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AUPHA is a global network of colleges, universities, faculty, individuals and organizations dedicated to improving health outcomes by promoting excellence in healthcare management education. AUPHA fosters excellence and innovation in healthcare management education, research and practice by providing opportunities for member programs to learn from each other, by influencing practice, and by promoting the value of healthcare management education. It is the only non-profit entity of its kind that works to improve the delivery of health services - and thus the health of citizens - throughout the world by educating professional managers at the entry level. AUPHA’s membership includes the premier Baccalaureate and Masters degree programs in Health Administration Education in the United States and Canada. Its faculty and individual members represent more than 500 colleges and universities. In addition, a large number of health care institutions, hospitals and other health services delivery organizations and associations worldwide participate in, and benefit from, the network and services of AUPHA.

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Critical Decision Points in Designing Inter-Professional Education
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This issue of the Journal follows the Annual Meeting of the Association of University Programs in Health Administration which focused on important matters associated with exploring how we teach what we teach. The sessions covered a variety of topics spanning the gamut of educational levels from undergraduate to doctoral and having implications for how we serve our local markets as well as our need for a global vision for our programs. The Association enjoyed its first year using the newly organized Networks for facilitating the work of the organization. The Editorial Board of the Journal recognizes the value of these Networks and proposes that the Journal serve as an additional outlet for their work. The Board voted to encourage Networks to develop a topic for a themed issue of the Journal. Several members of a Network may propose a theme and purpose statement for an issue, and then identify up to four or five article titles to be developed under that theme. The articles eventually submitted would be subject to the normal review process of the Journal and would appear in a regularly edited issue of the Journal. The organizers of the theme would be credited for their work in organizing the purpose for that issue and for soliciting authors for the articles. We are excited about this new undertaking and encourage Network chairs to work with us on this initiative.

The ability of ACEHSA/CAHME accredited programs to provide adequate numbers of qualified leaders for complex healthcare systems has been questioned (Warden & Griffith, 2001) as has the process of accreditation itself (Griffith, 2009). The lead article in this issue of the Journal by Garman, Goebel, Gentry, Butler, and Fine (2010) suggests that there is value in the educational experience provided through accredited programs during the
1970-1991 time period. The authors identified the educational backgrounds of the senior executive for the 173 hospitals identified as America’s best hospitals in 2007 by the U.S. News & World Report. They found that “health services management programs generally, and ACEHSA/CAHME accredited programs in particular, were significantly overrepresented among” senior executives (Garman et al., 2010, p. 95). It is worth noting that about half of these hospitals were lead by ACEHSA/CAHME accredited program graduates. While we need to look continuously for improvements in our educational processes and debate current practices in our health administration programs, it is worth noting that alumni competed successfully for these prestigious positions.

International business activity has increased over the last half of the twentieth century as trade barriers have been reduced, electronic communications have increased, and as many countries have liberalized the movement of capital across national boundaries. Business schools have recognized the transition and responded by incorporating international business education in their curricula. More recently we have witnessed increased interest in international health and global health as health problems have transcended national boundaries (Brown, Cueto, and Fee, 2006) and issues such as medical tourism (Lagace, 2007) have become part of our normal lexicon. The debates on healthcare reform also have forced Americans to examine healthcare organization and delivery in other countries. A recent article (Aaronson, Counte, and Ramirez, 2008) recommended that global health receive greater attention in healthcare management education programs with a global experience a required learning experience for students. In this Teaching Tip and Tool Nolin, Daly, Haley, and Zhao (2010) provide a comprehensive overview of the University of North Florida’s international experience in organizing a broad cooperative program in teaching and research with Shandong University in China. They describe the overall program goals as well as important details about a study abroad course they organized under the agreement. The authors share the pre-planning activities for the educational experience, the course learning objectives, educational activities in the U.S. prior to the trip, the experiences that occurred in China, and the lessons they learned from the experience. Nolin and her colleagues share an important template others might consider when organizing an international healthcare experience for their students.

In another article, authors Walston and Khaliq (2010) examine hospital CEOs views regarding continuing education (CE) and the extent to which they acknowledge their participation in different types of CE activities. Continuing education (CE) for professionals is based on an underlying
assumption continuously engage in ongoing appropriate learning activities of order to maintain a minimum level of competency for required of practice. is based on the notion that one must. The reasons for seeking CE are varied. Although most professional groups within healthcare fields require at least some minimum level of CE for continued licensure and re-certification, there is no formal requirement that healthcare management executives obtain CE. However, based on the analysis of data from a nationally representative survey of hospital CEOs (n=582) Walston and Khaliq found that a majority of hospital CEOs viewed CE as being increasingly important and on average, obtained about 45 hours of CE each year. The authors’ findings also indicate that hospital CEOs primary reasons for seeking CE were to understand the changes occurring within the field, to stay current with new developments, and as a way to solve problems. This article introduces a rather new but important topical issue for our readership and our hope is that it will generate additional discussion regarding the potential role healthcare management education programs might have in this life-long learning process. Our sense is that healthcare management faculty, given their different areas of expertise, would find a variety of issues concerning CE for healthcare executives to be interesting and rewarding areas for research. It is important that additional research be conducted to examine the role of CE within healthcare management and whether or not it represents a valid, career-spanning, professional developmental strategy that enables healthcare executives to acquire additional knowledge and skills to perform effectively. This research could address issues including, for example: executives’ specific educational needs and interests; current information seeking behaviors used by executive to stay current; evaluative frameworks for assessing how CE affects transfer of knowledge and behavior change; the extent to which CE content is evidence-based and free from bias; and what approaches are best-suited to provide CE programs.

Hospitals and other healthcare facilities exist to meet the healthcare needs of the communities in which they are located. Many healthcare organizations (HCOs) have mission statements that convey an intent to promote wellness and improve the overall health of individuals and communities they serve by providing safe, effective, and high quality services. Olden and Friedman (2010) point out that the facilities and practices used in care delivery processes are often environmentally unsafe and actually may be harmful to individuals and communities. Ironically, as noted by the authors, the healthcare industry, for various unspecified reasons, has been slower than other industries in adopting environmentally-sound or green management practices. However, when HCOs use sustainable, eco-
friendly green delivery approaches they are likely to derive numerous social and economic benefits. Olden and Friedman argue quite convincingly that students must acquire new knowledge, skills and attitudes (competencies) that are required for managing green, pro-environment HCOs. The authors of this Teaching Tips & Tools piece provide several valuable strategies that faculty could use for integrating green issues into existing healthcare management curricula. Our hunch is that while most healthcare management programs do not currently offer specific courses that emphasize (or perhaps even address) environmental issues and topics, we are likely to see an increased demand for such content in the near future.

Authors Howard, Ryan, Eudy, Mosser, and Boyd (2010) remind us in this issue’s other Teaching Tips & Tools that the complexity of a modern healthcare organization demands a management approach that fully considers the various perspectives of different professionals who work within the organization. Many healthcare organization behavior/organization theory and human resource management courses generally include some content to at least expose students to the management challenges that their graduates will encounter once they begin working in healthcare organizations and with different types of professionals and provider groups. Although this type of brief exposure may alert students to the kinds of future challenges they might expect, it is not likely to provide the in-depth understanding required for making fully-informed management decisions. Howard and her colleagues describe different inter-professional courses that have been taught at three universities. Each course requires active participation of students from different disciplines (e.g., medicine, nursing, laboratory science, pharmacy, healthcare administration) and is intended to foster inter-disciplinary communication and a genuine understanding of how individuals from different professions can work collectively to improve healthcare delivery. The authors provide the reader with a concise organizational overview for each course and offer suggestions for implementing an inter-professional course within a healthcare management curriculum. Although formal outcome evaluation data were not provided, it is reasonable to expect that inter-professional courses similar to the ones described by the authors would help students develop a collaborative competency that is necessary to manage effectively in most healthcare organizations.

Over the past three years it has been our honor and pleasure to work with you as editors of the Journal and to observe how responsive you have been to our efforts to enhance the value of the Journal. We hope that you have found the new features and the quality of the articles helpful in your professional activities. Implementation of electronic manuscript handling
through AllenTrack has streamlined many of the editorial processes that were burdensome in the past. Most importantly, your efforts as reviewers and authors have made these advances possible. We hope that the Journal will continue to improve over the coming years.

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Healthcare Leadership ‘Outliers’: An Analysis of Senior Administrators from the Top U.S. Hospitals

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Abstract

Research on top performers across a variety of fields suggests that the strongest predictors of pinnacle attainment are (1) the availability of opportunities early in one’s career as well as (2) the cumulative effects of much greater-than-average practice. The present study assesses these factors as they relate to the attainment of top healthcare leadership positions. We defined our sample as the chief administrative officers for hospitals ranked in the 2007 U.S. News & World Report Best Hospitals list as our sample. Educational backgrounds were determined through assistance from Witt-Kieffer, an executive search firm with an extensive database of executive profiles, which was supplemented by web searches and telephone contacts to ensure data integrity and currency. Staff of the Commission on Accreditation of Healthcare Management Education (CAHME) verified whether the MHA/equivalent programs were accredited at the time the individuals graduated by cross-checking against historical records. An aggregate estimate of degree prevalence was used to assess the extent to which academic background appeared to have stronger-than-expected prevalence on the list. Results suggest that representation among the top executives was associated with (1) having a master’s degree in administration; (2) the degree being an MHA/equivalent; and (3) the degree being from a CAHME-accredited program. The implications of the results are discussed in relation to views of health administration as a profession as well as the accreditation of professional graduate degree programs.

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INTRODUCTION

In the book, *Outliers*, author Malcolm Gladwell summarizes several intriguing streams of research on the influence that talent, early opportunities, and sheer volume of practice have on who will eventually become the most successful in their careers (Gladwell, 2008). Citing examples as diverse as hockey leagues, software engineering, flight safety, and the turn-of-the-century garment industry, he concludes that outstanding success in any field requires a combination of all three. This conclusion has interesting implications for professional fields in general, and health administration in particular, where each of these elements may hold specific implications for the eventual pathways to success.

In the present study, we sought to provide some exploratory analyses of the ‘outliers’—individuals who have achieved unusual levels of success—in healthcare management. We accomplish this by focusing on a single, high-profile group: individuals identified as the top-level administrator for each of the nationally ranked hospitals identified in 2007 by *U. S. News & World Report*. To place these results in some context, we will first provide a high-level overview of variables we examined.

TALENT VS. PRACTICE

Throughout history, virtuoso performance, like leadership, was often attributed to gifts people were born with. More recently, the role of innate talent has come into question. Research examining the relative effects of talent and practice suggest that it is the latter more so than the former that most reliably predicts who emerges at the top of their field (Ericsson, Krampe, & Tesch-Romer, 1993). In summarizing this research, Gladwell (2008) described the 10,000 hour rule—i.e., that expert performance typically required 10,000 hours of additional practice in the areas most closely associated with that expertise. He provides further support for this notion by analyzing the educational backgrounds of Nobel Prize winners. Through this analysis, he vividly demonstrates that attending the most competitive schools provides no apparent special advantage to receiving this top honor. Indeed, prize winners are as likely to come from less competitive state schools as from the ivy league.

EDUCATIONAL PREPARATION

Assuming this pattern holds true for healthcare management as well, it would imply that students are not necessarily advantaged by their academic pedigrees in pursuing the top leadership roles in the field, but rather by the practice opportunities their education affords them.
Leadership positions in healthcare are often considered to be a highly specialized subset of the broader management area and, as such, many of the broader debates about management education (e.g. Bennis & O'Toole, 2005; Pfeffer & Fong, 2003) have also been applied to healthcare management education. Indeed, although graduate education is generally recognized as important for success in healthcare management careers, there has been considerable divergence of opinion in terms of which type of graduate program provides the best preparation. The entry in the U.S. Bureau of Labor Statistics’ Occupational Outlook Handbook (2006) is particularly telling: on the one hand it states that “A master’s degree is the standard credential” for these jobs; on the other, it provides no guidance as to a specific type of degree program, suggesting instead that the master’s degree could be in “…health services administration, long-term care administration, health sciences, public health, public administration, or business administration” (U.S. Bureau of Labor Statistics, 2008, 1). This heterogeneity of degree programs is also reflected in the accreditation of graduate healthcare management programs. Accreditation by the Commission on Accreditation of Healthcare Management Education (CAHME) is based on the nature of the masters program itself rather than the title of the degree; their list of accredited programs include a breadth of degree titles including MHA, MBA, MHSA, MS-HSM, MPH, MSPH, and MSPHM (CAHME, 2010).

