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Values of Hospital Chief Executive Officers in Ontario

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A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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Abstract

Value-based health systems, where the fundamental goal of the system is to maximize patient value, have been suggested as a means to improve health service delivery. However, our understanding of various stakeholder values in Ontario is limited. This study collected interview responses from 26 Ontario hospital Chief Executive Officers (CEOs) in an attempt to understand their personal values, alignment with health-system values, and use of values to drive decision-making. Results suggest that Ontario hospital CEOs have two value sets; a set of core values (i.e. integrity, compassion, empathy) that are established at a young age and are largely non-negotiable, and a set of practical values (i.e. transparency, impact, engagement) that are established throughout the career journey and are specific to the leadership role. By developing an understanding of hospital CEO values, this research contributes to the growing body of evidence supporting value-based health systems, and hopes to act as a catalyst for value-based reform by aligning leadership values with consumer values.

Keywords: Chief Executive Officer, CEO, leadership, hospital, health centre, priorities, values, Grounded Theory, qualitative

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Chapter 1 : Introduction

1 Introduction

1.1 The Concept of “Value”

“Value” is a complex concept that is challenging to define, and is often misunderstood in the academic literature due to the complexity of the concept and a lack of consensus on the definition and components of value. The concept of value has been well-researched in a number of sectors, primarily in philosophy and business literature. In the context of industry, the concept of “value” has been poorly defined, and has been seen as synonymous with “goodness, or shininess, or luxury, or weight” (Zeithaml, 1988, p. 2). Similarly in healthcare, despite receiving limited research attention, some researchers have pointed out a lack of clarity in the conceptualization of “value” (Liu et al., 2006). Moreover, aside from conflicting definitions of value, nearly all value-based healthcare research focuses entirely on patients’ perspectives – with little understanding of value from the perspectives of other key stakeholders in health systems such as providers or administrators. This becomes problematic because, in order for health systems to be able to measure and deliver value to patients, they must first have a clear and consistent understanding of what they mean by value (Snowdon et al., 2012).

The definition of value in healthcare varies depending on the individual and field of focus (Teke et al., 2010, p. 1304). The research community and healthcare decision makers often draw on value concepts from the philosophy or business literature, which, although similar to patient value, do not reflect the uniquely sensitive nature of healthcare decisions.

This thesis adopted, as a basis, the value definition from Teke (2010), as it is one of few data-driven definitions that views value as a multidimensional concept. Teke (2010) defines value as, “the evaluation of the received benefits and the sacrifices made by the consumer” (p. 1301), consisting of (in decreasing order of importance) functional value (professionalism), social value, functional value (quality), functional value (installation), and emotional value. This and other value definitions are further explored in Section 2.3: Value in Healthcare.

Rising costs for global health systems have resulted in a priority focus for many health systems on cost-reduction (Kenagy et al., 2001). However, recent trends are seeing a shift from

a cost focus to a focus on quality and access (Kenagy et al., 2001). This trend indicates a need to “seek ways to broaden our understanding of stakeholder relationships within the health care system, and define more clearly the various factors that constitute value” (Kenagy et al., 2001, p. 159). This thesis research sought to further our understanding of value in Canadian healthcare, in particular, the perceived value of hospital Chief Executive Officers (CEOs). This question was pursued with the underlying assumption that health systems should be value-driven and are mandated to deliver value to the populations they serve.

1.2 Value-Based Health Systems

The concept of value-based health systems “centers on the premise that the fundamental goal of healthcare is to maximize value for patients, defined as patient health outcomes achieved per unit of cost expended.” (Porter & Guth, 2012, p. 25). In a traditional, supply-led healthcare system, individual practitioners and providers provide individual elements of care based on their specialty and experience, and are accountable for the individual patients whom they serve. Conversely, in a demand-driven, value-based healthcare system, practitioners and providers are organized into teams responsible not for individual services offered, but, rather, for reaching the value-based targets and outcomes of a prospectively defined population (McClellan et al., 2013).

The key differences between a supply-led and demand-driven system are the values of the health system itself. In a supply-led system, system values are focused on inputs such as cost, access, and quality, whereas, in a demand-driven system, values are focused on outcomes that are important to patients and populations (McClellan et al., 2013).

Many researchers have examined the benefits of value-based systems through the lens of the patient. From a patient perspective, “... values function as a filter through which patients interpret clinical evidence and make treatment choices” (Lee, Low & Ng, 2013, p. 1). Improved involvement of patients and their values in clinical decision-making improves adherence to treatment protocols and improves outcomes (Wilson et al., 2010). However, the benefits of value-based systems are not unique to patients. From a hospital perspective, “if the hospital managers give importance to the sub-dimensions of the patient value inclined to their own hospitals and they regularly examine the situation of these dimensions, they can move one step ahead in achieving patient satisfaction and loyalty (in an American private health-system context)” (Teke et al., 2010, p. 1302). “Strategies based on customer value standards and

perceptions will channel resources more effectively and will meet customer expectations better than those based only on company standard” (Zeithaml, 1988, p. 18).

Globally, health systems are moving towards value-based design at varying rates due to the complexity of system transformation. A shift from a cost-based, to a value-based, system requires “a transformational change in the culture” of Canadian health systems (Snowdon et al., 2012, p. 7). “Moving to a value-based system is guided by a set of universally applicable core principles. These principles start with a shared goal for all system participants; provide a framework for how healthcare providers should organize, deliver, and measure care; and establish new roles for patients, employers, and the government.” (Porter & Guth, 2012, p. 26). Central to the concept of value-based health systems is a common goal to provide value to patients (Porter & Guth, 2012). Prior to transitioning health system design to a value-based system, it is imperative that the values and goals of all system stakeholders are aligned. Only once all stakeholder values are understood can system redesign occur by identifying the misalignments between what is currently funded, organized, and evaluated, and what is currently valued (Snowdon et al., 2012).

1.3 Alignment of Health-System Values

A core tenant of value-based health systems is the alignment of population values with health-system values. One of the earlier proponents for value-based health systems in Canada was Roy Romanow, who led the Royal Commission on the Future of Health Care in Canada. One of the key directions for change outlined in the 2002 Romanow Report called for the “establish[ment] of a new Canadian Health Covenant as a tangible statement of Canadians’ values and a guiding force for our publicly funded health care system” (p. xxiv). Romanow also highlighted the need to adapt healthcare systems to the ever-changing values of Canadians, “a renewed Canada Health Act... will ensure that the health care system not only reflects Canadians’ values, but also continues to change and evolve to meet Canadians’ needs” (2002, p. 73). However, alarmingly, Romanow identified the beginning of a value disconnect growing in Canadian healthcare, stating that, “there is a growing tension between the principles of our health care system and what is happening on the ground” (Romanow, 2002, p. xx).

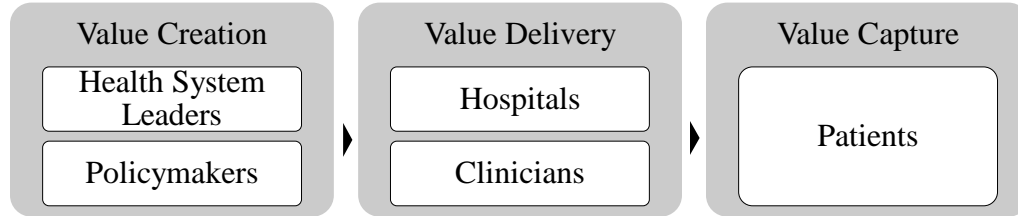
Few studies have been conducted, since the Romanow Report, focusing on values across different stakeholder groups in health systems. While research in this area is limited, it is clear that there is a misalignment between all stakeholder values in Canadian health systems:

hospitals value excellent care that achieves quality of life and collaborative partnerships; community organizations value empowerment and engagement to strengthen population health; health professionals value support for professional practice; and consumers value personalization, autonomy and empowerment in managing their own health care (Snowdon et al., 2012). These findings highlight the complexity of achieving a value-based health system, and indicate a need to better understand how health systems can achieve value across all stakeholders in Canadian health systems.

1.4 Negotiation of Misaligned Health-System Values

The leading American competitive strategist Michael Porter has become a proponent for value-based health systems. In his thought piece “A Strategy for Health Care Reform – Towards a Value-Based System”, Porter argues that, while most healthcare reforms focus on coverage and system-level policy, the biggest impact of value-based system design is through restructuring the delivery of value. Furthermore, speaking of the US health system, Porter argues “the current delivery system is not organized around value for patients, which is why incremental reforms have not lived up to consumer expectations. Our system rewards those who shift costs, bargain away or capture someone else’s revenues, and bill for more services, not those who deliver the most value... without comprehensive outcome measurement, it is hard to know what improves value and what does not” (Porter, 2009, p. 110).

By adapting Porter’s (1985) value chain framework to a public health-system context, one can construct a simplified value chain to understand how values are negotiated across stakeholders. Traditional value chain analysis focuses on one organization at the stages of value creation, delivery, and capture. However, the current thesis research was based on the view that the healthcare value chain can be seen as one entity, where value is created by the system designers, delivered by hospitals, and captured by patients. This simple framework is meant to demonstrate one method through which values are negotiated across stakeholders. A simplified healthcare value chain mapping all the central stakeholders is proposed:

Figure 1: Simplified Healthcare Value Chain

This value chain separates stakeholders into three categories: value creation, value delivery, and value capture. Through this model, health-system leaders and policymakers create value by organizing health systems and developing a service offering. Value is then transferred to hospitals and clinicians, who deliver value to patients. In its simplest form, there are two value transfers (creation>delivery and delivery>capture). The management of these value transfers occurs between health-system leaders and hospitals, and between hospitals and patients. Responsible for both of these transitions are hospital CEOs, who are directly accountable to both the health system (LHINs and Ministry of Health and Long-Term Care) and patients (through hospital boards of directors).

