Global Competencies Meeting

Wednesday, January 15, 2014
2:00 p.m. – 5:30 p.m.
Recorder: Megan Angelini

Members Present:
Mr. Alterescu
Ms. Angelini
Dr. Borrell
Ms. Bowen
Mr. Rodriguez
Dr. Ribeiro
Dr. de Roodenbeke
Mr. Dobson
Mr. Evans
Ms. Hahn
Dr. Holder
Dr. Rice
Mr. Jones
Dr. Lastra
Dr. Lee
Dr. Loo
Dr. Miguel
Dr. Mitchell-Fearson
Dr. Narvaez
Ms. Nugent
Mr. Pereira
Mr. Racette

Absent:
N/A

Key Discussion Points:
The meeting was called to order at 2:00 p.m. Megan Angelini was assigned to take minutes.

Topic 1: Welcome and Introductions
  • Introductions were made around the room

Topic 2: Toward a Global Competency Model (presentation)
  • Some of the challenges over the next few days will be agreeing on the competencies for healthcare executives at all levels
  • Goals
    o Customization for countries and settings (common and specific). The goal is to pull core competencies out.
Focus on individuals (not teams)
Define healthcare management in countries where healthcare management is not currently recognized
Help associations promote and support healthcare management globally

- Current State: Healthcare roles are growing closer together (no longer as much differentiating between roles and responsibilities)
  - Healthcare Executives
  - Public Health Executives
  - Physician/Clinician Managers

- Current Competency Model
- Examples:
  - Canadian College
  - Australia
  - UK-NHS Leadership Model
  - MSH
  - French 3X3 Model
  - PAHO Public Health Model

- Outcomes from 2013 meeting:
  - 5 Domains with many subdomains
  - Expansion of the public health competencies
  - Lots of wording that needs to be made more global. We want to hear if the current wording would not work in your country.

- Phase 1: Sent directory out to experts around the world (84 successfully sent, 14 complete responses + 5 from group).
- Phase 2: After this meeting we will incorporate all responses and then pull out the global competencies from those that are specific to different countries.
- Also in the middle of creating a Charter document to guide the mission. The Charter’s goal is to create a way to encourage professionalism of healthcare management on a global level.
- Special Interest Group of the IHF- support international recognition of the healthcare management profession. Online tools and working to increase visibility of the profession.

- Goals of Jan 2014 Meeting
  - Review results of survey
  - Talk about competencies

- Questions:
  - I am wondering where we will end up and what we think this means. It is challenging to have one framework for the world. But it is good to have a start and eventually have different frameworks. To us it is more important that something is being used for leadership. We may lose diversity if there is just one framework. I would like to be more comfortable with the end goal- are we using one framework or multiple frameworks?
  - Building blocks are the critical things that we absolutely all do. After we have those, we will create the diversity and the flexibility to build what makes sense within each of our countries. We are doing this with the
recognition that that we can evolve this framework for each country. Here is a little context to help expression the vision of the group:

- ACHE gets asked a lot, from people all over the world, what we teach. Some of these areas include: how to improve health by improving leadership, how to create an exchange where we can learn from one another. In the U.S. public health is becoming more popular and we can learn from each other through a global exchange. We are all in a business with a calling— you choose to manage in healthcare because we want to improve health across the world. We need to explain where you start and how you get to the next level from a healthcare management career point of view.
- I agree with everything you said. And by clearly articulating the career of healthcare executives, we can clearly articulate what needs to be taught.
- In Jamaica, many times promotion results in moving up but without mastery of competencies. Having the ideas from this competency work will help us with our training. We have been having problems finding people who are competent. The business school wants to take it on as a business perspective but we are finding that you cannot just have social skills or just leadership skills. These competencies will pull this all together and we can form something that will be able to train CEOs and make a difference.
- In Chile we are working to determine what skills need to be developed by defining the profiles of competency within each position. We are trying to use a more systematic approach than in the past.
- We are about to transition from one administration to the next in our country. Along with this change, training healthcare professionals does not currently exist. We need to have collaboration in this initiative. This is perfectly in line with what we have set for ourselves in our country. There are distinctions between countries but also within countries (hospital, clinic, etc.) that need to be define for specific competencies. Eventually we need to strike a distinction between each of these types of healthcare settings.
- In Peru, we are trying to refine these competencies too. We have a network of healthcare providers within a fragmented system.
- I think it is worthwhile for us to understand the end model.
- I would like to suggest that we need to define the framework. We need a list of both global, setting (primary care, hospital, etc.), system (the development of the country), target population (School based or experienced managers), and skills (basic technique to the leadership).
- I want to come back to the framework question because it could be a major hurdle if we do not address it. And the wording of the
“English” words. Under the framework- perhaps we should say that we are working on a directory of competencies. What is important is that we have building blocks- agree on components that are critical to the big picture. The second thing that we should be able to have an agreement on is the key principles of how to put together a competency framework. What is important is that the substance is there and there is a global agreement that these are the core competencies. We have to really work on consensus building-build on what we have in common and the elements that can build up consensus as we move forward.