ACCREDITATION AS A PROXY FOR PRACTICE
In the United States, most professions requiring higher education also have a profession-specific accreditation process for ensuring the quality of these programs. Accreditation is generally designed to serve the public interest, by promoting accountability as well as providing a mechanism for protection against fraud and abuse (Schray, 2006). Masters-level healthcare management programs have had a formal accreditation process since 1968, under the Accrediting Commission on Education for Health Services Administration (ACEHSA). In 2004, a Blue Ribbon task force was appointed to evaluate the accreditation process in response to the substantial changes and challenges the field was beginning to face. From this process ACEHSA evolved into its current structure as the Commission on Accreditation of Healthcare Management Education (CAHME), which is currently the sole organization formally recognized for this purpose in the United States and Canada (CAHME, 2008).

Throughout its history, the ACEHSA and CAHME accreditations have distinguished the programs bearing their designation in ways that are relevant to our study. Foremost among these is the emphasis they place
on ensuring that students have meaningful experiences applying their knowledge in real-world settings. Many accredited programs have strongly encouraged or required students to complete summer internships and/or an administrative fellowship, an intensive period of work under the supervision of senior leaders. Students completing these fellowships early in their careers distinguish themselves from their peers through this opportunity to develop “…an internal compass they can carry with them to their professional roles,” (Garman, Butler, & Brinkmeyer, 2006, 361). Such experiences appear to fit the Gladwell model of expert-relevant practice.

Methods

Ranked hospitals were identified using the online database provided by *U.S. News & World Report* (2007). The list, compiled annually as a guide for healthcare consumers, uses a combination of quality and reputation data to rank hospitals in 16 specialty areas (for a full overview of methods, see McFarlane, Murphy, Olmsted, Droz, & Hill, 2007). The 173 hospitals that received a national ranking in at least one specialty area represent a little over 3% of the 5,462 hospitals analyzed in their study.

For each of the 173 hospitals, the name of the senior administrator was identified from the *U.S. News* online database. Educational backgrounds of the administrators were then determined using a multi-method approach. The educational profiles of the majority of administrators were identified with the support of research assistants provided by Witt/Kieffer, the leading privately-held search firm for senior-level healthcare executives (Modern Healthcare, 2007). For individuals who were not represented in the Witt-Kieffer database, we identified educational backgrounds through a combination of phone contacts with the administrative offices of the hospitals, professional association database searches, and web searches.

Twenty of the administrators (12%) held more than one graduate degree, including three with PhDs. Given the small number of these cases, rather than developing a separate category for PhDs we categorized these administrators according to their masters or clinical degrees. Twelve of the remaining 17 administrators held either a clinical or an administrative degree as one of their graduate degrees, and we used this for their categorization. In cases where an administrator held a dual degree which included a healthcare administration degree (e.g. an MHA/MBA), they were categorized according to the healthcare administration degree. The remaining five administrators (3% of the total) held both clinical and administrative degrees; these five were categorized according to their administrative degree.

Once educational credentials had been identified for all administrators, a project assistant at the CAHME offices vetted terminal degrees against
historical accreditation records. If the program from which the terminal degree was earned was listed in the historical records as accredited at the time of the administrator’s graduation date, then the administrator was categorized as having graduated from an accredited program.

To determine an ‘expected’ composition of educational degrees among the administrator group, relative base rates of the leading degrees in the sample (health administration, MBA, and MD) were estimated by reviewing Digest of Annual Statistics reports from the National Center for Education Statistics (NCES), Institute of Education Sciences, US Department of Education. The Digest provides an annual report of graduates of programs at various levels from major disciplines (Digest of Education Statistics, 2008). These data were compiled from the reports for each year beginning in 1970 and ending in 1991, representing the period spanning the first and ninth deciles of the graduation years of the sample. (We analyzed this period rather than the full range of graduation dates to control for the effect of statistical outliers in the data; additionally, since accreditation of graduate health administration programs did not exist prior to 1970, the period before this year would be less meaningful in terms of the research questions of interest.)

The final step in our data preparation involved estimating the base rate of graduates from accredited health administration graduate programs, as a function of total graduate health administration graduates. Since we were unable to identify any repository or analysis of historical data that would allow us to straightforwardly estimate the breakdown of graduates from accredited vs. non-accredited programs, we constructed the estimate using program descriptions from Peterson’s Guide to Graduate Programs in Business, Education, Health & Law, an annual publication that is widely regarded as an authoritative guide for graduate education in the United States (U.S. Department of State, 2008). Analysis proceeded as follows: First, sections of Peterson’s Guide pertaining to graduate health administration programs were obtained from each of three intervals during the study period (1976, 1984, and 1988). Next, all master’s level graduate programs described in each guide were coded as either accredited or non-accredited, and total counts for each category were calculated. A linear regression model was then created to extrapolate these data points to create trend estimates for the in-between years.

Results

Figure 1 graphically represents the composition of healthcare administrators from the nationally ranked hospitals, according to the graduate degrees they held. As this figure illustrates, the largest proportion of administrators
(49%) were from programs that were accredited as health services management graduate degree programs. The MD was the second most frequently held degree among the group, comprising 18% of the total. Graduates of non-CAHME accredited MBA and MHA programs comprised a relatively small proportion of the total (5% and 3%, respectively), as did other health-related professions (3%). Another 3% of the total did not have graduate degrees. The remaining 18% were categorized “other,” which included degrees in areas such as special education, law, political science, liberal arts, urban planning, and (non-CAHME-accredited) public health/public administration.

If we assume that type of graduate education has no effect on career attainment for the sample at hand, then we would expect the composition of Figure 1 to reflect the distribution of the total population of graduate degree holders in the United States. So, for comparison purposes, Figure 2 graphically represents the base rate of graduate degrees conferred in the United States during the period under study, in the categories most frequently represented by the educational backgrounds of the administrators under study. As these graphs illustrate, business masters degrees represented the largest number of total degrees granted across the major disciplines analyzed, comprising 76% of the total administrative degrees and 55% of all degrees under study. Public administration and social services comprised
the next largest grouping, with 21% of the total for administrative-only and 15% for administrative and health sciences degrees. The MD degree comprised 14% of the total, and master’s-level health sciences degrees
comprised 13% of the total. Health services administration, in contrast, accounted for just 3% of the administrative degrees awarded, and less than 2% of total degrees awarded.

Our final analysis compares the proportion of graduates of CAHME-accredited programs to those of non-accredited healthcare management programs, as extrapolated from the Peterson’s Guide reviews described in the methods section. Results of this review are shown in Figure 3. Extrapolating from this review across the period of the study, we estimated that 37% of alumni with these degrees graduated from accredited programs, versus 63% from unaccredited programs. Once again, this contrasted sharply with the U.S. News sample, in which 95% of the administrators who had masters of healthcare management degrees were from CAHME-accredited programs, and 5% from unaccredited programs.

In summary, it appears that there is an association between graduate education and composition of the administrators under study. The strongest effect for degree type appears to be associated with health services management degree programs; although they comprised only 2% of the degrees in the underlying distribution, they represented 52% of the administrators in the sample. A Chi-square analysis of this effect yields a $X^2$ of 11.33 ($p < .001$). In comparison to the effect for degree type, the effect for CAHME ac-
creditation was even stronger; our estimates suggested that approximately 37% of health services management graduates during the study period were from CAHME-accredited programs, but comprised more than 95% of the administrators who held health services management degrees ($X^2 = 144.3, p < .001$). Finally, a positive association was also found for the MD degree, with 14% of the degrees awarded but representing 18% of the administrator group; however this result did not reach statistical significance ($X^2 = 1.19, p = .28$).

**Discussion**

The goal of our study was to examine the extent to which educational background and early career opportunities had an association with the attainment of top administration positions in leading hospitals. If there truly were no effects, then the leadership of the *U.S. News*–ranked hospitals should have represented, at least roughly, the broader population of degree graduates from which these leaders were drawn. The data we analyzed suggested that education did have an association, in that graduates from health services management programs generally, and ACEHSA/CAHME accredited programs in particular, were significantly overrepresented among this group of healthcare leaders. The sizes of the associations found in this study are compelling. In terms of degree program, at the population level, graduates of healthcare management programs represented less than 3% of the administrative master’s degree graduates for the study period, but comprised 49% of those who became the top administrator in one of the ranked hospitals, producing an overall advantage better than 16:1 for graduates of these programs. In terms of graduates from CAHME accredited programs, our estimates suggested an even more pronounced effect—as much as 80:1—favoring graduates of healthcare management programs with vs. without this accreditation.

Although the strength of these associations is compelling, they also raise important additional questions about these career pathways. Of particular note is the potential role of administrative fellowships, which can offer their participants greater relative access to the experience and perspectives of senior executives at a formative early career stage, as well as mentoring opportunities and a substantial jump-start on one’s professional network. It is conceivable that a properly structured post-graduate practicum, six to twelve months in duration, may have as much to do with ultimate career success as the preceding didactic experience. Some key questions which were beyond the scope of the present study include: are the senior leaders of top-ranked hospitals more likely to have fellowships in their history?
If so, in what types of settings, for what lengths of time, and with what kinds of operating models? Another set of influential factors might be the pre-graduate school life experiences of the study population, including post-baccalaureate years of employment and/or such diverse leadership opportunities as team captaincies, student government positions, and club/fraternity/sorority officerships. For this particular cohort of CEOs, another common life experience prior to graduate school might be the draft-era military.

Although more detail on career pathways could have enriched the results considerably, a more fundamental concern stems from the absence of more basic demographic data concerning the extent to which these leaders ‘looked like’ the pools from which they were drawn. There is a well-documented lack of diversity among healthcare CEOs (e.g. American College of Healthcare Executives, 2006, 2008; Garman & Tyler, 2004, 2006); it would be useful to know the extent to which demographics is associated with preferential treatment and/or better access to key social networks and, in turn, career trajectories.

These limitations notwithstanding, it remains clear that for these types of roles, graduate education in health services management matters, and CAHME accreditation matters even more. If we can assume that individuals are called to healthcare management in part due to their talents and in part due to early career interests, then it appears that Gladwell’s (2008) outliers model holds explanatory power for the field of healthcare management as well.

References


Cultivating an International Academic Relationship: The China Experience

JoAnn Nolin, JD, Mary Ann Daly, MHA, LCSW, D. Rob Haley, PhD, & Mei Zhao, PhD

Abstract
An increasingly global economy is driving the need to understand cultural differences that impact social, political, and business interactions. Recognition of the need for a more global perspective is evident in the design and delivery of increasing numbers of university-based study abroad programs which provide students the opportunity to study health and health systems around the world. This article chronicles the efforts by the University of North Florida’s (UNF) health administration faculty to provide study abroad opportunities for graduate and undergraduate students while developing academic relationships with faculty at several universities in China. Discussions of the planning, course objectives, travel, and student reflections of the experience are provided along with lessons learned by program faculty. Efforts to build academic relationships with faculty members at Shandong University’s Center for Health Management and Policy (CHMP) in Jinan, China resulted in transformational learning opportunities for UNF students, a collaborative research project, and the foundation for an active and productive international study program.

Introduction
The American education system has not traditionally put a strong emphasis on foreign languages or education that prepares students as global citizens (Altbach, 2004; Loveland, 2007). An increasingly global economy is driving
interest in understanding cultural differences that impact the social, political, and business interactions between countries. University based study abroad programs are seen as opportunities to introduce students to a global perspective relative to a specific area of study (Curran, 2007; Dekaney, 2008; Knight, 2006; McLaughlin, Tzafaras, & McCollough, 2008; Moreno-Lopez, Saenz-de-Tejada, & Smith, 2008). These programs enhance student learning by providing first-hand experience of cultures that are very different from their own. They foster critical thinking by encouraging students to identify similar and divergent issues as well as to critically assess public policy. Study abroad programs also allow the opportunity for development of collaborative relationships with faculty and government officials in the visiting country. These relationships provide the added value of developing faculty competency related to global issues. Ongoing faculty and student exchange programs and collaborative research projects can and should arise from cultivation of these important relationships.