In Canada, healthcare is largely delivered through hospitals. Hospitals remain the largest component of health-system costs, representing 28% of all health-care costs or \$45 billion per annum (Sutherland, 2011). As organizations, hospital values are well understood, as they are open and transparent through mission, vision, and value statements. However, as a collection of individuals, hospital values are less understood in the literature. That is, while hospitals are a key service delivery agency in all health systems, and hospital values are identified in mission, vision and value statements at the organization level, the link between values at the organizational level and how hospital CEOs execute and implement in relation to the value proposition of the organization, has not been examined to date. Existing research has focused on patient perceived value and, to a lesser degree, how clinicians deliver value. What is much less clear is how leadership shapes, influences, and creates conditions that influence how health systems achieve and deliver value. Value creation in health systems remains poorly understood, often neglecting hospital management and leadership. The purpose of this research is to fill this gap and understand the values of hospital CEOs who are accountable for hospital operations and delivery of patient value in Ontario hospitals.

1.5 Purpose of the Study

It is clear that there is a gap between what patients actually value and whether health services achieve value for patients. There is currently an incomplete understanding of the relationship between patient values and health-system values (Wylde et al., 2006). While the concept of patient value has been moderately explored in academic literature, it is ultimately the hospital leadership that implements policies and practices through which value is delivered to patients – and it is the hospital leadership that shapes decisions aimed at creating value for patients. “Hospital Chief Executive Officers play a critical role in shaping the performance of their organizations through setting organizational priorities, allocating resources, and hiring clinical leadership” (Joynt et al., 2014, p.61).

Several researchers have called for further research which looks at the practical implementation of health-care value learnings into action (Liu et al., 2006, p. 69). This study attempted to understand the values of hospital CEOs in Ontario and sought to address the following questions:

1. What do Ontario hospital CEOs value at an individual level?;
2. Are CEO values aligned with health system, patient, and community values; how are any misalignments negotiated?; and
3. How do CEO values drive or affect organizational behavior and decision-making?

Chapter 2 : Review of the Literature

2 Review of the Literature

This chapter identifies the current knowledge gaps that exist in the academic literature with respects to CEO values in Ontario hospitals. A literature review was conducted in three main phases exploring; a) the concept of value from philosophical literature; b) value in the business literature; and c) value in healthcare. The rationale for focusing on these three areas relates primarily to the interrelatedness between philosophy, business, and healthcare in hospital leadership.

To conduct a review of the literature, two databases were searched, including Ovid Medline and PubMed. These two databases were selected for their wide scope and broad reach in the health sciences literature – both necessary for the interdisciplinary topic of hospital CEO values. The search terms included: *Chief Executive Officer, CEO, leadership, hospital, health centre, priorities, values, value-based healthcare, and value-based health system*. The search was limited to English studies from 2004 onward. This initial search yielded 670 studies after removing duplicates. The articles' abstracts were scanned to determine their fit with the concepts under study: value and value-based healthcare. Excluded articles were primarily removed due to a lack of focus on CEOs specifically and/or a lack of understanding CEO perspectives on any given topic. The remaining articles were scanned for references, and a total of 74 articles were used for this literature review.

2.1 Value in Philosophy

Understanding the concept of “value” has led to the development, within multiple academic disciplines, of evolving subfields defined by the task of explaining the notion of “value”. In all these disciplines, the subfield is called “value theory”. Taken together, it is the study of what is valuable and why (philosophy); what individuals value and why (psychology); what is valued at a societal and community level (sociology); and what people value and to what extent are values related to goods and services (economics).

The value theory literature is generally in agreement that values, simply put, are what is good, and that values are individually defined and ranked in order of priority (Wankel, 2009). Furthermore, the individual constructs of value are relatively constant throughout the literature.

Table 1 highlights common themes in the philosophy-based value literature, along with the associated terms for these themes within each publication.

Table 1: Constructs of Value from Philosophy Literature

Construct of Value	Philosophy Literature Reference
Power: social superiority, status, or control	Power (Wankel, 2009), Power distance (Hofstede, 1983), Power distance (Smith et al., 2002)
Achievement: demonstration of competence in what is valued by the system or organization	Achievement (Wankel, 2009), Masculinity (Hofstede, 1983)
Physical pleasure	Hedonism (Wankel, 2009), Masculinity (Hofstede, 1983)
Stimulation: excitement and novelty	Stimulation (Wankel, 2009), Individualism (Hofstede, 1983)
Individualism: autonomy, independence, and self-thought	Self-direction (Wankel, 2009), Individualism (Hofstede, 1983), Individualism-collectivism (Smith et al., 2002)
Universalism: protecting the welfare of all people	Universalism (Wankel, 2009), Egalitarian-commitment (Smith et al., 2002)
Benevolence: improve the welfare of people close to the individual	Benevolence (Wankel, 2009), Loyalty-involvement (Smith et al., 2002)
Tradition: respecting cultural customs	Tradition (Wankel, 2009)
Conformity: upholding social expectations and norms	Conformity (Wankel, 2009), Uncertainty avoidance (Hofstede, 1983), Uncertainty avoidance (Smith et al., 2002)
Security: safety and stability	Security (Wankel, 2009), Uncertainty avoidance (Hofstede, 1983), Uncertainty avoidance (Smith et al., 2002)

The philosophy literature approaches value as a multidimensional concept, comprised of 10 valued sub-themes: power, achievement, physical pleasure, stimulation, individualism, universalism, benevolence, tradition, conformity, and security. These 10 sub-themes can be grouped into 3 key themes of value:

- **Functional Value:** Achievement, Physical Pleasure, and Security
- **Social Value:** Power, Universalism, Benevolence, Tradition, and Conformity
- **Emotional Value:** Stimulation and Individualism

In simple terms, functional value focuses on what an individual achieves, social value focuses on relative position or stature within a community or tradition, and emotional value is

what is experienced through stimulation and individual experience. These three core components of value offer a universal definition of the concept.

In relation to this thesis research on value within the healthcare context, the conceptualization of “value” described above leads to the proposition that patients, hospitals, CEOs, and health-system leaders all share a common understanding of value, with the same components of core values. What is unclear from the philosophical research – and is necessary to answer our research question – is how these values relate to specific industries, organizations, individuals, or situations. From a practical, pragmatic perspective, value theory is “not empirically operable”, and is overly-generalized (Ruggles, 1954, p. 147). These theories represent aggregate samples which are not unique to any one scenario. For example, Hofstede (1983) sampled from a variety of large corporations across the United States, and Wankel (2009) sampled from 38 countries. Due to the vague and ambiguous understanding of value from philosophy, different industries have begun to examine value theory at a more targeted level. Furthermore, philosophical value definitions are almost exclusively theory-based, rather than evidence-based. This limits the reliability and validity of any findings that could contribute to a value-based health system. In order to understand the values held by hospital CEOs, it is necessary to also understand the relevant literature on value in business and value in healthcare, as they are uniquely positioned in the two industries. The findings from the philosophy literature beg the questions; how do CEOs view, experience, or execute functional value in the hospitals they lead; what are CEOs’ perceptions of the social value their hospital contributes to the intended population; and what is the role of emotional value (at the individual level) that influences CEO leadership values and organizational outcomes?

2.2 Value in Business

The concept of value as it relates to consumers has been well documented in the business literature, especially in the fields of marketing and consumer behavior. Until the late 1980’s, the majority of consumer value literature focused solely on quality and cost. The general consensus viewed value as a simple function of quality divided by cost. In 1988, this definition was expanded to include a variety of inputs. According to Zeithaml (1988), “perceived value is the consumer's overall assessment of the utility of a product based on perceptions of what is received and what is given” (p. 14). This definition of value differs from quality and cost in two ways. First, value is a higher level concept than quality, and is more

individualistic. Second, value involves the tradeoff between “give” and “get”, where “give” does *not* have to be cost (Zeithaml, 1988, p. 14). The idea of value as a multidimensional concept is quickly spreading, yet “quality” and “value” are still often poorly differentiated from each other, the key distinction being that quality involves the appraisal of “get” without “give” (Zeithaml, 1988).

Similar to the philosophy literature, most modern definitions of customer or consumer value in business literature approach it as a multidimensional concept. Table 2 indicates the common themes in the multidimensional value concept from business literature. Sheth (1991) is used as a base definition for value in the business literature, as it is frequently sourced as a comprehensive definition of value from a consumer perspective. Sheth (1991) is updated and compared with more recent articles below.

Table 2: Constructs of Value from Business Literature

Construct of Value (Sheth, 1991)	Business Literature Reference
Functional value: “the perceived utility acquired from an alternative’s capacity for functional, utilitarian, or physical performance” (p. 160)	Perceived utility (Groth, 1995), functional (price/value for money), functional (performance/quality), functional (versatility) (Sweeney et al., 1999), Quality (Petrick, 2002), Monetary price (Petrick, 2002), Functional value (installations), functional value (professionalism), functional value (quality), functional value (price) (Sanchez et al., 2006)
Social value: “the perceived utility acquired from an alternative’s association with one or more social groups” (p. 161)	External value (Groth, 1995), Social value (Sweeney et al., 1999), Reputation (Petrick, 2002), Social value (Sanchez et al., 2006)
Emotional value: “the perceived utility acquired from an alternative’s capacity to arouse feelings or affective states” (p. 161)	Psychological/internal value (Groth, 1995), Emotional value (Gronroos, 1997), Emotional value (Sweeney et al., 1999), Emotional response (Petrick, 2002), Emotional value (Sanchez et al., 2006)
Epistemic value: “the perceived utility from an alternative’s capacity to arouse curiosity, provide novelty, and/or satisfy a desire for knowledge” (p. 162)	Cognitive value (Groth, 1995), Cognitive value (Gronroos, 1997),
Conditional value: “the perceived utility acquired by an alternative as the result of a specific situation or set of circumstances facing the choice maker” (p. 162)	Behavioral price (Petrick, 2002)

Comparing across researchers, the concepts of value in the business literature generally are very similar to those found in the philosophy literature. Both fields generally view value as a multidimensional concept consisting of functional, social and emotional value. However, several important differences are found in the business literature which provide a better understanding of CEO values and have important implications for this study.

The value concepts found in the business literature are far more discrepant than the concepts found in the philosophy literature. This is likely due to differences in context. As previously mentioned, philosophical definitions of value are commonly criticized for being over-generalized, lacking capacity for practical application in a specific context. In contrast, the business literature is largely context-specific. For example, few studies in the business literature identified epistemic value as a construct. Gronroos (1997) likely identified this concept because this research was specific to a marketing context, where “capacity to arouse curiosity, provide novelty, and/or satisfy a desire for knowledge” (Sheth, 1991, p. 162) is a sought-after outcome. Similarly, behavioral price, defined as easily accessible and requiring little energy to purchase, was only identified by Petrick (2002). Again, in this study, Petrick (2002) focused on the leisure services industry, where this concept is perhaps more important than it would be in, for example, a financial firm.