- To create this document we lined up all of the various models and made a big grid to identify similarities and gaps across the models. We started with the model we use in the U.S. because we know this approach (we create our competencies by surveying people on the job- tactical skills, decision making skills, etc.) When we did this we found both similarities and gaps. In the U.S. we have lots of different sizes and types of organizations. But what we have found is that there are still core things that define needed competencies. The challenge will be to think about similarities (easy to think about differences) and we may come up with more questions than we can discuss.

- Response- I agree and think it’ll be important to start with consensus building because we need to get to the core competencies. We can acknowledge when there is a difference and then come back to these at the end of the meeting.

- What we want to come out of this is the core regardless of where you are practicing and then use competencies to develop job descriptions. And then we can build the specialty (specific to each country) competencies into the framework.

- An additional thought- We need to keep in mind the ultimate customer of the product and provide a usable framework. One of the disciplines in this is to recognize all of the differences, but what really matters is making sure all of our customers have a product that can help advance healthcare management throughout the world. Do not want to overwhelm the customer.

- And the real value of this framework is to assess needs and then learn from those needs. Start with a physician who has very little training and determine where that person starts with trying to obtain the necessary skill set to manage effectively.

- IHF has been working with managers in Dubai and asked each participant to grade how much each of these competencies are useful for their job and how competent they are at each. This exercise shows the managers where they need to improve, which can be a very powerful tool to build up capacity and build-up management and leadership.
Topic 3: Background and Purpose-Review of Executive Summary of Jan. 2013 Meeting

- We are going to have a chance to talk more about the charter. If you have questions about what we did last time. But we are going to have more time to talk about the IHF involvement.

Topic 4: Goals for the Rest of the Meeting

- Goals
  - Review the Global Competency Directory survey results from Nov-December and refine the directory
  - Review the process from the phase 2 validation of the directory refine and adopt the charter
  - Develop a plan for promoting the Directory
  - Discuss the process for sharing best practices

Topic 5: Review of Draft Global Competency Directory/Validation Process and Feedback to Data

Original Thought: We are talking about basic skills that someone would need within your country.

- Someone who has been in healthcare management for 5 years or less
- Trying to get to the CORE body of knowledge that you must have
- We will then build from there to more advanced levels
- New to the field of management but may not be “young”
- Determinants ACHE use: early (just out of school or making a change in career), mid (about 10 years of experience) and senior careerist (more experienced) (in our context).
- Absolutely essential compared to aspirational → idea here is not to build the nice to have (a-z) but rather trying to make some judgment calls about absolutely need to know.

Generic Comments

- Having a hard time answering questions because each piece of the directory is repeated somewhere else and it is not really a list of competencies but rather more knowledge centered.
- In Latin American countries- about half of the document applies
- Lifelong learning and other things really come under leadership- example
- 1A7- not necessarily applicable in African context, nursing context
- “Physicians and other allied professional groups” because these associations are the negotiating groups. If they feel excluded it causes many problems. Make as inclusive as possible. Stakeholder engagement is the key
- It appears we need to be less concerned with the “who” and more concern about the required methods.
Comment about “leadership skills and behaviors” in Asian countries it is not as much about what the leaders know but rather how they behave. Not evaluating the “knowledge” because more focused on the behavior.

Concern with directory: competencies have to do with the ability to do and not as much about having the knowledge.

Some leadership models assume that knowledge is very important, but more important is the ability to scan the environment and then take action. Agree that we shouldn’t identify knowledge as this or that, but the ability to scan should show up. 1A1 and 1A2 (knowledge).

I have determined that we do not have the competencies within this directory. The basic building block for someone coming into the field is the knowledge. And then they build on that knowledge and on how to apply the knowledge. And then as an executive you build on that. For competencies, we cannot use knowledge as the measure because it doesn’t show the ability to do anything.