With the move toward a more global economy, it is essential for students from American as well as international universities to participate in learning experiences that provide exposure to the cultures and people impacted by a growing economic interdependence between nations. Recognition of the need for greater focus on international issues has produced increased participation by universities in design and delivery of study abroad programs in recent years. These programs allow students and faculty the opportunity to gain an understanding of the relationships between individuals and their environments that are often very different from their own. Additionally, students participating in international learning experiences gain a broader perspective from which to explore international career options (Dolby, 2005; Norris & Gillespie, 2009; Rapoport, 2007; Thomas, 2006).

As telemedicine and medical tourism emerge as cost-effective health service options, a global understanding of the healthcare industry is becoming increasingly important for students who aspire to leadership roles as health administrators (Forgione & Smith, 2007; Milstein & Smith, 2006; Schroth & Khawaja, 2007). To remain relevant in this evolving marketplace, health administration programs must provide opportunities for students to explore how the issues of culture, diversity, and communication impact the provision of services. Health administration faculty must also understand the impact of culture on health industry challenges in this new marketplace as they prepare students for the cultural transformations occurring within the field (Coyne, McLaughlin, & Cantoni, 2007). This paper chronicles the University of North Florida Health Administration Program’s initiative to develop a collaborative relationship with Shandong University’s Center for
Health Management and Policy (Jinan, China) and the resulting transformational learning experience for its students and faculty.

**BACKGROUND**

The University of North Florida (UNF) is a comprehensive urban university with an enrollment of approximately 15,500 undergraduate and graduate students within seven colleges located in Jacksonville, Florida. An important component of UNF’s mission is to include instruction and educational experiences which allow students to gain a global perspective. Offering students international experiences through study abroad programs contributes to the realization of that goal and provides faculty with opportunities to develop collaborative research opportunities with professors from international universities. The faculty of UNF’s Health Administration Programs, located in the Brooks College of Health (BCH), recognized the importance of exposing students to the magnitude of global issues and the global nature of many enterprises as part of both undergraduate and graduate education. The development of international study opportunities followed as a logical adjunct to curriculum focus in this area.

In 2000 UNF’s Health Administration Programs began offering students opportunities for international travel for the purpose of studying health systems in other countries. Prior to that time, study abroad opportunities were available through other programs within the university but none were offered that focused specifically on the study of health services administration or health systems. Working in conjunction with an established study abroad program offered by the University’s nursing program, health administration faculty and students traveled to Paris and to the Republic of Ireland and Northern Ireland to examine the health systems and health delivery practices in those areas. In 2004 the Program added a new Chinese faculty member and we began discussions on the possibility of establishing a collaborative education and research program with Shandong University’s Center for Health Management and Policy in Jinan, China.

Shandong University, founded in 1901, is one of the oldest and most influential universities in China. It has three campuses, all located in Jinan, which is the capital city of the Shandong Providence. Shandong University has 30 colleges with 9 major disciplines and an approximate enrollment of 90,000 students. UNF’s faculty member, a graduate of Shandong University, initiated conversations with the faculty and administration at the University’s Center for Health Management and Policy (CHMP) in regard to establishing a collaborative relationship with the CHMP.
In the fall of 2005 a delegation of senior academic faculty and administrators from UNF traveled to Jinan to meet with the faculty at Shandong University. This group included the Dean of the Brooks College of Health, the Director of the UNF International Center, the Vice President of International Studies, and a member of the Health Administration Program faculty. Strategic planning meetings were held to explore potential collaborative projects in the areas of teaching and research. Proposed development of an educational and research relationship between the Program at UNF and CHMP at Shandong University met with mutual approval.

Following the delegation’s visit, faculty of both programs agreed to work together to plan an initial study abroad program that would bring faculty and graduate students from UNF to Jinan in the spring of 2006. Letters of agreement were exchanged between the Universities detailing the interest and intent to collaborate on educational and research activity. The host university also committed to making arrangements for visits with health facilities, scheduling educational sessions with Shandong faculty and students, and to provide interpreters and transportation for those events. They also hosted a dinner for the UNF contingent.

All other travel, lodging, and meals were the responsibility of UNF faculty and students. Cost per individual for the trip was approximately $2,200. This initial educational offering was limited to graduate students, as Shandong University offers only graduate and doctoral programs in health management and policy. Priority admission was given to MHA students. However two openings were designated for students from other programs.

The selection of China, and specifically Shandong University, for a graduate study abroad program was influenced by the obvious connections available through the UNF program’s Chinese faculty member. Other factors influencing this choice were the similarities in challenges facing both China and the United States in delivery of care to large, economically, and culturally diverse populations. China’s current health system, which evolved during the county’s move from a centralized to a market-based economy, created enormous problems in the delivery and payment for healthcare. The lack of insurance programs and drastically decreased financial support from the central government meant that even basic healthcare became out of reach for a majority of the population. Efforts since that time to address health coverage include expansion of insurance programs for government workers, and development of new initiatives to subsidize healthcare for the rural population that once had access to free basic health services (Haley, Zhao, Nolin, Dunning, & Sun, 2008; Yip, 2008). At the same time, China and
the U.S. are both struggling with rapidly aging populations that are creating additional burdens on health systems unable to meet current demands. The selection of China for a study abroad program was seen as a unique opportunity to explore efforts by the Chinese health system to address some of the same critical issues facing the U.S. health system.

**Study Abroad**

In March 2006, the UNF Health Administration Program offered its first study abroad course that focused on the Chinese healthcare system. The course included a series of pre-visit meetings, lectures, and course study assignments followed by a 10-day visit to Jinan, China. Hosted by Shandong University, the visit included meetings with faculty and students at the university and visits to area hospitals and a nursing home. The program design mirrored earlier courses that provided students with an opportunity to learn about health systems in other countries and the cultural, economic, and political factors influencing delivery of care.

Much has been written about design of study abroad programs and particularly the differences in short and long-term programs. While some question the value of short international experiences, there is clear evidence supporting the value of even brief encounters across academic disciplines (Anderson, Lawton, Rexeisen, & Hubbard, 2006; Deloach, Saliba, Smith, & Tiemann, 2004; Ingram, 2005). Clearly stated academic expectations and course objectives, along with significant pre-trip research into the culture and health system being studied, provided the groundwork for a significant educational experience.

The students’ learning objectives were as follows:

a. Analyze structural and functional designs of healthcare services and systems in China

b. Recognize and explain cultural, historical, geographic, and environmental factors influencing the delivery and use of health services in China

c. Identify and evaluate economic and political factors that influence healthcare in China

d. Discuss differences and commonalities in the health delivery systems and health outcomes in China and the United States

e. Synthesize health management principles, theoretical concepts and cultural factors impacting management and policy decisions in the Chinese healthcare system

f. Demonstrate in class discussions, presentations, and forum assignments how the delivery of health services and the organization of
healthcare systems in China and the United States utilize knowledge from the disciplines of history, law, economics, political science, sociology, and psychology.

In preparation for the trip, students were assigned research activities that included exploration of historical, geographical, and cultural factors that impact China’s healthcare services. Faculty lectures included an introduction to the Chinese healthcare system and issues related to delivery of care to China’s 1.3 billion plus population. This was a 3 credit hour course and required students to participate in three seminar sessions and three online forum discussions. Each student researched a specific topic related to healthcare in China and led an online forum discussion of that topic. Two seminar sessions were held prior to traveling and one on return. All forum discussions were held prior to the trip abroad. Students were also required to keep a daily journal during the trip. The last seminar session was designed to allow students to review their pre-travel studies and the experience abroad in the context of the course’s stated objectives. Faculty goals for the trip were to maximize student learning opportunities and to identify collaborative research and teaching opportunities with Shandong University.

The twelve-member group included graduate students, health administration faculty, and a nutrition faculty member. It is common practice for faculty leading UNF study abroad programs to invite other program faculty to accompany the group as a means of encouraging development of related programs. Arrangements were made for the nutrition faculty member to meet with the nutrition program faculty at Shandong University. Dr. Mei Zhao, an assistant professor from the UNF Health Administration program who is a native of China and alumnus from Shandong University, led the study group. With the exception of Dr. Zhao, none of the study group had previously traveled to China. Four members of the group had never flown outside of the United States.

Dr. Zhao’s preliminary work with CHMP representatives provided access to information about the university and local health facilities. These representatives also scheduled meetings with faculty and students and made the arrangements for visits to several local health service providers. Two graduate students from Shandong University were assigned to the study group to serve as interpreters and tour guides. Class assignments completed prior to the trip provided information about demographics, culture, government, education, and health systems. However, it did not prepare students or faculty for the reality of the cultural differences or similarities they would encounter.
The cultural impact was felt immediately on arrival in Beijing. The airport bustled with activity and voices that only one in the group could understand. The activity was familiar; travelers, luggage, lines at ticket windows, and security measures. Those group members who had traveled to Paris or Ireland with earlier study abroad programs quickly noted they could not blend into the crowds by just remaining quiet. Other voices including French, German, and British soon emerged. UNF’s group members were not the only foreigners present but clearly were visitors.

Discovery continued as the UNF group traveled from Beijing to Jinan and their destination at Shandong University. There they met with faculty and students from the University’s CHMP and attended lectures presented by faculty from both Shandong University and UNF. Dr. Qingyue Meng, a CHMP faculty member, spoke about the history of reform in China and current challenges with access and financing of China’s healthcare system. Dr. D. Rob Haley, from UNF, spoke on the topics of organization and financing of health services in the United States. The discussion included demographic trends, quality issues, current U.S. health policy issues, and potential market solutions to rising costs. Students from both schools raised questions that prompted discussion on these topics and others including the use of traditional and western medicine and the needs of special populations in both countries.

In addition to faculty lectures at the University, visits were planned to local health services providers. The first was a visit to a local hospital, the Second Hospital of Shandong University. Students and faculty met with the Chief Executive Officer who explained the hospital’s mission, organizational structure, and financial and clinical operations. While touring the rehabilitation ward, clinicians explained the use of traditional Chinese medicine to augment western therapies. A demonstration of acupuncture therapy for a patient recovering from a stroke was observed by the students. UNF students and faculty were then offered, and several accepted, the opportunity to experience acupuncture therapy from Chinese clinicians.

The faculty at Shandong University also made arrangements for the study group to visit a local nursing home. It was located in a former hospital which was converted for that purpose and is the first nursing home in Jinan. Students had the opportunity to meet with facility administrators and discuss how China is preparing for its burgeoning senior population. Faculty and students toured the nursing home and visited with residents and their families. Students learned how China’s “one child policy” was impacting cultural norms related to care of the elderly. As a result of this policy, China is now faced with the need to make arrangements for com-
municipal living and personal care for many elderly who either outlived a single child or whose child could not work and manage the care of parents and grandparents. A young married couple, who are both only children, could conceivably be the only support system for four parents and eight grandparents. Changing demographics were noted as impacting healthcare in both the US and China.

Lectures by the professors at Shandong University, discussions with hospital and nursing home executives, and visiting health facilities provided a unique opportunity for students to learn and observe differences between the Chinese and the US culture and systems. A significant part of the discussion about the Chinese system related to the challenges of providing healthcare for such a large and aging population and the vast differences in availability of services between China’s urban and rural areas. Both countries are confronted with serious problems related to demographic changes and the impact of those changes on affordability and accessibility of services. Common ground was identified in discussion of problems related to the significant growth of the older population, the need for treatment of age related chronic diseases and disabilities, and the resulting demand for affordable resources. These needs affect providers, patients and their caregivers, and ultimately the economy as both governments intervene in attempts to provide affordable services.

Health delivery issues and the differences in financing of health services in both countries became a central focus of discussion between the study group and Center faculty. What began as a dialog about how the United States is attempting to develop and manage market solutions to these problematic economic issues led to continued discussion after the study group returned to the United States.

Lessons Learned

A greater understanding of the challenges facing China’s healthcare system was not the only lesson learned by the study abroad participants. The time spent exploring China’s history and culture was invaluable. Visits to Tiananmen Square and the Forbidden City in Beijing and a trip to the Badaling section of the Great Wall of China provided a glimpse of a culture capable of producing astounding artistic, architectural, and engineering marvels thousands of years before western culture.