An important finding from this analysis is the context-specific nature of value, as demonstrated by differing opinions and prioritizations of value concepts in the business literature. For healthcare, this means that there may be concepts of value that hold significant importance for different stakeholders, and there may be new concepts of value that are not found in the philosophy or business literature. Moreover, the context-specific nature of value may even vary within a single hospital. For example, is value in inpatient settings different from ambulatory settings, or is value different for seniors compared to children? This further indicates the importance of examining each field/industry closely to better understand the concept of value and also highlights the need to ask hospital CEOs if value is context specific in their organizations.

2.3 Value in Healthcare

2.3.1 *Value in Healthcare: Patients*

With the increasing trend towards consumer-driven health systems, healthcare value research from a patient perspective is growing rapidly. This research is largely divided into three main categories. In decreasing magnitude, these categories are: patient value in health economics (Brown et al., 2013; Brown, 2013; Abdulla et al., 2013), patient value in value-based effectiveness for specific therapies/treatments (Pitt, 2014; de Korne et al., 2009), and individual patient values (Liu et al., 2006; Teke et al., 2010).

The majority of patient value research has come from the United States, and largely focuses on the perceived economic value of care (Teke et al., 2010). This research focuses on the cost of individual services from a health economics perspective (Brown, Brown & Sharma, 2003; Brown & Brown, 2013), and generally views patient value as an objective measure which can be evaluated without patient consultation.

Many of the current definitions of patient value in the health-care literature are overly vague, such as “the features that matter most [to patients]” (International Patient Decision Aids Collaboration, 2006, p. 1) or “personal importance” (Elwyn et al., 2006, p. 3). Yet, some researchers have begun to define patient value as a multidimensional concept. Maccario (1999) defines patient value as the patient’s perception of quality, consisting of quality features of care and customer service (p. 74). Brown & Brown (2013) define patient value by the outcomes of healthcare, including increased quality of life and/or length of life, each consisting of several variables (p. 183). However, even amongst multidimensional definitions of patient value, there is still no consensus.

Lee, Low & Ng (2013), and several other studies, have “highlighted the need for expanding the current concept of patient values in medical decision making” (p. 1), since, in current systems, clinician consideration of patient values is almost solely related to treatment options. The authors report that, in addition to treatment-related values, patient values should include “patients’ priorities, life philosophy and their background” (p. 1). This newer trend in patient value research defines it as an individual perception of value. This trend is similar to the evolution of the concept of value in the business literature. Health economics closely mirrors the concept of value as cost, such that value-based effectiveness closely mirrors the

concept of value as a function of quality and cost, and individual patient value mirrors the value as a multidimensional, individual concept.

Although not specific to *patient* value, the majority of recent patient value research is rooted in, and references, Zeithaml’s (1988) findings. Health research that takes this approach translates Zeithaml’s findings to a healthcare context, primarily through theory rather than evidence. Zeithaml identified five key components of perceived value that were later adapted to a healthcare context (See Table 3).

Table 3: Zeithaml's (1988) Perceived Value and Associated Healthcare Relevance

Zeithaml (1988) Components of Perceived Value	Healthcare Relevance
“The benefit components of value include salient intrinsic attributes, extrinsic attributes, perceived quality, and other relevant high level abstractions” (p. 14).	“Few articles have clearly distinguished value in the health care domain and demonstrated that the concept of value has been assimilated into satisfaction in the health care domain” (Liu et al., 2006, p. 66). Value can be determined by external factors such as patient background, healthcare provider personality, and healthcare setting (Hall & Dornan, 1988).
“The sacrifice components of perceived value include monetary prices and non-monetary prices” (p. 14).	“Viewing value as only a trade-off between quality and price or the relationship between “get” and “given” is not true” (Teke et al., 2010, p. 1302).
“Extrinsic attributes serve as "value signals" and can substitute for active weighing of benefits and costs” (p. 15).	“It was found out that another important dimension of perceived value is social value... the hospital’s being preferred by other people” (Teke et al., 2010, p. 1305).
“The perception of value depends on the frame of reference in which the consumer is making an evaluation” (p. 15).	“Patients’ reasons for undergoing a surgical procedure can change over time; these changes can influence their perception regarding outcome” (Lieberman et al., 2003, p. 66).
“Perceived value affects the relationship between quality and purchase” (p. 15).	“Quality, relative to price, determines a patient’s perceived value” (Maccario, 1999, p. 74).

The same elements of functional, social, and emotional value are seen throughout both sets of literature. However, a key difference arises in the prioritization of values. Healthcare is one of the most personal and vulnerable experiences people go through, so the values associated with care are significantly important to the person and thereby increasingly sensitive. Most definitions of patient value are theoretical models developed by researchers.

Few studies have examined the concept of patient value by going straight to the source and studying/interviewing/consulting patients to create the evidence for value and what it means to the individual, or the community. This can be partially explained by the lack of tools which properly assess patient values on a large scale. “The vast majority of instruments fail to address the diversity of priorities and concerns of respondents and the varying weights and values which they attach to their concerns (Fitzpatrick, 1999, p. 1). However, to truly understand the sensitive nature of patient value, a more involved approach needs to be taken.

Perhaps the most robust definition of patient value that uses a patient-involved approach comes from Teke et al. (2010). Teke et al. (2010) pooled the business literature and asked how patients in American hospital systems perceived value. The authors describe patient value as a multidimensional concept built from functional value (professionalism), functional value (installation), functional value (quality), emotional value, and social value – including both the benefits *and* sacrifices that patients perceive in their care (p. 1301). The most important dimensions (in decreasing order of importance) are:

- **Functional Value (Professionalism):** “hospital employees’ being professional in their field, their following the developments in their field daily, their carrying out their job willingly, [and] the acceptance of the advices they gave as valuable” (p. 1305)
- **Social Value:** “the hospital’s being preferred by other people, getting health service from the hospital being regarded as a prestige by individuals, and the service that the hospital offers being accepted as valuable by other people” (p. 1305)
- **Functional Value (Quality):** “hospital services should be well organized, high quality service should be offered, [and] the offered service should be better than the services offered by other hospitals and the results of hospital services should be in an acceptable level” (p. 1306).
- **Functional Value (Installation):** “cleanliness of the hospital, modern structure of the building, getting and finding the hospital easily, easy transportation, [and] the well design of the hospital to make the mechanism in the hospital smooth” (p. 1306).
- **Emotional Value:** “satisfying service, positive opinions, the employees giving their all, and leaving the hospital with contentment” (p. 1306).

There is a large difference between these findings and the findings from business literature. The most important construct of value in the consumer literature was power,

whereas, in the patient value literature, power is not a priority at all. Again, this further indicates the need to study value within the specific context of interest.

2.3.2 *Value in Healthcare: Health Professionals*

“Health professionals... view healthcare in terms of their ability to practice and care for patients in a timely and effective manner. They are key stakeholders in the healthcare system, and as such, their values are oriented towards how the system provides their livelihood, how the system enables them to care for patients, and the efficiency with which they are able to practice” (Snowdon et al., 2012, p. 10). Few studies have looked at the relationship between patient perceived values, and health-system players’ values. Many factors influence healthcare professionals’ values other than from patient interactions, including “education and training, socialization within their scope of practice, and the patient population for which they care” (Snowdon et al., 2012, p. 10). Therefore, there are opportunities for gaps in understanding of patient values between the patient and the practitioner/manager. Wylde et al., (2006), examined the relationship between patients’ self-perceived values and healthcare professionals’ perceptions of patient values, and found that there were significant differences. Healthcare professionals generally ranked the importance of Health Assessment Questionnaire items lower in importance than patients ranked for themselves. The gaps in perceptions of patient value not only affect patient experience in the care they receive, but also affect clinical outcomes (Wylde et al., 2006).

2.3.3 *Value in Healthcare: Hospital CEOs & Leadership*

Hospital CEOs are the leaders of acute care delivery in Canada, and as such, are key drivers of value delivery to patients. “Strong leadership and the involvement of Canadians is key to preserving a system that is true to our values and sustainable” (Romanow, 2002, p. xv) Hospital CEO expectations vary slightly province by province, yet the core responsibilities are relatively similar. Focusing on Ontario, Snowdon et al. (2012) examined the roles and responsibilities that hospital CEOs chose to be evaluated on as indicated by the annual Quality Improvement Plans. This analysis showed that the primary roles of hospital CEOs in Ontario involved managing safety (ex. Clostridium Difficile Infection rates, hand hygiene compliance, falls), effectiveness (ex. hospital standardized mortality ratio), access (ex. emergency room

length of stay for admitted patients), and patient centeredness (ex. patient satisfaction survey scores). However, through deep analysis of CEO contracts, Snowdon et al. (2012) found that there was a misalignment between Canadian patient values and hospital CEO incentives/evaluations.

Existing literature targeting hospital CEO values is limited. Hospital CEO literature in general is largely quantitative and focuses primarily on CEOs' financial responsibilities. Multiple studies focus on both CEOs and CFOs together, and do not differentiate between the two. "They [CEOs and CFOs] are responsible for the ongoing financial management of the organization, including reporting financial information to the hospital board, auditors, and the Centers for Medicare and Medicaid Services" (Holmes & Pink, 2011, p. 93). Nearly all studies involving hospital CEOs are based in the United States. This is a significant limitation when applying these findings to a Canadian context, as the role of CEOs is very different in the two countries.

While no existing literature explicitly focused on CEO values, several published CEO interviews exist which reveal key priorities and professional values. Tam (2012) interviewed CEOs of Palomar Pomerado Health with the intention of revealing CEO perceptions of new hospital construction. During this interview, it was revealed that key professional values included: achieving the hospital's mission, patient-centred care, long-term planning, and creating a positive workplace/culture for hospital staff.

It should also be noted that hospital CEOs' values are different from other healthcare leaders' values. Perceptions of results differ by hierarchical levels within hospital structure (Walston & Chou, 2009). Formella (2012) outlined the difficulties many Chief Nursing Officers face when transitioning to a CEO position, including the importance placed on operational activities outside of patient care.