At ACHE for our test (FACHE), we define competency as the knowledge, skills and abilities because we cannot test how well someone does something, but we can test if they have the knowledge.

My idea is that we should define the model of competencies and not build upon knowledge. First the theory and then the practice. I think we should move consistently towards the competency model because if you put knowledge here you are breaking the whole competency model. Competency is the capacity to be a manager.

One thing that we might be able to do is take the knowledge statements and make them into actions. This will allow us to work with the wording without losing the content.

We are looking at what we think is necessary to do the job of a healthcare manager. In our world (U.S.)- this is a test. If you want to carry a credential, you have to pass a test. This may not work in what we are talking about and that is ok.

In my view, the competency is the task. To the extent that you continue to improve, the level of performance changes. The task may be the same. For example- junior cannot anticipate problems. A competent manager does it well. What we need to state here- build on what is already there. Give it the characteristics that specific that is a CEO. Nobody is going to read a document that is so long. But I don’t think I see a definition of a CEO. So we can reach the core- we need to know what a CEO does. This is what a manager does since the beginning.

We might be speaking about different things here. We need to identify what we need to achieve. The first key thing we have been trying to do is precisely identify the competencies we think are essential as a healthcare manager. We were able to
come up with 4 very basic and common competencies. These include the ability to scan the environment, focus on the essentials, align and mobilize others, and be able to inspire others. (Much more summarized.) Then you have in practice-competency in management (beginner to manager) and then third thing you have the ability to teach. We built upon the capacity model framework, the different levels of a healthcare management position and then how to educate.

- Let’s look at it from a different perspective. What do I need to have or know to become a manager? If I look at this document- I need to have the 5 big bucket competencies. And then being a novice I look at how I learn more about these competencies. These statements define what leads to the competency. The competency is leadership and if I want to plot a path to this competencies, then I need to look at these individual sentences. I did not consider each statement as a competency but rather what leads to being competent.

- This clarifies things. I think there are different needs that different managers might have. So the challenge here is to put together a competency assessment that doesn’t relate so much to knowledge but rather how to put knowledge into action. How to develop a career and a study program, what are the necessary competencies that must be taught in this field of study? That is the challenge- it has been fully fleshed out and developed and that is why we tend to fall back to knowledge. But we need to look at competency. The knowledge was just the pre-requisite, but it is necessary to develop the competency. We need to tease out necessary performance to ascertain the final capabilities that his or her employees have in terms of being good performers.

- I have an idea that I would like to throw out there- I agree that it seems like we are talking about a lot of different aspects all at the same time. Maybe it would be helpful to talk about the process of how you become a leader. It’s this kind of knowledge that you start with (preparation) and then as you progress you start out with this short list of things that you do. And then as you advance in your career- you grow in complexity of the ability. (Performance and how you demonstrate abilities). Maybe we need to think more about the whole paradigm.

- From where I sit- we need to understand if there is any preparation of what you need in terms of knowledge and the jobs that you need to enter the field of healthcare management.

- Need to know the knowledge and skills that someone in a healthcare profession needs and then identify how to apply. We need to focus on the end competencies and the end skills of our leaders. We can continue with a competencies, abilities framework.

New Idea: We may need to define two documents: one with core competencies (leadership, business, etc.), and then a directory document which can serve as a defining tool of what is needed for those competencies.
• Let’s start with what a competent manager looks like- profile of expertise.
• This allows us to pick out what a competent manager looks like and forget about
  the prep and go right to the outcomes.
• We can look at the Directory as training programs, assessments, promotions, and
  how to mentor the career of a healthcare manager.
• Need to spend some time on the competencies and then spend some time on how
  you acquire these competencies.
• In Brazil- the way we build the profession is that the person goes to school and
  then goes the hospital to practice. The knowledge is the base and then practice
  how to be a competent manager by doing the skills. This is the difference between
  pre-service and in-service training; and adult learning (how you get there).

Decision for tomorrow’s group work: If we don’t first define core competencies then we
cannot have this discussion. My recommendation is for tomorrow we focus on the core
competencies. Determine what stays and what goes. Boil down to core competencies.
Others can be eliminated because they are not really competencies at all.
• What I heard is that we want to focus on the requirements of being a competent
  manager.
• Focus on competencies that are action oriented (not just knowledge and skills).
• Focus on the competent manager (not just a beginner but also not necessarily a
  CEO)