At the same time, visiting Beijing as it prepared to host the 2008 Olympics meant visitors saw new buildings, modern hotels, electronic billboards, signs of pop culture, and evidence of a global economy in the many western companies conducting business in China. There was also clear evidence
of many of the same problems facing other large cities in industrialized countries including pollution, overcrowding, and homelessness.

Negotiating restaurants and formal dinners in China provided a lesson in cultural differences that made some reconsider how we treat international travelers as they visit the US. Many of the Chinese delicacies offered as a sign of respect to guests were not appealing to the less adventurous diner. Coaching in Chinese customs by UNF’s Chinese faculty helped to prepare the study participants for some situations that could have otherwise been awkward.

The language barrier provided a lesson in tolerance and patience. Traveling in China without an interpreter is difficult. Many taxi drivers and service providers do not speak or read English. However, the younger Chinese population seemed eager to practice their English and was extremely helpful in assisting with directions and negotiations with shopkeepers.

Filled with activities, the days in China passed quickly. The participants agreed the trip was intellectually stimulating, emotionally challenging, and physically exhausting. In an effort to capture the impact of the experience each member of the group was asked to submit a written response to the question: “What was the value of this trip to you?” Students responded with a greater awareness and appreciation for similarities and differences in the culture and health systems in China and the United States. They also reported an increased interest in, and an awareness of, China’s increasing role in the world economy and the challenges of meeting healthcare needs in a country of over 1.3 billion people.

Establishing and maintaining international academic relationships and associated study abroad opportunities for students requires time, effort and financial support. University backing of these programs is critical. UNF has committed to an ongoing relationship with colleagues in China and to provide students the opportunity to participate in meaningful activity related to that relationship. To this end, in 2008 the UNF faculty members leading the China Study efforts applied for, and were awarded, two grants to support ongoing international study in China. These grants were offered by UNF’s International Center for the purpose of encouraging and supporting development of international study opportunities. In spring 2009 UNF faculty and 5 graduate and 18 undergraduate students traveled to Qingdao Medical College to continue exploration of Chinese health services and systems as members of a global community.

Building on the lessons learned from the first trip, the faculty constructed a different learning experience for the second group of students. They again scheduled several sessions prior to the actual trip to introduce
students to China’s history, culture and health system. This study group was different in that it was made up primarily of undergraduate students. For purposes of organization, and to better keep track of the participants, the 5 graduate students were assigned as leaders to groups of 3 or 4 undergraduate students. Each student was also asked to identify one other student in their group to whom they were accountable. This aided in the logistics of organizing and transporting the group which, including faculty, staff, and alumni, totaled 27.

Other than size and makeup of the group, the other major change in the course was development of separate objectives for undergraduate and graduate students. While the objectives were similar in content to the initial graduate course and both graduate and undergraduate students were focused on critical thinking in regards to specific issues. The graduate students were also required to prepare presentations on different aspects of the U.S. health system that they would deliver to the graduate students at Qingdao Medical College.

Understanding the value of reflective exercises in evaluating learning (Jackson, 2005), the faculty again asked the students to share experiences in a variety of formats following the trip abroad. The students shared experiences that ranged from their recognition of differing perspectives, to fascination with a new culture and recognition of the value of expanding their view of healthcare. Some of the most frequent observations included:

- How the opportunity to interact with Chinese students heightened their awareness of the importance of learning to communicate across cultures
- The opportunity to talk with Chinese students provided a perspective on how they perceived Americans and the opportunity to address some of those perceptions
- Observation of the application of alternative medicine in practice provided a new perspective on the potential value and applicability of TCM modalities in the US health system
- Gaining an understanding of the Chinese health system and comparing practices with the US system in meetings with the representative from the Chinese version of our CDC, hospitals, and clinics helped frame understanding of the globalization of healthcare
- The importance of exposure to the culture, politics, and history of a country as a framework to understanding that country’s current health system

Faculty reported that they valued the opportunity to meet and develop relationships with faculty from one of China’s leading centers for health
management and policy. International travel and study of other health systems were seen as positives in building understanding of global health issues and providing opportunities to explore collaborative research projects. The faculty leaders also identified that frequent and ongoing communication with colleagues in the host country is important to ensure that students from both countries have the opportunity and the time to interact and share information. They also noted that understanding the differences in teaching methods between the two institutions and the cultural underpinnings of those differences is critical in planning educational exchanges (McGury & Shallenberger, 2009).

Bringing tokens of appreciation for the leaders involved in scheduled visits and small tokens of thanks for the host’s students appeared to be valued. The opportunity for faculty to travel to the host country and begin development of relationships with international colleagues and meet with the leaders of the host institution prior to the initial study abroad program was invaluable. Additionally, the advantage of having a faculty member fluent in the language and knowledgeable about the history and culture of the country cannot be overstated. Finally, as things do not always go as planned, prepping the students to be flexible and willing to adjust to any minor and major change was seen as critical.

**Collaboration**

One month after returning from China, the UNF Health Administration Program and Shandong University Center for Health Management and Policy agreed to pursue an ongoing collaborative relationship. This agreement was forged to encourage collaborative scholarship, broaden cultural competence of participants, provide continuing opportunities for students to participate in international study, and support and encourage collaborative research activity. Since that time several significant events have occurred. A research project examining the integration of Traditional Chinese Medicine (TCM) and Western medicine was developed by faculty from UNF and Shandong University and data collection completed in Jinan in summer 2007. An initial report on the results of that study was published in 2008 and second in 2009. In the spring of 2007, Dr. Qiang Sun, a faculty member from Shandong University and collaborator in the research on TCM and Western medicine, accepted an invitation to speak at UNF on the topic of healthcare reform in China. His presentation, titled Healing the Dragon: Reforming China’s Health System, was attended by students and faculty from UNF’s health administration, business administration, and public health programs.
In fall 2007, two faculty members and an alumnus of the UNF graduate Health Administration Program returned to Shandong University’s Center for Health Policy and Management to lead a one week healthcare summit on the topic of healthcare reform. Following the summit, the UNF delegation traveled to Qingdao Medical College (Qingdao, China) and the University of Macau (Macau, China) to explore collaborative relationships with these Universities. At each location the UNF delegation met with province officials and then with students and faculty of each University. They were invited to speak on the U.S. health system and facilitated discussion on issues of system reforms at each site.

The relationship established between Shandong University and the University of North Florida continues to evolve. A planned visit by students and faculty from SDU’s Center for Health Management and Policy to UNF to study healthcare in North Florida is scheduled for summer 2010. As part of the exchange program developed by the universities, UNF will arrange visits with various segments of the local healthcare community. These will include visits to hospitals and nursing homes, as well as contact with local public health officials. On campus meetings with UNF students, faculty members, and College and University administrators are planned. Through these activities, we hope to provide the visiting faculty and students with greater understanding of the issues facing healthcare consumers and providers in this area and to allow opportunities for continued collaboration between the schools. A third study abroad group from UNF will travel to China in spring 2011.

**Conclusion**

Development of study abroad programs can clearly be easier when program faculty have already established relationships with colleagues in other countries or when the faculty complement includes international faculty. However, many effective formats are seen in program development and many do not include efforts to establish ongoing university relationships or joint research projects.

The health system study undertaken in China was based on earlier work by UNF’s health administration faculty in France and Ireland. Those programs, which included studies of the health systems in the respective countries, included visits to health facilities and meetings with health professionals, but did not include contact with specific universities or foreign colleagues. In those cases, the program contracted with professional study abroad organizations to assist with travel, lodging, and arrangements for visits to selected facilities, organizations, and cultural sites. The program’s experience with these organizations has been positive and faculty are
continuing to offer study abroad programs in European countries using
this model while the China study program continues as a university based
program.

Faculty participating in both types of study abroad programs will
find the experience challenging and rewarding. The complexity of the
preparation will vary with the differences in language, culture, and ge-
ography. Culture shock, illness, lost luggage, lost passports, and an ever
changing variety of issues will face faculty on each trip. The challenges
are as unique as the student participants. However, the opportunity to
expose students to new ideas and information that expand understand-
ing of the relationships between peoples, cultures, and healthcare can
produce transformational learning experiences for students and faculty.

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The Importance and Use of Continuing Education: Findings of a National Survey of Hospital Executives

Stephen L. Walston, PhD & Amir A Khaliq, PhD

Abstract
Continuing education for healthcare executives is an important aspect of maintaining skills and preparing for future challenges. A recent national study of hospital executives, sponsored by the American College of Healthcare Executives (ACHE), surveyed over 2,000 hospital CEOs to ascertain the importance and use of continuing education. This research suggests that CEOs perceive that the greatest value of continuing education is for information to keep them updated on technological and market changes that are focused mostly on current job responsibilities. Continuing education does not seem to be valued or used specifically very often for career or succession planning. The study also identifies preferences for the methods of continuing education, including the increasing use of some internet based tools. The data are also segmented to examine the effect that professional affiliation has on the use of and preferences for continuing education. CEOs who are not affiliated with ACHE spend more time per year on continuing education and have certain distinct preferences to ACHE affiliates.

Introduction
Professional growth and development is critical in the complex and evolving world of healthcare administration. The profession has become more difficult with changing regulations, technological advances, and increased demands. Hospitals must demonstrate constant learning and development...
of their leaders to meet the current and future challenges. Hospitals attempt to achieve professional development of their executives through different continuing education means. However, the needs and motivations for continuing education have not been recently explored. To meet the challenges of the future, it is important to understand the underlying purposes, processes, and resources used for continuing education of healthcare leaders. To this end we utilize data from a recent national survey of hospital CEOs to assist healthcare leaders to better understand the attitudes regarding, choices among, and preferences for continuing education. This article also subdivides the data by professional affiliation to differentially address the value of providing continuing education, what methods of continuing education are preferred, the amount of time annually spent by CEOs on continuing education, and the change in the past five years in total expenditure, its importance, and type. The article concludes suggesting reasons for our findings and the future direction of this research.

Professional development has been identified for many years as an important organizational function that some believe has been inadequately addressed (Romano, 2004). Across all US industries, over $50 billion is spent annually on employee training and about 27% of this amount is allocated for leadership development (Dolezalek, 2005). The purpose of leadership development is to assist participants to improve their skills to manage their organization more effectively. Accordingly, continuing education activities are often specifically designed to improve individual job performance and managerial skills. Such efforts seek to positively impact organizational culture and climate (McAlearney 2005). Developing leaders for healthcare organizations has been identified as one of the most pressing challenges for the future (Meyers, 2007).

Hospitals can access many different types of continuing education programs to improve quality of care, employee morale, and organizational viability. The type selected may vary according to the characteristics of the participating individuals and those of the parent organization. In general, options include hands-on experience, on-campus leadership training, skills building workshops, job rotations, self-study, and formal degree programs (Rice, 2007, Peterson, 2002, Sherer, 1994). While some organizations have established “leadership academies” and hired “chief learning officers” to promote professional and organizational development, others now require their leaders to take a fixed number of classroom hours in leadership development each year (Dixon and Bilbrey, 2004). Appropriate continuing education and professional development benefit organizations by allowing for individual growth, longer tenure, and planned successions (Meyers, 2007).
This research provides the CEOs’ view of the methods preferred for continuing education and its perceived value by hospital CEOs and their subordinates in the US. This data also provide valuable information to demonstrate how the importance of continuing education has changed in the past five years. Further, we also divide the data by professional affiliation to better understand the differences of CEOs affiliated with the American College of Healthcare Executives (ACHE) and those who are not.

**Methods and Results**

A written survey sponsored by the ACHE was sent to a random sample of 2,001 hospital CEOs across the US in late December of 2008. Prior ACHE surveys had produced a lower response from non-ACHE members. As a consequence, non-ACHE members were over sampled. A second copy of the survey was sent to non-respondents in January 2009. A total of 582 useable responses (29.1% of the sample population) responded. Seventy four percent of respondents indicated that their primary professional society affiliation was with ACHE. The next highest was 10% that had no professional affiliation and 6% identified HFMA as their primary professional society. Of the entire respondent group, 25% were non-ACHE members, 28% were ACHE Members and 47% of the respondents were ACHE Fellows.