Hospital CEO values and perceptions drive organizational decisions and actions – regardless of reality (Weick, 1995). "Researchers have found that the CEO's attitudes, perceptions, and actions heavily influence the success and outcomes of firms" (Walston & Chou, 2009, p. 190). The opinions of hospital CEOs are commonly used in research as a proxy for organizational outcomes, as CEO values are highly influential over the organizational culture and climate (Cycyota & Harrison, 2006; Nieva & Sorra, 2003).

Hospital CEO Demographics

Seventy-two percent of US hospital CEOs are over 50 years of age (Collins et al, 2009). Furthermore, nearly half of all US hospital CEOs are planning to retire by 2020 (Matthews et al., 2013). As a new wave of younger CEOs enters hospital leadership, values in the industry may shift. However it is unclear how generational values may influence hospital CEO values.

Eighty-six percent of CEOs agree that an academic degree is essential for successful hospital CEOs, yet only 50.8% think healthcare management degrees are more effective in preparing for success (Collins et al., 2009). Furthermore, less than 10% of CEOs believe that business skills alone (without additional healthcare training) effectively prepare individuals for CEO positions, with 66.7% believing hospital administration required a unique skillset unseen in the business world (Collins et al., 2009). Thirty-four percent of healthcare managers hold healthcare management-related degrees, while 24.75% hold degrees in business administration and 41.75% hold technical degrees (Matthews et al, 2013). This wide range in experience and training likely has an effect on individual CEO values and priorities, however, the influence of education, generational values, is not clearly defined in the literature.

To understand CEO values, it is important to understand the drivers of becoming a CEO, as past experiences can drive the emotional construct of value (Petrick, 2002). Waldman et al. (2006) surveyed US hospital CEOs to determine why they chose their occupation; 31% indicated personal reasons (compensation, status, location, combining what they are good at with what could help others); 26% said altruism; 23% serendipity; and 19% for the challenge. These findings were common across genders and institutional sizes. These results indicate that, even in private healthcare systems, the desire to improve the lives of others is of clear value to hospital CEOs.

Hospital CEO Priorities

From a compensation perspective, Joynt et al. (2014) assessed the drivers of hospital CEO compensation and found that the primary indicators of higher compensation were overseeing larger teaching hospitals, a higher level of advanced technologies, and higher patient satisfaction. There was no association between patient outcomes and community impact with respect to compensation, and a very weak correlation between financial performance and compensation (Joynt et al., 2014). Financial compensation is a main driver

of professional values and priorities, yet US hospital CEOs are not incentivized to focus on many of the quality drivers (Joynt et al., 2014).

Wilson-Stronks & Mutha (2010) interviewed 59 US hospital CEOs to determine their motivation for engaging in cultural competence practices. The top motivators were (out of 59 interviewed): alignment with priority and mission (49), meet patient needs (40), perception of benefit (36), law and regulation (31) and external funding (18). Interestingly, some of the patient-focused indicators ranked among the lowest, including patient satisfaction and patient safety. This suggests that CEO values may be more heavily weighted on organizational performance, rather than on delivering value to patients. However evidence is limited on the link between values and CEO motivations.

Hospital CEO Leadership Influence on Organizational Activities

From a change management perspective, hospital CEO leadership and values act as a linchpin to institutional change. “Proactive leadership is key for policy-makers, just as it is for providers and payers: it can help greatly to change expectations and culture, and sharpen the focus on value for the whole patient” (McClellan et al., 2013, p. 38). While all employees are involved in strategic direction of a hospital, without CEO approval, capacity for change is limited (Walston & Chou, 2009). Walston & Chou (2009) conducted 263 interviews with American hospital CEOs and found that organizational change cannot occur without positive executive perceptions.

Chapter 3 : Methods

3 Methods

3.1 Study Design

This study employed a grounded theory methodology through a constructivist paradigm. Grounded theory offers an important tool to discover new knowledge and concepts which have not previously been well researched. Values in healthcare from the perspective of CEOs leading hospital organizations have not been well described to date. Grounded theory is a qualitative research approach involving “theory that was derived from data, systematically gathered and analyzed through the research process” (Corbin & Strauss, 1998, p. 12). Constructivist grounded theory seeks to mutually create knowledge by involving both the researcher and the researched through all levels of study progression (data collection, analysis, reporting, etc.). Constructivist grounded theory embraces the researcher’s biases, and acknowledges that the researcher is part of knowledge creation. Unlike traditional grounded theory, constructivist grounded theory does not claim to interpret “the” reality, but rather “a” reality contributed to by the researcher and participants (Charmaz, 2006).

The grounded theorist asks broad questions with few to no preconceived notions about the topic. The grounded theory approach is a constantly iterating research design, which employs the constant comparative method, whereby data is constantly being compared and contrasted throughout the entire research process. As the research study continues, the research question, participant interview questions, and the coding used to analyze data all become narrower.

3.2 Study Recruitment and Sampling

The study design remained highly flexible as input from each stakeholder and participant was considered throughout the planning phases. A Letter of Information was emailed to all hospital CEOs in Ontario, describing the purpose and intent of the research and requesting their participation. Follow up emails were distributed to elicit participation of the CEOs approximately 1 month after the letter was distributed to encourage participation in the study. The study was open to CEO-level positions only, both to manage scope, and as the literature review indicated their needs are highly unique.

Ninety-eight hospital CEOs were identified, 26 of whom participated in this study. Participants were balanced in terms of rural/urban hospitals, academic hospitals, faith-based hospitals, and clinician CEOs.

3.3 Data Collection

Semi-structured interviews were pre-developed and conducted in-person when possible, and via teleconference otherwise. Interviews were recorded and transcribed by the researcher.

Consistent with a constructivist etiology and the goal of the research project, no specific definition of “value” was used. Rather, the study was open to different interpretations by the involved participants. However, the semi-structured interview included multiple features of value (evident in Teke et al., 2012 and others), describing it as a multidimensional concept built from functional value, emotional value, and social value.

The researcher engaged in active reflectivity practices through the use of reflective journaling. Cargo & Mercer (2008) describe the need for reflectivity; “academic and nonacademic partners must use critical self-reflection to understand how status and privilege impact partnerships and to have a sense of cultural humility and overall humility toward all partners” (p. 336).

3.4 Ethics

Research Ethics Board Approval was obtained from Western University prior to any participant recruitment or data collection commencing.

3.5 Data Analysis

Data analysis began at the onset of the study and continued throughout the study in an iterative manner. Using constant comparative analysis methodology, each interview was compared with subsequent interviews to consciously identify the similarities and differences between data sets, until saturation was reached.

Data analysis was conducted through line-by-line open coding, whereby data is broken down into units of analysis, then labeled, and questioned. Coded concepts are grouped into categories with maximum coherence and explanatory capacity. Consistent with constructivist

grounded theory, “active” coding was given emphasis – which focuses on what people are doing and how it is happening (i.e. rather than putting in a code about choice, a constructivist would code the action) (Charmaz, 2006).

Data that would have falsified the working hypothesis were consciously looked for to ensure a qualitative theory. The flip-flop technique was adopted, whereby working hypotheses are challenged by asking contradicting questions to ensure reliability.

For the purposes of this research study, the conditional matrix model proposed by Strauss & Corbin (1990) was used to understand the negotiation CEOs conduct when faced with values from competing interests. The conditional matrix is based on the belief that each action or opinion is influenced by, and influences, all of the additional levels of the matrix. CEO values cannot be looked at in isolation without first understanding political and public values and priorities. This study will consider all levels of this matrix, but will focus primarily on the central three levels:

- **Action Pertaining to a Phenomenon:** representing the CEOs’ personal values and actions;
- **Interaction:** representing the value negotiation that CEOs are faced with; and
- **Group Individual, Collective:** representing the values of health systems, hospitals, and public, and how the CEO interfaces with and executes these values.

3.6 Quality Criteria

Several criteria have been previously identified by researchers to measure and ensure high quality research in grounded theory studies. Corbin & Strauss (1998) identified four key attributes of good substantive grounded theory:

- **Understanding:** the theory should be replicable with different participants with similar lived experiences;
- **Fit:** the data should approximate reality.
- **Generality:** the theory should be abstract enough with sufficient information to make it generalizable to different contexts; and
- **Control:** the theory should allow for action towards changing the phenomenon.

These quality criteria will be used to address the theory quality.

Chapter 4 : Results

4 Results

The results of the study have been organized into three sections, based on the initial research questions;

- 4.1 What do Canadian hospital CEOs value at an individual level?;
- 4.2 Are CEO values aligned with health system, patient, and community values?; and
- 4.3 How do CEO values drive or affect organizational behavior and decision-making?

4.1 Results: What do Canadian hospital CEOs value at an individual level?

Throughout the interviews, participants offered many personal values that they felt were most important to them. The values identified can be stratified into two subsets; core values and practical/learned values.

I think my core values in terms of who I am as a person, they were probably established in childhood, you could probably attribute those to my parents and the environment that I grew up in. Some of the personal things in terms of how I think of myself and how I interact with people, those probably were formed long before my senior formative education years if you like. I think along the way, going to school and the learning opportunities maybe teaches some different kinds of values, values that maybe allow you to function well as a clinician or healthcare provider to administration in healthcare, so they're kind of tier 2 level values if you know what I mean. Like practical values as opposed to sort of fundamental personal values. I suspect my fundamental personal ones were formed way before right, very early on. (Participant Y)

4.1.1 Core Values

Core values are those which were established at a young age. Participants explained that these values were most often passed down from parent to child, representing the foundations of a moral code. Described as the “motherhood and apple pie” (Participant M) values, core values are the typical values that are expected in society, but are increasingly important in a healthcare service context.

I don't think that my core values are much different from anybody else's. (Participant M)

Many of these values were described as non-negotiable, meaning they would not be compromised in any decision-making. These values are also very static in that they do not change over time and are not questioned. Multiple core values were discussed, highlighted in the following sections.

Hospital Values

All participants acknowledged that their personal values were aligned well with the hospital's values, which were fairly standard. Most hospitals involved in this study adopted values using the "iCare" acronym, including integrity, compassion, accountability, respect, and excellence, or a similar variation. Many participants commented that these values are not surprising or unexpected, and should be standard for all health-care workers.

