participate in this research study, it is important that you read and understand the information provided in this informed consent form. If you have any questions, please ask the interviewer (investigator) for clarification. Before the interview can start, the investigator and the interviewee sign two copies of this form. The interviewee will be given one copy of the signed form.

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-

***Consent for Participation in Interview Research***

I volunteer to participate in a research project by Lisa Hompe of the University of Pennsylvania. I understand that the project is designed to gather information about executive coaching at my organization. I will be one of approximately 10-12 people being interviewed for this research.

1. My participation in this project is voluntary. I understand that I will not be paid for my participation. I may withdraw and discontinue participation at any time without penalty.

Whether I participate, decline to participate, or withdraw from this study, no one from my organization will be told.

2. I understand that most interviewees will find the discussion interesting and thought-provoking. If, however, I feel uncomfortable during the interview session, I have the right to decline answering any question or end the interview session.
3. Participation involves being interviewed by a researcher from the University of Pennsylvania. The interview is scheduled to last approximately 30-45 minutes. Notes will be written during the interview. An audio tape of the interview and subsequent dialogue will be made but for academic purposes alone and will not be available to anyone except the interviewer.
4. I understand that the academic researcher will not identify me by name in any reports generated from information obtained from this interview, and that my confidentiality as a participant in this study will remain confidential and anonymous. Study-related records will be held in complete confidence.
5. The information you provide will be kept strictly confidential. The informed consent form and other identifying information will be kept separate from the data. Any records that would identify you as a participant in the study, such as informed consent form, will be destroyed by me, the Investigator, one year after the Capstone study is completed.
6. No [REDACTED] or University of Pennsylvania employees will be present for the interview nor have access to the raw notes or interviews.
7. I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
8. I have been given a copy of this consent form.

**University of Pennsylvania**  
**Capstone Research Informed Consent Form**

\_\_\_\_\_  
NAME OF PARTICIPANT (Please Print)

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF RESEARCHER (Please Print)

\_\_\_\_\_  
SIGNATURE OF RESEARCHER

\_\_\_\_\_  
DATE

RESEARCHER TELEPHONE NUMBER: \_\_\_\_\_

APPENDIX C

CAPSTONE RESEARCH  
QUALITATIVE INTERVIEW QUESTIONS

EXECUTIVE COACHING WITH  
SENIOR HEALTHCARE LEADERS

## Executive Coaching Capstone Research

### Interview Questions

#### I. Background Information

- Tell me a little bit about yourself and your current leadership role.
  - In your role do you oversee a clinical or a nonclinical area?
  - What is the size of the team you manage
- Coaching Experience
  - How long ago did you complete coaching?
  - Walk me through how you got started with Executive Coaching.
    - *Probe:* What made you decide to participate in the program? Why?
    - *Probe:* What is your experience with executive coaching prior to the program

#### II. Goal Setting

*Let's walk through your coaching experience.*

- If you're willing to share, what were some of the areas you were looking to focus on as it relates to your leadership role?
- Did you have a 360 feedback process completed by your peers/team?
- How would you describe your experience with that process?
  - *Probe:* What did you learn from that experience?
  - *Probe:* What, if anything, would you have done differently because of that process?
- In your coaching engagement, what goals did you set out to meet?
  - *Probe:* Were they individual goals, team goals or organizational leadership goals?
- Looking back, how did you do meeting your goal(s)?
  - *Probe:* How did you specifically meet some of those goals?

#### III. Individual Impact

- Name a few examples of how you believe you have changed since your coaching experience?
  - *Probe:* Specifically in your current role?



- What were some behavior changes you made as a leader?
- How has your approach to problems and challenges changed, if at all?

#### **IV. Team Impact**

- What are ways your coaching experience changed how you relate/related to your team?

#### **V. Organizational Impact**

- How and in what ways did your coaching experience change or impact your work at the organizational level?

#### **VI. Barriers**

- What were the largest challenges you faced during your coaching experience?
  - *Probe:* What were some challenges you faced when trying to implement your goals?
  - *Probe:* How did you try to resolve these?

#### **VII. Sustaining Change**

- How have you been able to continue focusing on your goals since the coaching experience?
  - *Probe:* Different organizational structure? Change in process? etc.
- Specifically, what are some of the ways that coaching has helped sustain change?
- What has been difficult about this?

#### **VIII. Coaching Experience Satisfaction**

- Overall what was your satisfaction with your coaching experience (s)?
- MOST TO LEAST QUESTIONS
  - What was the most valuable thing you learned?
  - What was the least?

#### **IX. Conclusion**

- Is there anything you thought I would ask in this interview but didn't?
- Or anything I may have missed that you would like to add?