Differences in professional affiliation are also statistically explored using Duncan’s Multiple Range Test in ANOVA SAS analysis. This allows the significance differences to be identified among CEOs by their affiliation type.

The data were tested for response bias using a Chi-Square procedure in Proc Freq in SAS. The total responses (582) were compared to the full sample (2,000). Four variables were used to determine if response bias might have occurred. The factors examined include the geographic region of the hospital, the type of organizational control/ownership, the bed size of the hospital, and whether the hospital CEO was an affiliate of ACHE. Three of the examined variables were significant and one non-significant. The region of the country was significant with the Chi-Square probability of 0.023, indicating that over response may have occurred in some of the regions. Heavier responses seem to have occurred in the West North Central, which had a 37.8% response rate. All other regions appeared to have response rates between 23 to 30%.

Likewise, the Chi-Square for type of control/ownership for the hospital was also significant (0.039). There appears a relatively lower response rate from investor owned hospitals that in our survey have a 20% to 22% response rate. On the other hand, Governmental Non-Federal City and County hospitals had higher rates of responses with 37% and 39% respectively. There
did not seem to be sample bias present for hospital bed size. There was also a higher rate of response for ACHE affiliated hospital CEOs. Only 18.4% of non-affiliated ACHE hospital CEOs responded to the survey, versus 41% of ACHE affiliated hospital CEOs. The higher rate of response by ACHE CEOs was anticipated. As a result, as mentioned, non-ACHE members were over sampled. Therefore, we suggest that the survey responses may over-represent hospitals in the West North Central Region, governmental hospitals, and ACHE affiliated hospital CEOs.

**Value of Continuing Education to CEOs**

Our research suggests that hospital CEOs perceive that continuing education is most valuable to gain new knowledge and less for career advancement. Although we recognize that improving knowledge and skills should ultimately lead to career advancement, our study does not look at this longer term causality, but the reasons for the initiation of continuing education. Our responses demonstrate that most CEOs select continuing education for more immediate knowledge and less for longer term advancement. As illustrated in Table 1, CEOs mostly value continuing education to understand changes (81%), keep themselves abreast of current trends (74%), to solve problems (62%), and to learn about new technology (60%). Functions relating to careers, as the value of continuing education for career development (55%) and for succession planning (48%) were perceived by many CEOs as less important.

We also find in Table 2 that CEOs who are not affiliated with ACHE appear to value continuing education more to learn about new technology, but see it as being of less value for career development than ACHE affiliates do.

**Table 1**

How important is continuing education for you for the following functions? (n=582)

<table>
<thead>
<tr>
<th></th>
<th>Unimportant or Very Unimportant</th>
<th>Indifferent</th>
<th>Important or Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>To understand changes</td>
<td>7%</td>
<td>12%</td>
<td>81%</td>
</tr>
<tr>
<td>To stay current</td>
<td>10%</td>
<td>16%</td>
<td>74%</td>
</tr>
<tr>
<td>To solve problems</td>
<td>9%</td>
<td>29%</td>
<td>62%</td>
</tr>
<tr>
<td>To learn about new technology</td>
<td>13%</td>
<td>28%</td>
<td>60%</td>
</tr>
<tr>
<td>For career development</td>
<td>13%</td>
<td>32%</td>
<td>55%</td>
</tr>
<tr>
<td>For succession planning</td>
<td>20%</td>
<td>31%</td>
<td>48%</td>
</tr>
</tbody>
</table>
Preference for Types of Continuing Education

The ways hospital executives prefer to receive continuing education vary widely. As illustrated in Table 3, a high percentage of executives prefer offsite seminars (78%) for continuing education. Somewhat surprising is that the next preferred modes of continuing education are onsite seminars (52%) at the respective hospital and webinars (50%). Webinars are different than online seminars in that webinars are typically short-term, one-way, generally online meetings with limited audience interaction. A webinar can include polling and question & answer sessions to allow full participation between the audience and the presenter. In some cases, webinars are accomplished with discussions over a standard telephone line and the audience responds over their own telephones. Online seminars generally involve multiple encounters and may involve a greater depth of studying and learning.

Fewer CEOs liked large conferences (43%), and even fewer liked books/discussion groups (29%), CDs or DVDs (26%), self-study (24%), and online seminars (15%). It should be noted that these last four had sizable proportions of the respondents expressing “not preferred”—online seminars (49%), self-study (41%), and CDs/DVDs and books/discussion groups (32%). Non-ACHE members, as can be seen in Table 4, disliked offsite face-to-face seminars and large conferences more than Fellows and ACHE members. Interestingly, ACHE Fellows disliked self study manuals more than non-Fellow ACHE members.

Table 2

Comparison by ACHE Affiliation: Value of Continuing Education for CEOs+

<table>
<thead>
<tr>
<th></th>
<th>Non-member</th>
<th>Member</th>
<th>Fellow</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To stay current with political changes</td>
<td>4.00</td>
<td>3.94</td>
<td>4.03</td>
<td>3.99</td>
</tr>
<tr>
<td>b. To learn techniques to solve immediate problems</td>
<td>3.68</td>
<td>3.86</td>
<td>3.72</td>
<td>3.74</td>
</tr>
<tr>
<td>c. To learn about new technology</td>
<td>3.78*</td>
<td>3.58</td>
<td>3.56</td>
<td>3.62</td>
</tr>
<tr>
<td>d. To understand changes in healthcare delivery</td>
<td>4.06</td>
<td>4.15</td>
<td>4.16</td>
<td>4.13</td>
</tr>
<tr>
<td>e. To assist in career development</td>
<td>3.32**</td>
<td>3.65</td>
<td>3.64</td>
<td>3.57</td>
</tr>
<tr>
<td>f. To contribute to succession planning</td>
<td>3.28</td>
<td>3.44</td>
<td>3.39</td>
<td>3.39</td>
</tr>
</tbody>
</table>

*Data shows the mean score for each category for a Likert scale of 1 (Very unimportant) to 5 (Very important)
* indicates a significant difference between one other value;
** indicates a significant difference between the two other values.
Table 3

What is your preference for these various modes of continuing education?

<table>
<thead>
<tr>
<th>Mode of Continuing Education</th>
<th>Not preferred or somewhat not preferred</th>
<th>Neutral</th>
<th>Preferred or somewhat preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offsite Seminars</td>
<td>6%</td>
<td>16%</td>
<td>78%</td>
</tr>
<tr>
<td>Onsite Seminars</td>
<td>15%</td>
<td>33%</td>
<td>52%</td>
</tr>
<tr>
<td>Webinars</td>
<td>16%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>Large Conferences</td>
<td>17%</td>
<td>40%</td>
<td>43%</td>
</tr>
<tr>
<td>Books or Discussion Groups</td>
<td>32%</td>
<td>39%</td>
<td>29%</td>
</tr>
<tr>
<td>CDs or DVDs</td>
<td>32%</td>
<td>42%</td>
<td>26%</td>
</tr>
<tr>
<td>Self Study Manuals</td>
<td>41%</td>
<td>36%</td>
<td>24%</td>
</tr>
<tr>
<td>Online Seminars</td>
<td>49%</td>
<td>36%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Table 4

Comparison of ACHE Affiliation: What is your preference for these modes of continuing education?

<table>
<thead>
<tr>
<th>Mode of Continuing Education</th>
<th>Non-member</th>
<th>Member</th>
<th>Fellow</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Face to face seminars at your healthcare facility</td>
<td>3.53</td>
<td>3.56</td>
<td>3.41</td>
<td>3.48</td>
</tr>
<tr>
<td>b. Offsite face to face seminars</td>
<td>3.78**</td>
<td>3.99</td>
<td>4.09</td>
<td>3.98</td>
</tr>
<tr>
<td>c. CDs or DVDs</td>
<td>2.94</td>
<td>2.96</td>
<td>2.83</td>
<td>2.89</td>
</tr>
<tr>
<td>d. Webinars</td>
<td>3.41</td>
<td>3.41</td>
<td>3.45</td>
<td>3.43</td>
</tr>
<tr>
<td>e. Large conferences with 90 to 180 minute presentations</td>
<td>3.16*</td>
<td>3.24</td>
<td>3.37</td>
<td>3.28</td>
</tr>
<tr>
<td>f. Self study manuals</td>
<td>2.73</td>
<td>2.93</td>
<td>2.64*</td>
<td>2.75</td>
</tr>
<tr>
<td>g. Books/journal discussion groups</td>
<td>2.83</td>
<td>3.02</td>
<td>2.86</td>
<td>2.90</td>
</tr>
<tr>
<td>h. Online seminars for several weeks</td>
<td>2.46</td>
<td>2.48</td>
<td>2.48</td>
<td>2.47</td>
</tr>
</tbody>
</table>

*Data shows the mean score for each category for a Likert scale of 1 (Very unimportant) to 5 (Very important)
* indicates a significant difference between one other value;

**Time Spent by CEOs on Continuing Education**

CEOs invest very different amounts of time in continuing education annually, as can be seen in Figure 1, a small number (4%) of CEOs spent less than 10 hours in the past year. On the other hand, 13% participated in more than 80 hours. The median number of hours engaged in continuing education was 36 hours and the mean was 45 hours. Surprisingly, non-ACHE affiliates report that they spent significantly more time on continuing education...
Figure 1

Number of Continuing Education Hours in Past 12 months

<table>
<thead>
<tr>
<th>Hours</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10</td>
<td>4%</td>
</tr>
<tr>
<td>10 to 19</td>
<td>15%</td>
</tr>
<tr>
<td>20 to 29</td>
<td>19%</td>
</tr>
<tr>
<td>30 to 39</td>
<td>14%</td>
</tr>
<tr>
<td>40 to 49</td>
<td>19%</td>
</tr>
<tr>
<td>50 to 59</td>
<td>7%</td>
</tr>
<tr>
<td>60 to 69</td>
<td>7%</td>
</tr>
<tr>
<td>70 to 79</td>
<td>2%</td>
</tr>
<tr>
<td>80 or more</td>
<td>13%</td>
</tr>
</tbody>
</table>

across the past 12 months (56.1 hours) compared to Fellows (40.6 hours) and ACHE members (44.5 hours).

**Importance of Continuing Education for Direct Reports**

Hospital CEOs directly influence the amount and type of continuing education that their direct reports receive. Our research shows that most CEOs feel that continuing education is important for their direct reports to understand the changes that are happening related to their work. Table 5 shows that except for succession planning, more than half of the respondents felt that each of the potential benefits was deemed to be important. Of the responding CEOs, few thought that continuing education was unimportant for staying current (12%), learning technology (11%), and career development (10%). When ACHE affiliation is compared in Table 6, we find that the only significant value is that non-members feel that continuing education is less important to assist their direct reports’ career development than those affiliated with ACHE.

**Involvement of Direct Reports in Continuing Education Over the Past 12 months**

Most direct reports had been either moderately (51%) or considerably (35%) involved in continuing education over the past 12 months. Very few had little (4%) or very little (1%) involvement in continuing education. There was not a significant difference among the CEO comparison groups.
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Change in Expenditures on Non-clinical Continuing Education

Although the past few years have been very difficult for many hospitals, interestingly, in the past 5 years the amount of money spent on non-clinical continuing education has increased at many hospitals (8% increased substantially and 30% increased somewhat). However, over one-fourth of all hospitals also decreased their expenses in this area during this time (8% decreased substantially and 20% decreased somewhat). The change in the amount of money spent on professional educational activities was not significantly different among the three categories of respondents.