I have 5 [values] that I tend to stick to that are part of my fabric... So there's trust, respect, integrity or honesty, presence is an important value for me, and humor. And presence for me is that real value of truly being engaged and listening to people, and truly thinking about what people are saying and giving them your undivided attention, and that's a tough thing to do sometimes but it's a very important value for me. (Participant M)

Empathy

Similar to common hospital values, empathy was also discussed heavily as an all-encompassing value to guide behavior. This value rests on the CEO's ability to consider all stakeholder viewpoints when making decisions. This value ties in closely with the CEO's system-level perspective, discussed later. Empathy was the most frequently discussed core value, indicating its importance in grounding decisions and making positive choices for patients and communities.

If every single member of this organization put themselves in the other person's shoes, this would be a phenomenal place, because you would be compassionate. You would be respectful. You would be committed to helping, and quality, and working together. So the one [value] I really, really wanted was empathy. (Participant K)

For me, the number one is empathy - always put myself in the other's shoes. Respect, I grew up in a small town and everybody waved to each other and respected each other because they knew each other. I would say empathy, respect, a commitment to quality and working together, a real team player. I'm a collaborator. Those values are near and dear to me - empathy, respect, compassion, and team player. (Participant K)

4.1.2 *Practical Values*

Different from core values, practical or learned values are those that have been developed through a specific career path and are intended to serve a practical purpose. These values are not likely to be found in hospital missions, with few exceptions, and are specific to a leadership role.

I would say the value for money piece, I wouldn't have thought about that before. But that I would say the efficiency and value for spending money from the public purse probably has evolved more over time. But my core values - I was raised in a home where you thought that being respectful and dignified and kind and compassionate and thinking about others, that was pretty core to our upbringing. (Participant I)

And a new value for me, I guess that I've labelled is innovation. Because if I've done anything over the last 30-40 years, it's that you're constantly scanning the horizon looking for opportunities and looking for creative options, or looking at creative partnerships. I'm a puzzler by nature, and so I bring that to my job, and it's very much about constantly reading all the documents and the articles and the constant learning. Because that's what you're really trying to do, is to create a learning environment that's rich for innovation. (Participant G)

Interestingly, when discussing these practical values, participants provided anecdotes and stories which demonstrated how that value had been acted upon and more importantly, why. Also, while these values were highlighted as important to CEOs, they were more negotiable than their core values. Multiple accounts were provided where two or more of these practical values were in conflict with each other and tradeoffs had to be made.

Transparency /Authenticity

One of the more frequently discussed practical values was transparency/authenticity. CEOs tried to ensure that they were always approachable and open to all stakeholders, in an effort to increase the transparency and distribute accountability to a broader group.

Authenticity is also a value that I have for myself. I want people to see me for who I truly am, warts and all, and I try to make myself vulnerable to an extent, or I allow myself to be vulnerable. I don't want our employees to have to have a work mask and a personal mask. I would want them to come into the workplace as the people that they truly are, because it takes effort to have a work mask. People, I think, are more relaxed and more productive if they can just be who they truly are. (Participant X)

I think it's really important for the staff to see me and to know me, not that I make decisions about their everyday work, but I make sure there's communication and staff forums, and they're able to ask me any questions, I make sure I'm in places where they can see me and stop me in the hall or I'll say hello, I make sure that I get to the orientation of every new staff person that comes so they meet me then. (Participant Q)

The key for us has been transparency in those conversations about what can we do and what can't we do. And if we have limitations, why those limitations are in place. So we have this great expectation that if something goes wrong in the course of the patient's care, then we disclose to the patient and family right away. That would not have happened 10 years ago. (Participant L)

Multiple reasons were given for why this was an important value to CEOs, many of which related to practical initiatives for setting the culture of the organization.

- **Transparency as a tool to address staff concerns before culture is negatively affected:** Participants found that a traditional top-down hierarchical approach to management can lead to a poor culture full of speculation and gossip. By opening up communication lines, staff concerns can be managed as early as possible, preventing any negative culture effects.

When I stand up in front of the employees, I do so expecting to deliver on transparency. So I ask my favorite question, so what's the rumors? There's an opportunity for people to bring up the rumors. There's been all kinds of rumors, and I answer them to the best of my ability - including I don't know but I'll get back to you. (Participant O)

So I've discovered or I've always held the belief that you just be yourself and explain to people exactly what information you are aware of and can possibly share, you should always share it as soon as possible, and talk about it openly. Because if you don't then people are left to speculate and to gossip and ultimately you create higher levels of anxiety when you don't share information. So the more open you are and honest and even if things are, if what you're communicating is challenging, frightening things, you need to do that. (Participant F)

- **Transparency as a tool to lead by example and demonstrate values to influence culture:** Transparency was perceived as allowing CEOs to shape behavior by leading by example. By being visible in the organization, with value-driven behavior, participants were able to clearly demonstrate their expectations on the delivery of their organizational values.

I think first of all, the CEOs have got to be visible to the staff, and they have to be seen living the values in everything they do - whether it's an email

communication, a CEO letter, it's walking in the hallway, it's going to the cafeteria, it's in the parking lot. People have to know who you are, and people have to see you living the values. It's not good enough to say these are our values, and I can't stress that enough. (Participant K)

I actually have a sheet of paper on the door to my office where I have what I call my leader standard work, so it's basically a declaration of anyone who comes to my office of how I believe I need to spend my time in order to be successful as the president of this organization. On that are things like, I need to visit three huddles every week throughout the organization. I need to spend an hour every week with teams that are going through lean training. I need to have at least one 1-on-1 meeting of someone who reports directly to me... So on this sheet, this is all I need to do, so then I write on the sheet when I do it, and I get a nice green market when I do it. And when I don't do it, I get a red marker and I color it in, so it's a really transparent way for people to assess whether I'm walking my talk. (Participant L)

- **Transparency as a tool to gain staff and community buy-in:** By engaging stakeholders in the decision-making process, and gaining their buy-in for the process itself, the outcomes of any such process were felt to be better accepted. Some CEOs used transparency as a tool to ensure stakeholders could respect the process of any given decision without necessarily agreeing with the outcome.

The process we're going through to engage patients and families in a proactive way is certainly one [demonstration of transparency]. Engaging our staff around process changes is another. Being visible in the community and standing up and being accountable is the third. I think that's the big one. People may not like the decision that's being made, but if the people who make the decision are standing up and answering questions, not hiding behind whatever, that trust level will go up. I don't have to agree with you to trust you... You want people to trust that what you're doing is in the best interest of the organization and the best interest of the community and the healthcare needs of the people that you're service. (Participant C)

Decisions have four components: every decision you make has to be transparent. It can't be made in a boardroom without including the medical staff, the nursing staff, and communicating widely, so it has to be transparent. It has to be deemed by a reasonable person to be fair. It has to be seen also to have been inclusive, it wasn't just you, it was the key stakeholders that were included in making the decision. And the fourth condition is, there has to be an appeal mechanism for someone who feels you have made a flawed decision. And I've lived by that and I think it gets you out there to announce the decision, it gets you thinking about how am I going to ensure that I've shown this to be fair, transparent and inclusive, and if you still don't like it, you can appeal. (Participant K)

- **Transparency as a means to improve communication and establish relationships:**

Transparency was described as being particularly useful for improving community relationships. Participants suggested that the trust between community and hospital relies heavily on open, transparent communication, and less on tangible patient outcomes.

Every patient that gets admitted to the hospital gets a welcoming letter from myself welcoming them to the hospital. And also, in that letter, I provide all of my contact numbers and email, which includes my cell phone and my home phone, so patients have the opportunity to call me, and they do call me. And where I find my role again is coordinating 99.9% of the time... it's being available. So again, that's something unique. I think if you try to find, unfortunately, a CEO is sometimes impossible to find as they have 20 layers of communication so you sometimes can't even find their email address, definitely not their phone numbers. And you'll never get them live, and I think that's really a bad thing for the overall system. But again, that's just part of being accountable, being transparent, being open, and being available for patients and families. (Participant S)

Impact

Impact was a key value that CEOs described as developing through their career paths. Many participants were attracted to healthcare because of its potential to positively impact individuals. This value developed in one of two ways.

Some participants valued impact because they were able to see the great potential for impact in healthcare.

I think having worked on the front line and being able to see what a positive impact good care and good service can have on a patient and family, and just the opposite of that, seeing what bad care and bad service what the impact of that is, it really for me, reinforces why we are here. It's not to run a business, it's not to employ people, it's to meet the needs of those in our community who need care. (Participant L)

My career started for me working as a nurse, and that came from me from a really significant desire to help and support people who are vulnerable, and vulnerable because of illness. So I would say as a leader and as an executive very much at the core for me is the, always being grounded in really what matters to the people we're serving. (Participant R)

Some participants left jobs in other industries because they felt they were not achieving the desired level of impact.

When I was practicing law, I had healthcare clients, I found it very intriguing, helping people, making a difference. Healthcare plays such an important role in our day to day lives and our community, and I thought if I can help and make a difference, then that would be an area I could help, and sure enough, it does feel good when you can make a difference in some people's lives. (Participant S)

I came to realize that I didn't care if these for profit companies made money or not. And I was actually, not doing a disservice to my for-profit clients, but they deserved something better than me. So I wanted to leave the world of organized greed, and find a job that would allow me to make a difference in people's lives in a more direct, more tangible way. And I received an unsolicited offer from one of my hospital clients, and I accepted it on the spot, and that's how I got into healthcare. (Participant X)

Patient/Community Engagement

The value most frequently described by the study participants was engagement, particularly patient and community engagement. Talk of patient engagement dominated discussions on values, even when unprovoked. This suggests that either patient engagement is a key value for hospital CEOs, or health-system priorities have pressured hospital leadership to adopt the value of patient engagement as their own. However, despite a desire to engage patients and community, managing and engaging staff was given priority by most CEOs.

To me it's all about engaging the right stakeholders at the right time and so if anything, there's a core value that I have around, around that engagement piece. (Participant V)

There's only two types of people who work here: those who directly support patients, or those who support those who support patients. (Participant I)

However, despite being raised in every interview, interpretations of engagement differed significantly across participants.

There's legislation that says you're expected to actually engage. And that's where we anchor from a legal perspective and from a system perspective, we anchor to that and said you know what, this is expected of us and we're not going to engage by putting up a survey on our website and say that's how we're engaging. That to me is not meaningful engagement, and so the legislation doesn't delineate how to engage and when to engage, or how to engage and what level, to what degree. (Participant V)

Three levels of engagement were documented.

- Patient Surveys and Mandatory Reporting:** Some participants who identified engagement as a key value felt that existing patient experience metrics and reporting required by the provincial ministry were sufficient. By using patient survey data and regular observation of clinical experiences, some CEOs felt they could understand patients' expectations and values without having more formal discussions directly. Others expressed frustrations with the impracticality of many of these evaluation metrics and tools, such as the most commonly used survey tool, NRC Picker, which provides aggregate data.

I don't know that we have a forum that is patient-specific, beyond providing a health service and asking them to complete a satisfaction questionnaire. (Participant X)

I review patient information, quality improvement data, information that comes to me from front line providers, I do walkabouts here at the organization talking directly with patients and family members, and really trying to understand what is the patient journey, what is the experience of care that happens here? (Participant J)

Well we do patient satisfaction surveys. We were with NRC Picker on the provincial satisfaction survey, but we've strayed from that and are measuring patient satisfaction ourselves through different methods. Part of the reason for that is so that we could ask those things that we're most interested in. Typically, it is about clinical care and expertise, but it's also about people's perceptions of how they were treated, and that really gets to the value piece. (Participant T)

The information that comes to us from NRC Picker is really aggregate data that if you truly look at it, it really isn't meaningful at all. What it does, is it gives us data to put on our quality improvement scorecard. And it really allows us to report up to government that we are surveying patients. But it's aggregate data, it's anonymized, it really doesn't give you any real meaningful information around the actual lived experience of the patient. (Participant J)

- Forums to Discuss Large Decisions:** In addition to surveying metrics, some hospitals engaged patients and community members to inform key hospital decisions. Engagement mechanisms included patient advisory committees, town hall forums, and focus groups. The decisions around which patients and communities were engaged were largely non-clinical and had direct impact on patients.

So we actually had a community reference panel, 36 people representing the community. They gave 4 weekends and one weeknight evening of their time to edit the plan, they spent time educating, they had speakers we met with them, but they gave us probably 40 hours of their time each, the 36 residents of the community, about what was meaningful to them in the community for our organization to be providing. It was very informative and helped us realize that the values of the community or public isn't necessarily aligned with what we're doing in healthcare. And what we think we should be doing well or what we believe we should be doing isn't necessarily what they're looking for or asking for, and so sometimes we put our emphasis in the wrong place. (Participant M)

People will generally focus in on one or two of the changes proposed, and it can be quite negative. Ironically, the less controversy it is, the fewer people show up. The ones that are more valuable from the point of view of engaging people are the ones where there is a difference in opinion of what should be going on. (Participant C)

One of the methods to insure that you have a quality patient experience is by opening up the doors of your hospital and letting the population and the community who owns the hospital, participate in the direction, so this is my second strategic plan that we've engaged over 1000 community partners, be it community members, other health care institutions, healthcare professionals, policy makers, the 5 partners in health under the world health organization, to come and give us feedback and help us decide on what direction this hospital would go, this is my second plan. (Participant N)

- **Operationalizing Patient Input:** In addition to discussing patient engagement for individual decisions, some CEOs had operationalized a process which engaged patients and communities for a multitude of regular decisions. These hospital leaders had embedded engagement into standard processes so that it became routine practice. This perspective on engagement was seen as distinct in its sustainability. In this model, patient and community engagement was automatic and expected. Engagement was embedded in the culture of the organization. Conversely, forums to discuss large decisions were seen to be established on an ad hoc basis.

We have multiple mechanisms where we have patient family advisors that actually represent patient, be it on my senior management team, we have two former patients that sit there and actually bring the, brings the debate and the discussion back to what are patient's needs, all the selection of our management staff, our chief of staff, we have patients involved. (Participant N)

Our culture is this focus on every, any decision where there's a material impact on the experience of patients, the patient will be at the table. That's

part of the accountability, it applies to respect, it's part of our engagement, operationalizing the engagement and within the organization. (Participant W)

So one of our values is keeping the patient at the centre of what we do, so pretty much everything we do and everything we talk about and everything we operationalize, we look at the patient and the patient being the centre of everything we do. So I'll give you an example. We're going through an operational process right now because we took over responsibility for another entity, so we're standardizing operation between our two campuses. And in looking at how to standardize the operations, not only are we looking at what's best practice, but we're looking at it from a patient's perspective. And the way we do that, is we get the patients in the room and they're part of the process. So it's not just a bunch of nurses and doctors and administrators sitting around talking about what we think is best for our patients, or our feelings, which are important. But we get patients in the room and they're there as well and they're part of the discussion. (Participant S)

Staff/Clinician Engagement

CEOs also valued engaging their staff, for a variety of reasons. Participants largely used this engagement to build and strengthen the organizational culture. Interestingly, most participants considered patient engagement a value, but did not perceive staff engagement as a value. Engagement of staff was seen as more of a professional responsibility, required by their mandate. Conversely, engagement of patients was seen as an extra task which was over and above their mandate. Participants saw value in both staff and patient engagement, but staff engagement was given a higher priority.

So when you have a lot of long term employees, change doesn't happen that easily, but they'll follow you as long as you build a relationship with them, but they have to understand why. (Participant Q)

Once a month we do what we call a RAP, a random act of pizza, where I go out and buy a couple of pizzas and take it over to a clinical area and sit down and have a chance to chat with people and talk about what's going on. We provide mechanisms and forums for people to interact with myself and other members of the senior team, we call 3C events where we sit down for an hour and rotate to all of the different areas of the hospital, and it's essentially an opportunity for me to listen to front line team members and the challenges that they're experiencing. (Participant P)

So as we're revising our strategic plan, as an example, we've probably had about 30 focus groups, so we go out there and we ask them what they think of our current mission, vision and values, and our strategic objectives. We

ask them specifically what do you like, what do you not like, what should we be paying more attention to, if we could change one thing, what would it be? So we're very deliberate in doing that and we identify who our major customers are and we go out and ask them. And we're doing that because we're revising our strategic plan, but I do it on an annual basis as well. (Participant B)

And we're actually doing staff walkabouts as well, so that we can understand what it is that the staff are experiencing, and how are those experiences of the patient and experiences of the staff contributing to each other's outcomes and goal achievement. (Participant J)

4.1.3 Distinct CEO Groups

Overall, the values of CEOs interviewed were fairly similar. There were some small differences in certain subgroups, such as an increased emphasis on practical values from academic hospitals, as well as an increased emphasis on community engagement from rural hospitals. Two key subgroups did have significant differences between them.

Clinician CEOs

Several participants interviewed had clinical backgrounds in medicine and nursing. Physician CEOs in particular were more data-driven and tended to rely more heavily on quantitative metrics to make decisions. Their decision-making processes were typically more scientific and pragmatic in approach.

So coming again from an academic background, we did lots of literature reviews, we looked at strategies, and then we began some qualitative and quantitative research, some data collection, we engaged some academic colleagues, third-party independent, to come in and look at are we what we say we are, or are we deluding ourselves into believing that might be a nice piece of paper on the wall, but does it translate into day-to-day behaviors. (Participant I)

Both CEOs with and without clinical backgrounds acknowledged these differences as an unspoken, accepted industry truth, but there was some disagreement as to whether or not these differences were positive.

I can tell you again, having been a physician and as an administrator, a CEO, I have spent an inordinate amount more time on making sure the patient experience and we live our values, way more time on that as a CEO than I did as a physician. I think as a physician, you take for granted that

you're living the values and that the patient is the centre of your focus. (Participant K)

[Physician CEOs] are attention-seeking somewhat, when they run hospitals it's all about them. They're all about money first, and while they'll say they're about patients, most of them are about making sure that their coffers are filled. And you look at all the hospitals that are run by physicians, and look at the hospitals that are run by nurses, and I think hospitals that are run by nurses give better patient care. (Participant Q)

Both CEOs with and without clinical backgrounds did agree, however, that having clinical skillsets was not a requirement to be a successful hospital CEO.

One, the exposure you have to what the front-line decision maker looks like and feels like is a little bit different. But I don't think it actually matters if the CEO is a clinician or not. I think it matters that in the senior management team there are loud voices of senior team members who do have deep and rich clinical experience. (Participant I)

What I've noticed is that it doesn't so much matter that the CEO has a clinical background, it matters that the team is able to be rooted in loud voices from clinicians. And the CEO engenders and empowers that. And I've worked with clinicians who've become CEOs, and people with pure management backgrounds, and I wouldn't say that they're better or worse, they have different strengths. (Participant I)

Faith-Based Hospital CEOs

The topic of faith-based hospitals came up extensively throughout the interviews. Faith-based hospitals were seen to be more values-driven than their peer hospitals, with a stronger identifiable culture. This was largely due to the longevity of these hospitals with a consistent mission and mandate. By having a long-established culture and set of values, these hospitals were seen as less prone to the frequent priority changes seen with changing political powers.

I met with a friend of mine who's a CEO at a non-faith based organization earlier this week. And she has only been there now for about a year. And she had previously been to a faith based organization. She's an accreditation surveyor for Accreditation Canada. And we were talking about the values of a faith-based organization versus the values of a non-faith based organization. And one of the things she commented on is that when she goes around and does her accreditation surveys, she sees that faith-based organizations talk a lot more about their values and how those values influence the work within that organization. And she said that non-faith based organizations, it's not necessarily that their values differ from a faith-

based organization, but it's not as evident how those values are affecting the everyday work of the organization. It's not as apparent as she has seen in faith-based organizations. (Participant L)

Yeah, and we're a Catholic organization. I'm not Catholic, and I would bet the majority of our staff are not Catholic either. But the values of the organization very closely align with the values of the individuals who work here, and so I think that's why they're very obvious in the work that happens on a day to day basis. (Participant L)

I started my whole leadership journey in a faith-based organization back in the day in Vancouver. And really, that was probably my first clear understanding of values. They were in other organizations I worked in, things on the wall, and I was a front line staff person and certainly never thought about, you guys have to do that in administration, but I care about my patients and I'm taking care of them, and that's all administrative mumbo jumbo to keep them busy in their jobs, but I'd never thought about it. (Participant M)

It is a values-driven organization and I know everybody will say they use their values, but they are truly used whether it's rationalizing resources, whether its investing, they're used in our hiring practices, so that we make sure that we've got an organization that reflects what we believed our mission is in faith-based care. And it is around serving everyone, but we do have a particular mission and focus on making sure we're taking care of the disenfranchised and vulnerable population. (Participant M)

The values of these hospitals and their CEOs were more patient focused, particularly on vulnerable populations.