Table 6

Comparison of ACHE Affiliation: Importance of continuing education for CEOs’ direct reports…...+

<table>
<thead>
<tr>
<th></th>
<th>Non-member</th>
<th>Member</th>
<th>Fellow</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>To stay current with political changes</td>
<td>3.69 %</td>
<td>3.63 %</td>
<td>3.74 %</td>
<td>3.70 %</td>
</tr>
<tr>
<td>To learn techniques to solve immediate problems</td>
<td>3.76 %</td>
<td>3.95 %</td>
<td>3.85 %</td>
<td>3.85 %</td>
</tr>
<tr>
<td>To learn about new technology</td>
<td>3.86 %</td>
<td>3.69 %</td>
<td>3.74 %</td>
<td>3.76 %</td>
</tr>
<tr>
<td>To understand changes in healthcare delivery</td>
<td>4.01 %</td>
<td>4.13 %</td>
<td>4.06 %</td>
<td>4.06 %</td>
</tr>
<tr>
<td>To assist in career development</td>
<td>3.47 %**</td>
<td>3.76 %</td>
<td>3.90 %</td>
<td>3.76 %</td>
</tr>
<tr>
<td>To contribute to succession planning</td>
<td>3.32 %</td>
<td>3.37 %</td>
<td>3.48 %</td>
<td>3.42 %</td>
</tr>
</tbody>
</table>

*Data shows the means for a Likert scale of 1 (Very unimportant) to 5 (Very important)
* indicates a significant difference between one other value;
** indicates a significant difference between the two other values.
The Importance and Use of Continuing Education

Change in the Importance of Continuing Education Since 2003

Continuing education not only remains important to hospital CEOs, but our research suggests that its importance has increased in the past 5 years (See Table 7). A majority (51% and 54%) of CEOs feel that continuing education has become more or much more important since 2003 for themselves and their direct reports. Interestingly, as shown in Table 8, ACHE members who are not Fellows feel stronger that continuing education has become more important in these past 5 years.

Table 7

The importance of continuing education for you when compared to 2003

<table>
<thead>
<tr>
<th></th>
<th>For CEOs</th>
<th>For Direct Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much less important</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Less important</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>About the Same</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>More important</td>
<td>30%</td>
<td>34%</td>
</tr>
<tr>
<td>Much more important</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 8

Comparison by ACHE Affiliation+: Importance of continuing education...

<table>
<thead>
<tr>
<th></th>
<th>Non-member</th>
<th>Member</th>
<th>Fellow</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>For CEOs - Continuing education today compared with 2003</td>
<td>3.61 %</td>
<td>3.89** %</td>
<td>3.58 %</td>
<td>3.67 %</td>
</tr>
<tr>
<td>For Direct Reports - Continuing education today compared with 2003</td>
<td>3.66 %</td>
<td>3.85** %</td>
<td>3.64 %</td>
<td>3.70 %</td>
</tr>
</tbody>
</table>

+Data shows the mean scores for a Likert scale of 1 (Much less important) to 5 (Much more important)

* indicates a significant difference between one other value;
** indicates a significant difference between the two other values.

Change in the Importance of types of Continuing Education Since 2003

It appears that the use of new modes of continuing education have increased in the frequency in recent years, as shown in Table 9. The most technologically driven of these, webinars (72%) have increased dramatically in importance.
for CEOs since 2003. Online seminars (29%) and offsite seminars (24%), self-study (23%), books/discussion groups (23%), and large conferences (22%), had the greater number of CEOs stating that they had diminished in importance since 2003.

Table 9

How has your use of the various modes of continuing education changed from 2003?

<table>
<thead>
<tr>
<th>Mode</th>
<th>Decreased a lot or somewhat</th>
<th>About the Same</th>
<th>Increased a lot or increased somewhat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onsite Seminars</td>
<td>16%</td>
<td>63%</td>
<td>22%</td>
</tr>
<tr>
<td>Offsite Seminars</td>
<td>24%</td>
<td>55%</td>
<td>21%</td>
</tr>
<tr>
<td>CDs or DVDs</td>
<td>13%</td>
<td>53%</td>
<td>34%</td>
</tr>
<tr>
<td>Webinars</td>
<td>5%</td>
<td>23%</td>
<td>72%</td>
</tr>
<tr>
<td>Large Conferences</td>
<td>22%</td>
<td>63%</td>
<td>13%</td>
</tr>
<tr>
<td>Self Study Manuals</td>
<td>23%</td>
<td>62%</td>
<td>15%</td>
</tr>
<tr>
<td>Books or Discussion Groups</td>
<td>23%</td>
<td>60%</td>
<td>17%</td>
</tr>
<tr>
<td>Online Seminars</td>
<td>29%</td>
<td>58%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Table 10 demonstrates very little difference between the different types of CEOs. The only significant difference is Fellows’ use of offsite seminars decreased more in the past 5 years than that of Members.

Table 10

Comparison of ACHE Affiliation: How has your use of these modes of continuing education changed from 2003?

<table>
<thead>
<tr>
<th>Mode</th>
<th>Non-member</th>
<th>Member</th>
<th>Fellow</th>
<th>Overall Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Face to face seminars at your healthcare facility</td>
<td>3.08%</td>
<td>3.01%</td>
<td>3.07%</td>
<td>3.06%</td>
</tr>
<tr>
<td>b. Offsite face to face seminars</td>
<td>2.92%</td>
<td>3.06%</td>
<td>2.87%</td>
<td>2.94%</td>
</tr>
<tr>
<td>c. CDs or DVDs</td>
<td>3.24%</td>
<td>3.21%</td>
<td>3.22%</td>
<td>3.22%</td>
</tr>
<tr>
<td>d. Webinars</td>
<td>3.93%</td>
<td>3.86%</td>
<td>3.94%</td>
<td>3.91%</td>
</tr>
<tr>
<td>e. Large conferences with 90 to 180 minute presentations</td>
<td>2.86%</td>
<td>2.93%</td>
<td>2.86%</td>
<td>2.89%</td>
</tr>
<tr>
<td>f. Self study manuals</td>
<td>2.84%</td>
<td>2.94%</td>
<td>2.84%</td>
<td>2.87%</td>
</tr>
<tr>
<td>g. Books/journal discussion groups</td>
<td>2.86%</td>
<td>2.90%</td>
<td>2.91%</td>
<td>2.90%</td>
</tr>
<tr>
<td>h. Online seminars for several weeks</td>
<td>2.66%</td>
<td>2.71%</td>
<td>2.76%</td>
<td>2.72%</td>
</tr>
</tbody>
</table>

+Data shows the means for a Likert scale of 1 (Decreased a lot) to 5 (Increased a lot)
* indicates a significant difference between one other value;
** indicates a significant difference between the two other values.
CONCLUSION AND LIMITATIONS

Continuing education is an important tool for healthcare administrators. Our research demonstrates that hospital CEOs perceive continuing education to be valuable to keep them current with the rapidly changing healthcare environment. The focus of continuing education appears to be more on information and trends that directly relate to current jobs and less about providing additional training and structure to prepare individuals for future jobs.

This article suggests that some of the newer methods of continuing education using online technology are gaining popularity, while some are very unpopular. Although offsite seminars for multiple days remain the preferred mode of continuing education, half of CEOs now prefer webinars. However, very few preferred online seminars. This may suggest that the internet is perceived as better for short, succinct programs (webinars); while more traditional offsite formats are still preferred for longer educational courses.

Our study also demonstrates that there are some significant differences between CEOs affiliated and not affiliated with ACHE. Non-members tend to spend more time on continuing education and feel there is a greater value in learning about new technology. Not surprisingly, non-members prefer less the traditional offsite conferences (e.g. ACHE’s Annual Congress). Nonetheless, non-members do claim to spend significantly more time on continuing education. This may be a result of the weaker professional networks that CEOs who do not affiliate with ACHE experience, or that they lack easy access to professional society education. Perhaps, this indicates that ACHE, needs to recognize these differences between their members and non-members and adapt their services accordingly. Nevertheless, this is an interesting finding that requires more research.

Relatively consistent with their own perceived values, CEOs also believe that continuing education is important for their direct reports, more important for their career development, and still not as important for succession planning. The perceived lack of value of continuing education for career development and succession planning is an interesting finding. Continuing education, if integrated with goal setting and performance appraisals, has been suggested to be very valuable in developing careers and preparing executives to succeed leaders in their organizations (Coffield, 2000; London, 1996). Our finding may imply that the focus of many executives is on more short-term items and not on long-term employee development. This may be one reason that many healthcare organizations fail to plan for successes (Maxwell, 2004).
In more than a third of hospitals, the amount of money that is being spent on non-clinical continuing education in hospitals has increased over the last five years. Since the main reason CEOs value continuing education is to keep updated on change, an increase in the money spent might be expected during a turbulent time, as in the recent past. The impression that continuing education has become more important also supports this premise. It is also interesting to note that the value of webinars has increased dramatically for most CEOs, yet other internet based-learning tools are not well accepted yet. As cost pressures continue, hospitals will certainly have to find more economical methods to deliver continuing education. It would be of value to extend this research to examine why other online means are not preferred and what could be done to improve these.

Our research does have limitations. As mentioned above, a significantly greater response rate came from ACHE members, not-for-profit hospitals, and specific geographic areas. Also, our information is from hospital CEOs and is perceptual and retrospective. We did seek to minimize these problems by over sampling non-ACHE members and randomly sampling approximately half of hospital CEOs across the county. Also, we did not examine the means for obtaining educational degrees. This may be also a topic of future research.

Our healthcare system faces many significant challenges, which our leaders need to be prepared to face. Continuing education is critical to maintain and improve the skills of our healthcare leaders. Understanding the preferences and status of continuing education is a first step to understand the needs and improving the quality and content of this important function. Our research provides a helpful view of the current CEO perceptions of continuing education and we hope that it can encourage other work to better understand and improve the modes and content of continuing education.

REFERENCES


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TEACHING TIPS & TOOLS

Preparing Today’s Students to Lead Tomorrow’s Green Healthcare Organizations

PETER C. OLDEN, PhD, MHA & LEONARD H. FRIEDMAN, PhD, MPH

ABSTRACT
Healthcare organizations must become more eco-friendly and ‘green’ in the future. To help accomplish this in their future jobs, healthcare administration students will need green knowledge, skills, and attitudes (KSAs). They will also have to apply KSAs developed in healthcare administration courses. Ideas are offered for faculty to prepare students to lead green healthcare organizations.

INTRODUCTION
The healthcare industry is one of the largest users of energy, producers of waste, and emitters of CO₂ ... yet it lags other industries in going green. Healthcare facilities produce a continual stream of toxic gas, liquid, and solid waste 24/7 that ends up in the air, water, and land of communities and the world (Sandrick, 2009). Healthcare buildings themselves are often toxic and harmful to people who work and receive care there. Many stakeholders—employees, patients, labor unions, investment bankers, governments and regulators, pension funds, consumers, volunteers, environmental activists, trade groups, and others—have been demanding that healthcare change and ‘go green’ (Buell, 2009; Woodward, 2008). Stakeholders expect healthcare organizations (HCOs) to help conserve, preserve, and sustain the natural environment while also making healthcare facilities healthier places. This applies to providers, insurers, suppliers, and all parts of the
health industry. Thus, healthcare administration education programs must prepare today’s students to lead tomorrow’s green eco-friendly environment-sustaining HCOs. In the future, how green an HCO is will affect how well that HCO acquires resources, produces its products and services, achieves its mission and goals, satisfies its stakeholders, and survives.

This article has two objectives: 1) demonstrate how the green movement is affecting healthcare and HCOs, and, 2) explain how health administration education programs can prepare students to lead green healthcare and HCOs. The article should interest healthcare administration faculty and HCO leaders who realize that managers must change today’s brown eco-unfriendly HCOs to be green and eco-friendly. This is important for HCOs leaders because of stakeholder demands as well as the many benefits (discussed later) that come from going green. Today’s healthcare administration students will have to create greener HCOs, so educational programs must prepare them to do that. This article will next report green healthcare, its benefits, and interesting examples. Then the article will explain how faculty and their programs can help students prepare to lead tomorrow’s green HCOs.

**Green Healthcare, Benefits, and Examples**

Green healthcare includes policies, programs, procedures, and investments that contribute to a safe, healthy, ecologically sustainable environment (Keckley & Fam, 2008). Sustainability is “meeting present needs without compromising the ability of future generations to meet their needs” (World Commission on Environment and Development, 1987, p. 1). Green healthcare involves paying attention to resource use, depletion, and renewal in order to help the natural environment maintain and prolong itself for future use. The green movement for a sustainable natural environment has been gaining support and participation because of increased understanding of the need (Bolch, 2008).