But our Sisters were all about change. Our Sisters were all about where are the needs and how do we fill them. Who's the neediest, and that's where we need to go. And that, in service to value, is palpable throughout this organization. So it isn't just respect, dignity, compassion, and stewardship, it is around being in service to the patients and the community. (Participant Q)

They really grew out of the Sisters' mission and legacy. And so most of the values that remained have come forward from a model of particular care for disadvantaged populations and particular focus on those most in need. And while it originated out of a religious view of the sisters, it's very much been translated into a broad-ranging view for all. And special attention on those most at risk or in need. (Participant I)

You know we were the first hospital to openly welcome AIDs patients back in the day when men were dying mysteriously from you know obviously a lethal infection or something and nobody knew how it was transmitted or how they got it, so institutions were terrified of looking after them and of

course, we're not sympathetic to a lifestyle that went with the disease, and the Sisters said come here. (Participant Y)

We were called out by the LGBTQ community who didn't feel we were as acceptable even though we're completely acceptable, for all comers. There was a certain sense that maybe they wouldn't be taken care of at a Catholic hospital properly. And so we've been out now working with those community groups, and better understanding are there specific needs and things that need attention when they come to hospital? Or are there services they need that we don't have that we should be providing? (Participant M)

4.2 Results: Are CEO values aligned with health-system, patient, and community values?

When examining the alignment of stakeholder values in healthcare, participants believed that most individuals working in the health-care industry had shared and aligned underlying core values. Where they felt some conflict and misalignment was with the practical or learned values. Participant responses indicated that the relative weighting of values used to make decisions is heavily influenced by professional mandate and accountability. In a finite resource system, these practical values are in conflict in many cases, and trade-offs must be made. Even if all stakeholders share these practical values, their different professional mandates influence the value trade-offs made in decision-making, and value conflicts arise.

4.2.1 *Conflicting Values*

System-Level Perspective

Throughout the interviews, it was clear that participants had a system-level perspective. Personal values such as engagement and impact, as well as professional mandates for entire communities of care, motivate CEOs to consider all perspectives when making decisions. Their accountability to a number of stakeholders including hospital boards, staff, LHINs, and ministries make hospital CEOs the common denominator for healthcare decisions. Participants described multiple examples of this.

Even though I'm hospital-based, and that's my direct responsibility, we work very closely with a whole variety of community partners and we don't work in isolation. I work in a smaller community where we are the hub, we're the major employer, we're an economic driver, and so we have a responsibility to make sure that we work well with all sorts of system partners to improve

the health status of our population. It's not just about hospital care. (Participant B)

My job is the health system. Hospitals are included in my job. (Participant I)

I'd like to think we're evolving less towards managing an institution, and more towards managing a population. (Participant I)

To give you a specific example, we don't have a pool complex here. So I've been involved in the accommodation review studies for schools. As an example, we've been advocating for building a new high school and a new public school and our vision in that is to have a recreation complex in the middle that would include a community pool and an ice rink and fitness facilities. And the reason I'm interested in that as a health leader is because it will help our community to improve their health status. So it really is far beyond where my responsibilities are as a hospital CEO. But it's looking up and looking forward and saying, if we did that, we'd be a healthier community. So that would be one of my goals. If I could see a shovel in the ground for that before I leave, I would be very content. (Participant B)

So we look at our hospitals, regardless of where patients may be, as a system. So patient may come to an emergency department in one, and be admitted to another one, if that's where it's most appropriate from our perspective from a care point of view. We've really tried to integrate the organization and are now very much involved in integrating outside the hospital system into the community sector, long-term care, primary care, where is in my opinion where you're going to see the greatest value in moving the system forward. (Participant C)

Community Value Conflicts

Value conflicts with community groups and forums were mostly related to resource allocation. Community members did not have the same system-level perspective as CEOs, and were motivated to improve their own community only. Many hospitals dealt with multiple communities, each with their own, often conflicting, priorities.

Our board is looking at the health needs of the community we serve, not necessarily the health of each individual community, whereas the communities are looking at what's in it for them and how does it affect their individual community, not necessarily the healthcare piece. So there's a bit of push pull, but that's positive. You turn it into a positive by capitalizing on their engagement and involve people as much as you can in what you're doing. (Participant C)

Participants also noted that the communities across Ontario, both in urban and rural settings, are relatively change-averse, particularly related to cost-savings measures.

Any time you change anything in healthcare your community gets engaged. We've had some fairly tense discussions in some of our communities as we've looked at new models of care. It's really pitted the notion of what healthcare has been traditionally, against what it's capable of providing today. So where we have most of our conflict is sort of in that ideology of what the system should be. Some people view it as being all things to all people. Some people view it as needing to have some very consistent services from community to community... I would say where we've had the greatest conflict from a values perspective is how we define what healthcare is and what it means to people. (Participant C)

If people think you're making a change in healthcare because you don't have resources, the actual change itself is almost irrelevant, even if it's the best thing you can do whether you have one dollar or a million dollars, if it's driven by a perceived loss of money, it's very hard to convince the community that it's the right thing to do. People don't look at innovation because of resources as a good thing, they look at it as a loss. (Participant C)

Conflicting LHIN Values

Value conflicts with LHINs were mostly related to frequent changes in strategic priorities. CEOs felt that LHINs too often changed their direction and priorities, without giving hospitals enough time to establish sustainable improvements. CEOs felt that the health system would benefit from a longer-term strategy which would allow for more significant changes and evaluation.

It's a real challenge to align the goals throughout the organization and to keep them aligned because you're, while we have our strategic plan and our mission vision and values, and key initiatives that help support the strategic plan, the LHIN comes along and says oh this is what we're going to do. And then the ministry comes along and says this is our priority. So you now have 3 separate priorities and you're pulling your staff in 3 different directions. Now I will say that in the last year or so I think the LHIN is getting better aligned with maybe the ministry's priorities, but every 4 years you have an election and you have a potentially new ministry... Emerge wait times, ALC improvement, the new funding formula, so you get all of that layered on top of what you're trying to do within your organization. It's a little bit of a challenge. (Participant H)

Conflicting Ministry Values

Most of the value conflicts highlighted by participants were related to the Ontario Ministry of Health and Long-Term Care (the Ministry). Similar to the LHINs, CEOs felt that the Ministry changed its priorities too frequently, often with unattainable expectations of hospitals in very short time frames. Participants expressed their frustrations with the wasted resources resulting from these inefficiencies.

So where butt up against the Ministry or the LHIN at [our hospital] is sticking to knitting and not getting distracted by the shiny ball that the Ministry has just gotten distracted by and running down the road and constantly shifting what you're doing, like run over here because today the theme of the week is Health Links or today the theme of the week is integration, or over here we're going to work on senior's populations. Running your team versus paying attention to what are the needs, what are we driving at, does that fit, and sometimes saying 'you know what, we're going to let that shiny ball go.' That may be where the ministry is saying if you come do this, we'll give you a little bit of money, but it can really distract and take away from the work that you're doing and completing the work successfully and staying focused. (Participant M)

I wouldn't say what they're trying to implement is flawed, but I think their process is flawed, so in January of this year I received notification, I heard that they were going to give funding for new a program called assess and restore. In February I got the letter, it was significantly different than what was bantered about, but I mean the money, they gave you this money and it has to be spent by March and generally, it generally requires that you have to hire staff, and put in new processes. Geriatric assessment nurses, you get the money in February, you have to spend it by March and you have to hire people. You can't hire people in 4 weeks and have them actually do something. Those kinds of things often will come out of the blue, they're, I'm sure that somebody at the ministry has been negotiating for the funds, they get it at the last minute and then they throw it out. And that happens all the time. (Participant H)

Yea so senior friendly strategy. So right in the middle of nowhere we get this massive survey to complete and I said when we were asked to do it, I said you can bet that there's going to be an initiative or a mandate that comes out of this. And sure enough within the year there was a mandate that thou shalt implement the senior friendly strategy within your organization. (Participant H)

Another conflict CEOs felt with the Ministry was poor communication and engagement. Participants felt that they should be more involved in some of the higher level system policy discussions. This was particularly worrisome for rural hospitals and hospitals

outside of the Greater Toronto Area, where health policy was driven. This bias towards Toronto-based hospitals was seen as leading to system inequities.

Ministry, stop trying to tell us how to provide a good care model. That's not your expertise. Just like it's not my expertise to tell you how to achieve royal assent of legislation. You have every right to tell us what you want, by when, with what investment and what metrics, and feel free to hold us accountable if we deliver or don't. But when you start saying you have to do it this way, you have to jump through this hoop, and you have to do it on a Tuesday afternoon by 4, you're giving me a great excuse as to why I couldn't deliver. (Participant I)

Well I think hospital leaders need to be engaged and brought in to the planning and the vision for how the ministry would see making some of these changes. And I'll be honest with you, those organizations that are in Toronto are better informed and so they're better informed, they have more of a head's up, they can begin their planning and integrate maybe some of the ministry priorities sooner or more in line with what the ministry, if you happen to be fortunate enough to be on one of the planning committees, you have more of a head's up. And can anticipate and make changes within your organization before they actually happen and are rolled out. (Participant H)

Some of the Ministry's policies were seen as contradictory by some participants. Funding models were thought not always to reflect the strategic priorities of hospitals and health systems. For example, one CEO described how existing funding formulas act as a disincentive for collaboration.