There are many compelling benefits for HCOs that are green and eco-friendly. The President of a green hospital says a green HCO improves the health of the environment, society, organization, and employees while also helping the HCO earn respect, legitimacy, positive image, and stakeholder support (Gehant, 2008). The business case includes: less expense, less risk to safety/health, and improved employee satisfaction (Guenther, 2008). Going green can positively improve businesses’ profits, public opinion, customer relations, employee recruitment and retention (Fox, 2008), and obtain social, economic, and environmental benefits (Brockett, 2006). “There is no question that going green generates a beneficial financial return” such as from
reduced costs for energy, water, supplies, building cleaning, and waste management (Gehant, 2008, p. 8). “The financial benefits of green buildings include lower energy, waste disposal, and water costs; lower environmental and emissions costs; lower operations and maintenance costs; and savings from increased productivity and health” (Kats, Alevantis, Berman, Mills, and Perlman, 2008, p. v). Costs to go green are declining and ROI rates are improving (Serb, 2008). And, going green can help HCOs comply with environmental laws.

A big benefit is health itself—health of patients, employees, volunteers, visitors, and others. Today many healthcare buildings are surprisingly unhealthy (Harris, Pisa, Taltioaga, and Vezeau, 2009; Sandrick, 2009). Indoor air is polluted by harmful gases, fumes, and chemicals from toxic furnishings, cleaning solvents, carpets, upholstery, paints, adhesives, insulation, aerosols, molds, and fungi. This is worsened when windows are sealed and fresh air cannot enter. Toxic indoor air has been associated with asthma, cancer, respiratory diseases, and other health problems (Vittori, 2002). Green healthcare buildings are associated with better patient outcomes, staff morale, performance, and health. “Patients in green hospitals have greater emotional well-being, require less pain medication and other drugs, and have shorter hospital stays” (USGBC, 2009, p. 1).

A 2009 survey by nonprofit Practice Greenhealth found among its 700+ member hospitals that 93% implemented energy conservation, 80% reduced use of hazardous materials and chemicals, 64% implemented waste reduction, 47% purchased green supplies, 31% implemented water conservation, and 12% generated onsite some of their energy (Commins, 2009). Some HCOs are reducing and recycling waste, reducing energy, using renewable energy, and reducing supplies, materials, construction, furnishings, and equipment that have toxic chemicals, fumes, and substances. Green management has entered the executive suite where organization-wide green goals and strategies are planned and executed (Popely, 2009).

Keckley and Fam (2008) offer interesting examples. Kaiser Permanente has 35 farmers’ markets with local and organic produce on its campuses. Providence Newburg Hospital (Oregon) obtains 100 percent of its energy from renewable sources such as wind, geothermal, and hydroelectric. Highmark Health Plan (Pennsylvania) built a new data center entirely of recycled materials, included many energy saving features, and now reclaims rainwater for cooling systems. Johnson and Johnson (worldwide) reduced toxic polyvinyl chloride (PVC) in packaging by 84%. Further, this healthcare supply company gets 38% of its electricity from renewable non-carbon sources such as wind and sun. The national Premier Alliance
created an ‘Executive Scorecard on the Environment’ to measure sustainability performance of its hundreds of member institutions. Alderson (2008) reports that Emory University’s Winship Cancer Institute (Georgia) saves almost one million gallons of water annually by water recovery.

Happily, green progress has been made in healthcare. Yet, HCO leaders realize there is more to do (Vernon, 2009). In the future, the healthcare industry and HCO leaders will have to increase their green efforts and activities, which will require certain KSAs of their leaders. Thus, healthcare administration education faculty and programs will have to prepare students so they can create and lead green HCOs.

**How to Prepare Students to Manage and Lead Green HCOs**

Green management needs to be part of educating undergraduate and graduate healthcare management students. Given this, we address the following three questions.

1. What are the knowledge, skills, and attitudes that tomorrow’s leaders will need to manage green HCOs?
2. How can faculty today help students develop the requisite KSAs needed to lead green HCOs?
3. Where does a green management approach fit in an existing curriculum?

**Knowledge, Skills, and Attitudes**

Bloom’s taxonomy of learning domains (1956) speaks to three forms of learning: cognitive (knowledge), psychomotor (skills), and affective (attitudes). Providing knowledge is necessary but not sufficient. Students must also develop skills and attitudes to put knowledge into action. The knowledge component of green management is generally straightforward and can be obtained in traditional classroom and learning modalities. In addition to knowledge of overall structure and function of health systems and organizations, students should be provided with fundamentals of environmental awareness and impact in operational areas such as site/facilities management; chemical, energy, and waste management; environmental (housekeeping, laundry, maintenance) services; food services; and purchasing.

Skills required for green management include those used when trying to implement any significant change to an organization’s culture or operations. Students should have skills ordinarily developed in healthcare management curricula including:

- finance (e.g., to calculate ROI of green capital investments);
• human resources (e.g., to conduct job appraisals based partly on green performance);
• organization structure (e.g., to design green positions and teams);
• leadership (e.g., to lead green change);
• operations management (e.g., to design green work processes); and
• law and policy analysis (e.g., to comply with green laws and regulations).

Students must be able to bridge the gap between knowing and doing, transform knowledge into action, link theory and practice, possess effective communication and facilitation skills, and encourage and model teamwork.

The attitudes associated with green management go beyond students simply understanding the environmental impact of their organization. They must possess attitudes, values, and ethics for an eco-friendly approach to management. Students need to be open to green management and avoid some common but harmful stereotypes, assumptions, and biases. Essential attitudes include risk taking, openness to new ideas, unselfishness, and acceptance of new (green) stakeholders, goals, and practices.

How do we provide students with opportunities to develop knowledge, skills, and attitudes for green management? Providing knowledge is fairly straightforward and something we probably all do well in our teaching. Skills can be developed in several ways. Basic hands-on methods can be used in many courses. Perhaps students in the past did exercises applying skills (from financial management, organization theory, operations management, etc.) to traditional cost, quality, and access problems. Faculty could now assign hands-on exercises for students to apply skills to sustainability problems or create a green management action plan. Team oriented case studies can help students to think about the opportunities and obstacles to green management. If possible, develop practicums and other forms of experiential hands-on learning. Many hospitals are developing green initiatives and students might spend time within those HCOs and shadow the staff responsible for those initiatives. Finally, consider arranging for more advanced students to work as consulting teams developing green implementation plans for eco-friendly operations in a local HCO.

Pedagogy to shape students’ attitudes towards environmental awareness and management should differ from pedagogy for developing knowledge and skills. Students have to start with developing a willingness to listen and carefully consider alternative ideas and constructs. The next step is to assist
students in moving towards an examination of their personal values and see how they align with organizational and environmental needs. Finally, students need to be given the opportunity to revise their judgments and change behaviors in light of new substantive evidence.

These processes do not come out of a textbook. Rather, students should be given opportunities to critically examine their core beliefs and values and examine how the principles of green management can help shape their world view. To change attitudes, Borkowski (2009) recommends role play, coaching, group discussion, listening, feedback, rewards, and patience. Cialdini (2004) suggests six forces that influence attitude change: reciprocation, consistency, social validation, liking, authority, and scarcity. These forces apply to how one person can influence attitude change in another, and they can start to move attitudes in the classroom.

**Fit Within an Existing Curriculum**

Perhaps some people might not view environmental awareness and going green as relevant to the hard work of healthcare management nor essential to a healthcare management curriculum. Yet not many years ago, some people said emotional intelligence and self awareness were perhaps nice but not necessary to prepare our students. We believe that students today are acutely aware of the environmental movement, have likely already been reducing their own environmental footprint, and expect their curricula and classes to include this subject.

Rather than create a whole new curriculum or courses around green management, it makes sense to integrate this into the existing curriculum and courses. Ideas were presented above for how to weave green KSAs into courses on finance, human resources, organization theory, operations management, and other subjects. Practical KSAs can also be developed in courses for organization behavior, strategic management, leadership, and any other course in a curriculum. The capstone course and fieldwork provide opportunities to integrate and apply KSAs from multiple courses to solve sustainability problems in HCOs.

Besides adding green content and learning into an existing curriculum and courses, a program might want to have a specific course for this. An introductory course in environmental health could be taught within the program or offered within a different academic program or department. Programs might also wish to offer a green healthcare elective or independent study option for students who are especially interested in this subject.
Conclusion

Healthcare organizations must become greener and more eco-friendly, and their leaders will need knowledge, skills, and attitudes to accomplish this. Healthcare administration education programs and faculty can modify their courses, pedagogy, and program activities to help prepare today’s students to lead tomorrow’s green healthcare organizations. Future writing on this subject might discuss how environmental policy could be integrated into the curriculum.

References


Critical Decision Points in Designing Inter-Professional Education

Diane Howard, PhD, Kevin Ryan, JD, MA, Ruth Eudy, PhD, Gordon Mosser, MD, Keith Boyd, MD

Abstract
Appreciating the contributions other professions bring to the table is a process that can begin early in training and education. Numerous studies speak to the merit of taking students preparing for clinical and managerial careers in healthcare out of their respective silos and exposing them through classroom presentation and interactions to their future professional team members and colleagues. In this Teaching Tips and Tools, faculty from three university programs present their experiences in developing and conducting interdisciplinary healthcare education courses. Although the authors report significant differences in class size, composition, and topics presented, they note some common themes and lessons learned in the development and fielding of courses intended to increase interdisciplinary dialog and prepare healthcare professionals for working in teams.

Interprofessional Training
The IOM Report on Health Professions (2003) generated considerable interest on the part of medical education in the United States. Subsequent to the report, the Association of Academic Medical Centers issued a report that recommended fundamental curricular change in graduate medical education to enhance physicians’ understanding of and participation in quality improvement (Kroboth, Crismon, Hogue, Reed, Johnson, Robinson, et al., 2007). The quality improvement initiative included interprofessional educa-
tion. The AAMC joined with the Institute for Health Improvement on the IHI Health Professions Education Collaborative that involved representatives from 18 US medical schools, their co-located schools of nursing, pharmacy, and programs in healthcare administration, and three international collaborators (Zwarenstein, Reeves, Barr, Hammick, Koppel, & Atkins, 2006). The national education associations for each discipline participated in the Collaborative (Zwarenstein et al, 2006).

The American Association of Colleges of Pharmacy has been proactive in encouraging interprofessional education and recommends that students be competent in four ways including that they (Kroboth et al., 2007):

1) Share a common language that facilitates communication among healthcare professionals.

2) Demonstrate an understanding of the health professions—understanding the value that each profession adds to the delivery of healthcare.

3) Learn how to work effectively as a team that utilizes the unique and complementary talents of each member through interprofessional courses, seminars, activities, clinical experiences, and research projects.

4) Be able to promote the interprofessional delivery of healthcare in all practice settings.

APPLICATION OF INTERPROFESSIONAL EDUCATION

The University of Arkansas for Medical Sciences, University of Minnesota, and Rush University use team-based learning concepts for their medical, nursing, and allied healthcare students in their graduate interdisciplinary courses. The courses Reforming the American Healthcare System, Interprofessional Teamwork for Health Professionals, and Health Care in America, respectively, provide graduate students with the opportunity to train collaboratively. Table 1 presents a description of each course. Clinical and management students are not permitted to participate passively in the courses but share the classroom experience by interacting on assigned, cross-disciplinary teams to address leadership, public health, finance, quality, and workforce issues.

While the three courses differ —two provide an overview of the U.S. healthcare system to foster interprofessional understanding and teamwork by working in groups across professions while the other teaches content, skills, and attitudes needed for interprofessional teamwork—the three courses bring the students together to prepare them for the real world of work by acculturating them to the importance of communication and by fostering mutual understanding of roles and values, thus enhancing
Table 1

*Description of Interdisciplinary Courses*

<table>
<thead>
<tr>
<th>Course title</th>
<th>Rush</th>
<th>Minnesota</th>
<th>Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health Care in America</td>
<td>Interprofessional Teamwork in Health Care</td>
<td>Reforming the American Health Care System</td>
</tr>
<tr>
<td>Course credit</td>
<td>2 quarter hours</td>
<td>2 semester hours</td>
<td>3 semester hours</td>
</tr>
<tr>
<td>Session</td>
<td>2-hour weekly session with 30 breakout groups of 8 to 10</td>
<td>2-hour weekly session with 25 breakout groups of 10</td>
<td>2.5 hour weekly session with blog participation; two physical locations linked through videoconferencing</td>
</tr>
<tr>
<td>Class size</td>
<td>250</td>
<td>250</td>
<td>35</td>
</tr>
<tr>
<td>Taught since</td>
<td>1994</td>
<td>2005</td>
<td>2008</td>
</tr>
<tr>
<td>Methods</td>
<td>Lecture</td>
<td>Lecture</td>
<td>Lecture, discussion, videoconferencing, blog, paper presentations, critique</td>
</tr>
<tr>
<td></td>
<td>Team-based assignments and discussion</td>
<td>Group projects and discussion</td>
<td></td>
</tr>
<tr>
<td>Student body</td>
<td>Medicine, nursing, audiology, clinical nutrition, laboratory science, communication disorders, health management, perfusion therapy, vascular ultrasound</td>
<td>Medicine, nursing, pharmacy, social work, healthcare administration, public health, dental</td>
<td>Public health, health services administration, law, public policy</td>
</tr>
<tr>
<td>Class Topics</td>
<td>Public health and disease patterns in groups; workforce diversity; quality, patient safety, and patient experience; finance, cost, and access</td>
<td>Stereotypes of professions; effective and ineffective team communication; AHRQ TeamSTEPPS training; Plan-Do-Study-Act simulations; Root Cause Analysis</td>
<td>American healthcare reform, history, state models of health reform, international models of healthcare delivery</td>
</tr>
<tr>
<td>Technology</td>
<td>Blackboard</td>
<td>Moodle</td>
<td>Videoconference with Tandberg, Smart Classroom</td>
</tr>
</tbody>
</table>
their abilities to work together effectively in the healthcare environment. The University of Arkansas for Medical Sciences incorporates law school students into the classroom which provides an additional dimension of interprofessional richness in the classroom.

**Discussion / Lessons Learned**

The interdisciplinary course faculty has to be prepared for the challenges of inter-professional coursework. For the most part, overview courses that require students to study material outside of their clinical or management specialty can be perceived as superficial at best or at the worst unnecessary for professional development by students. The student body reaction and the support given the course in the curriculum by various program directors have a major impact on the perception, and thus the success of the class. The course orientation must elaborate upon the importance of interdisciplinary communication and the value this communication has on the patient experience, managerial effectiveness, and clinical outcome. The long-term success of interdisciplinary coursework requires the endorsement of the program chairs and fulfills the mission, vision, and values of the university and its leadership.

In reviewing student course evaluations and engaging in reflective assessment the authors note a series of lessons learned. These lessons are described in detail below.
TEXT / READING MATERIAL
The course should have reading materials that apply to the variety of disciplines represented in the course. The reading level of the text is important to engage the interest of the student and also reflects the background that they bring to the course. For example, there have been experiences where students taking an interdisciplinary course from the biological sciences read a policy book and have no interests in understanding the governmental bureaucracy and how this impacts them personally or their discipline. Supplemental readings are warranted if the course text is not applicable to the entire student body. Complementing course text with current readings from magazines, journals, and popular press works to engage the students. For example, the University of Arkansas Medical Sciences works to acquaint law students with policy jargon and management students with legal jargon by using online readings. Rush University incorporates current topics from The Atlantic, The New Yorker, The New York Times Magazine, and Philadelphia Magazine to help visibly ground the coursework to emerging challenges and opinions related to healthcare that are in the mainstream of public attention.

CLASSROOM
The physical space where an interdisciplinary course is taught can make or break the course. The room must be spacious and quiet enough to allow movement and discussion. The physical space must also promote communication and visual contact between students and faculty. Videoconferencing adds a dimension of challenge to the learning process because technical difficulties can damage the reputation of the course and frustrate students and faculty. It is very important to incorporate technical training for faculty into course preparation and have the appropriate technical support available for assistance.

CLASS TIME
Scheduling interprofessional courses can pose unique challenges due to clinical rotations, meetings, personal obligations, and poor student concentration. The faculty needs to be particularly clear on student expectations of attendance and participation.

LECTURERS
Given the diverse nature of interprofessional classes, lecturers need to be particularly effective for lectures to reliably stimulate student curiosity and learning. Faculty need to also set the expectation with students that they
come to class prepared and ready to interact with faculty and each other. The days when faculty served as ‘talking heads’ in front of the room are over. Simulations that allow the students to apply their book knowledge and get the students talking and invested in course content are necessary. The University of Minnesota includes interprofessional discussion of patient care cases in which care was suboptimal or simply unsafe. Medical, nursing, pharmacy, social work, and health administration students have the opportunity to discuss their differing roles, perspectives, and values. Time is provided to discuss conflicts within care teams and how to resolve them. Rush University assigns real-life medical center projects at the beginning of the term and imbeds 30-60 minutes of classroom time to work on the projects for presentation to the affected medical center departments.

COURSE CONTENT

The nature of inter-professional education requires the faculty to have a broad knowledge of the healthcare delivery environment. The course must identify competencies that the students should learn upon course graduation. While there may be emphasis on different aspects of the healthcare sector, the student should complete the course understanding the organizational structure, stakeholders, public policy, quality/patient safety, technology, and financial issues affecting the healthcare sector. A central course focus has to be on encouraging students from different disciplines to interact. A review of the competencies advocated by accreditation programs such as the Commission on Accreditation of Healthcare Management Education and the Council on Education for Public Health, and the National Center for Healthcare Leadership, a non-profit healthcare organization conducting a leadership education demonstration project that promotes competency education, suggest that communication, collaboration, interpersonal understanding, and team leadership be student learning outcomes of the course.

DELIVERY MODE

The technology available to students has to engage their current lifestyle using various digital communications (e.g., Facebook, Twitter, YouTube). The paper, pencil, and chalkboard of the 1960s will not engage students. There must be multiple modes of communication that incorporate readings, simulations, small group discussion, and presentations. For example, the University of Arkansas has employed web-based platforms upon which readings are posted and that also serve to host and facilitate discussions by students and faculty.
ASSIGNMENTS

The assignments must allow students to work with students from a variety of disciplines to resolve a problem. Through research, dialog, and project management and development, students interface with each other. The projects should allow them to develop technical knowledge of an issue, write up their analysis into a paper, and present to a cross-section of faculty. See Table 2 for an example of interdisciplinary course projects. In addition, assigned course material must be timely as far as its relevance to retain student interest. Because of the rapidly changing nature of the material covered in the University of Arkansas course, faculty have to review and update materials used in previous fielding of the course much more carefully than is the norm in other courses (e.g., health reform).

GRADING RUBRIC

The grading rubric may vary based on the nature of the disciplines included in the class. It should be made clear if the grading is on an A, B, C, Pass/Fail, or numeric scale. The definition of what constitutes each grade should be specified. This will limit the confusion when faculty award grades at the end of the term.

AREAS FOR ADDITIONAL CONSIDERATION

There are additional areas for consideration as faculty pursues interdisciplinary education. The authors of this article debate the best methods to address when interdisciplinary courses should be taught, who should be in an interdisciplinary class, and how individual assessment in groups should be managed.

PLACEMENT OF INTERDISCIPLINARY COURSES IN THE CURRICULUM

The placement of an interdisciplinary course can vary and depends on the mandatory or elective nature of the course. For example, the Rush course is mandatory and occurs in the first term of the curriculum for allied health, nursing, and medical students. This has disadvantages for students who are trying to absorb the graduate school experience and may find it difficult to digest the amount of work and also the professional differences with their new colleagues. There are varying levels of academic sophistication between allied health, nursing, and medical students. To expect them to compete at the same level can generate some frustrations for those who feel they lack the level of training or feel they are being held back because of differences between their training. Assigning the student groups at the beginning of
Table 2

### Team-Based Interdisciplinary Topics

#### Patient Safety

1. Analyze a real, specific event that jeopardized patient safety and make recommendations to prevent another such event.

2. Design and suggest a plan for implementation of a medication reconciliation system for the transition of a patient from outpatient to inpatient and back to outpatient.

3. Develop an evidence-based medicine protocol to standardize practice in the Emergency Department for (name a specific condition)

4. Develop a protocol to reduce the occurrence of urinary tract infections in hospitalized patients.

5. Develop a specific procedure describing how a hospital should use the National Practitioner Database before hiring a new physician.

6. Develop recommendations to prevent falls in hospitalized patients without unduly restricting patient freedom.

7. Write a position paper recommending changes to resident physician work hours.

#### Quality Management/Process Improvement

1. Improve the systems for “hand-off” communication with the purpose of reducing errors made as a result of a “hand-off” to near zero.

2. Describe a model in which a hospital can improve the management of pain for hospitalized patients.

3. Develop a system to ensure 100% of providers wash or alcohol rinse hands prior to patient contact.

4. Study the relationship between the number of tests that a doctor orders and the risk of being sued and make a recommendation regarding this issue.

5. Develop a system of public reporting of statistics on hospital and practitioner performance that patients can use to direct their medical care.

#### Contemporary Issues in Health Care

1. Develop a position paper describing how nurse practitioners should or shouldn’t establish primary care practices in pharmacies.

2. Examine the issue of whether physician-assisted suicide should be legalized.

3. Examine the issue of whether the prescription of marijuana for medical conditions should be legalized.

4. Design a plan to help people pick the right health insurance.

5. Develop a national recommendation for genetic testing and insurability.

6. Improve the quality of the care offered at the end of life while cutting the costs.

7. Describe the cost of obesity management at a hospital and how the hospital could contribute to the control of the obesity epidemic.
the course works in that student groups can develop relationships over the 10-week period. Team meetings are embedded into the two-hour course where the final hour of class involves team project discussion.

At the University of Minnesota, several professional schools participate, and their students are at different stages in their educational careers. Medical students are in their second year and have basic sciences but no clinical exposure. Nursing students are in their third undergraduate year and have had substantial clinical exposure. The mismatch of experience has posed problems, and the difficulties of scheduling have prevented reaching a solution. In contrast, all students participating in the University of Arkansas course are either graduate students who have completed required core courses or third year law students (the latter of these two groups must have permission of the law faculty to enroll). As such, the experience levels between the two disparate groups is more on par and appears to mitigate feelings of frustration and similar issues noted in the other programs discussed here.

WHO SHOULD BE IN THE COURSE?
For academic institutions that can manage the various clinical and management programmatic schedules along with the availability of classroom space, the students in their initial academic term should be in the course. At some point in the students’ professional careers, they will be working on interdisciplinary teams so there is no time like the present. At the University of Minnesota, there is a strong commitment to including all healthcare professionals in the inter-professional education at some point so that the current silos among the professions become things of the past. The current course has succeeded in including medical, nursing, administrative, pharmacy and social work students, but very few public health or dental students have participated so far. At the University of Arkansas, this issue is moot. The Arkansas course serves as an elective, and students are mandated to complete core and required courses prior to enrollment. As a result, all students are at an upper level in their respective programs with concomitant experience and expertise.

INDIVIDUAL ASSESSMENT IN GROUPS
Inter-professional courses rely to a large extent on group projects, as portrayed in Table 2. Grading group projects can present challenges because the group is being assessed and there are varying levels of participation. When the group size is over six, there is a tendency for additional group members to become invisible or lost to the process. Faculty may not be aware of this
so the introduction of a group assessment by each group member may be warranted. The grading scale may include an assessment on student timeliness, meeting attendance, writing and research participation, and overall performance. Prior to distributing the assessment form, students must be educated on the importance of the evaluation tool and their role in assessing each other honestly. Performance criterion and expectations must be clearly articulated so there is no misunderstanding.

At the University of Minnesota, individuals are assessed in simple quizzes following the individual sessions of the course. While students receive credit for assessing their peers, student class presentations, group projects have not been assigned to date in the University of Arkansas course.

Conclusion

Today as never before, the healthcare system is one that is intricate and complex. Effecting positive outcomes for healthcare services consumers requires input from and interaction with a series of professionals. Optimizing the interaction between and across these individuals can be an arduous but critically important task as the healthcare field continues to evolve in complexity.

It is long accepted that providing healthcare students with an interdisciplinary perspective in the course of their respective training can positively impact their future practices. We contend and our experiences support that the investment of efforts to develop and optimally field such courses pays long term dividends for individuals, their professions, and the healthcare system as a whole.

References