You got this dynamic where you're expected to collaborate and integrate your services from a systems perspective which makes sense, but then you've got a funding model that doesn't mirror that and creates a different incentive because at the end of the day you're responsible to insure the liability of your hospital and making sure you know, you're maximizing your revenues, and with the new funding formula you maximize your revenues through the actual patient. If they come into your door, you're going to get revenue, if they don't come in through your door you're going to lose revenue, so you're introducing that competitive model. So it's introduced this interesting dynamic among hospitals. We're collaborating but we're competing. (Participant V)

The government in the last few years is making mental health a priority, especially people with severe persistent mental illness are a very underserved population in this province and everywhere. So the government has talked a lot about making that a priority but the amount of money has not been there, it still isn't there, so I guess government has a hard time blowing resources for that because it's difficult to measure the benefit of doing it right. It's challenging right because you know, just giving money doesn't necessarily get immediate results, like suppose there's a waiting list

for cardiac surgery it's pretty easy to link additional money to additional operations right. (Participant Y)

Finally, participants felt that healthcare decisions were too often politically-motivated rather than based on the best decisions for patients and communities. Political biases also were seen to lead to disadvantages for hospitals in ridings with political ideologies differed from those of the party in leadership.

Politicians have too much influence on the system. So changes in the system are made because of votes as opposed to what's right. (Participant H)

I think most people at the ministry of health and long-term care share the value of we'd like to provide high-quality evidence-based care, I think at the highest level yes they do. I think they're so far away from the patient at times, I don't know that they know what that really translates into. And I think unfortunately, there are many, many decisions that could and should be made to improve the system that are politically unpalatable. (Participant I)

That is, and I think I mentioned it probably not in those words earlier, is that every 4 years you can get these major changes, but also you know, [our political riding] is a conservative riding, we get no favors from the government so if you're not a Liberal riding you can forget, if you're trying to build something it is not going to happen in that term. If you're looking for funding or major dollars from the Ministry, you can pretty well forget it. Or it's a much more uphill battle. It's very much influenced by the politics and by the party and just as you said, it can swing like a pendulum. (Participant H)

People have to understand that there's a massive bureaucracy within the ministry and it's less the legislation and more the regulation and implementation of regulation that have become barriers. And then the gap between let's say high level theory and execution is incredibly complicated and so whilst they may say one thing, they frequently actually perverse incentives with the way they put funding models together or the barriers they put between moving resources between the sectors... So I don't question the overall direction the government is trying to go in, but the capacity and ability to make it simple and easy is quite, quite limited. (Participant D)

4.3 Results: How do CEO values drive or affect organizational behavior and decision-making?

With an understanding of the stated personal values of hospital CEOs, we can now examine how these values influence behavior.

4.3.1 *Internal vs. External Focus*

One of the more common tradeoffs that has to be made in the CEO role is between focusing internally and externally. CEOs recognize that managing the internal environment of a hospital and managing external community relationships are both heavy workloads that often require a sacrifice on one end. When asked how they weigh these decisions, participants indicated that, while managing external relationships is important, it is often not as pressing as managing internal conflicts. Participants acknowledged that external accountability measures set by the LHIN and the Ministry assure a base level of community attention, but increasing engagement beyond the base level requires hospital leaders to expand their mandates. In a system where human resources are often stretched to capacity, expanding mandates can be difficult.

It is important to note that each CEO participating in this study came from a unique community with its own characteristics and needs, such that different approaches and levels of engagement would be expected.

So first of all, hospitals in Ontario are governed by individual boards, and those boards are made up of community representatives, so you have, from the outset, community involvement in everything that you do. In our particular case, in addition to our board, we have what are called local advisory committees, which are site specific committees that are made up of volunteers, we have foundations that raise money for our four hospitals, again, made up of volunteers. So obviously internally, as we are looking at new ideas and new directions, we try to engage our internal audience before we would discuss things publicly. (Participant C)

We just redid our strategic plan this year. And one of the things we realized we weren't doing was, we talk about this healing ministry for the disenfranchised, but really we were internally focused and not really externally focused. So we made a conscious effort to change our mission statement to advancing the health of our community by being the best community teaching hospital in Canada. We added that community piece so that we could be held accountable to make sure that we are addressing the needs of the community by looking externally and engaging the community and helping us make those decisions, as versus us sitting inside the building making decision without looking out, and aligned with what we want to do versus really listening to others. (Participant M)

Participants found it easier and more important to manage internally, likely because internal hospital stakeholders have greater involvement and say in many hospital decisions.

This indicates that mandate can take priority over values. Participants saw external engagement as a value, but internal engagement as a mandate.

It's easier for me to make decisions that align with the provider and sometimes tougher with making sure it's a patient focus. (Participant M)

I can't do my job without doing that internal piece. I probably prefer it, but I can't, nor can I ignore the external piece. I do the external piece; I have to, it's part of my job. I think the internal stuff is interesting and challenging to me. (Participant R)

Ultimately the board and the organization are accountable for the decisions they make, so you can't just simply hand over the decisions to a community that is not necessarily aware of the intricacies of managing an organization. But at the same time, you don't want to be viewed as an organization that unilaterally makes decisions without seeking input from members of the community that use your services. It's a balance. (Participant C)

One of the other things that you see is in times of high activity or crisis, people help each other out. Where before they were much more self-focused and stayed within their own areas. And you see that time and again so if [the emergency department staff] have a sudden influx of large volumes, you'll get staff who actually just show up from other areas to assist and help out whether, and that's the same with any of the other care units as well. So they're less inwardly focused, more outwardly focused. (Participant H)

It was very important that the kind of the values as we created or as they were developed that it had input from staff, patients, families, community, etc. We actually went through a whole process of engaging over 2000 people almost 3000 in the, sort of the testing of them and what do they look like, what should they mean, what do they mean and how then we spent the past couple of years really operationalizing the values in everything that we do (Participant W)

Some participants, particularly from rural hospitals, indicated that they see value in managing the external population, attempting to remain patient-centered.

I use my personal values for all of my decisions with any group, that I try to make sure it's aligned from a 'who we serve' basis versus the provider basis, and making sure we don't get distracted on the provider side, because that's when you'll make bad decisions. (Participant M)

And my commitment to everyone has been that if we're going to be reducing services or reducing the number of employees or whatever in order to stay financially viable, we're going to take two things in mind. The first thing is that whatever we do will have the least amount of impact on patients, and the second is that our decision will have the least impact on our employees, so using those guidelines, that's how we are going to choose the options that we have to introduce. (Participant X)

One CEO indicated that managing the external population was less important with an established career.

This is the last CEO role I will have. I'm a few years away from retirement. So I'm not in the career building stage. When you're in a career building stage you have to care about the external stuff and it's not that I don't care about it, it's that I, I need, I need to do the external stuff for the good of my organization, 100%. I don't need to do it to further my career. So that helps me decide you know, when I'm in a situation of either or, I always have to make sure I'm doing what's in the best interest of my organization and the people we serve. (Participant R)

4.3.2 Principles of Value-Driven Behavior

Throughout the interviews, participants offered many principles which suggested how personal and organizational values might be used to affect behavior.

Conscious: Values Require Regular Reflection

Participants stated that values had to be conscious to be effective. Individual values are innate, but, when working in an organization, a shared set of common values is needed, which requires conscious thought and consideration. Time must be taken to think about personal values and how they are aligned with other stakeholders. Participants indicated that this is not common practice in healthcare, and some had not consciously thought about values before this study. Conscious thought about values, from a CEO's perspective, is usually initiated because of a significant event or career change. Leadership seminars, business courses, and transition to CEO role were common reasons for value consideration.

We have a strategic directive to really up our game on the innovation and creativity side, asking people, 'could we do this in a different way?', 'what's stopping us from doing this a different way?', 'if there's a piece of your job that when somebody asks why you do that and you respond 'I don't know, we always do that around here', then you could quite easily say, maybe you should stop doing that or we should have a process to ask, 'is that a benefit to somebody?'. Because if you're doing it and you don't know what the benefit is to the patient, why are we wasting you or the patient's time? (Participant I)

I guess the first time I thought about values was shortly after I became the CEO, and that was in early 2002. And the reason I did, is because I had done a master's degree in health administration, and I realized that a leader has got to introduce an organization's mission, vision, and values. In fact, that's

what you base your entire strategy on is your mission, vision, and values. (Participant K)

I think your core personal values are integral to your professional behavior. And I think you have to take time to think about them, and to know what they are. I don't think a lot of people do take the time to think about that explicitly. I had taken a masters of leadership program years and years ago, so we had to do that as part of our training and part of our education. I think that was the first time, back then, where I'd really sat down to think about that. They were more implicit than explicit for me. (Participant M)

Well maybe it's just having a conversation around values. I don't think we've had that from a ministerial level, around why that's important and are we aligned with our values? Maybe it's just starting that conversation for people to really understand why it is important, especially as it's going to get harder and harder for us, doing more with fewer dollars. (Participant M)

Unyielding: Values are Non-Negotiable

Successful value-driven behavior requires that values are non-negotiable, according to participants. Participants felt that all of the organizational values could be preserved in any decision (though not necessarily all of the CEO practical values).

Everything we did was driven by the values. And understanding that the values weren't a shopping list. It wasn't 'I'll take excellence today, but I really don't give a hoot about social responsibility so I'm only taking one.' The values are all together in how we decide what we're doing. It's not one or the other, it's all of the values that are set out there. (Participant M)

You've heard 'oh, he doesn't have much of a bedside manner, or he's a really good physician, or a really good researcher'. I don't buy that. I think that the physician or person who's going to work with me is equally skilled as making people feel good as well as providing quality care. I don't think you could provide quality and make people feel horrible, nor can you make people feel good and provide lousy care - I think they go hand in hand. (Participant K)

Foundational: Values are the Base of Decision-Making

Participants conveyed that organizational values are the base of every decision, and always need to be considered when making changes that affect stakeholders. Therefore, it is important to ensure they are known by all members of the organization. Having fewer, stronger values is easier to guide behavior.

I don't want any more than 3 core values, because we will have an organization that knows we have 6, 7, 8, 9, or 10, but they won't know what

they are. I'd rather have 3 where everybody knows what they are. (Participant K)

For orientation, for new staff, I personally go and spend the first 10 minutes that if they can't remember anything from the day, they have to remember the Ottawa Hospital's mission, vision, and values. Otherwise, you'll come to work in a vacuum. You won't know your purpose. You won't know what your value is in helping us achieve a vision. And you certainly won't know the rules of engagement or the environment when you don't know the values. (Participant K)

A lot of hospital CEOs actually speak to the new employees at orientation - fair number, but what do they speak about, I don't know. But I'll tell you what I speak about, I deliver an hour long message on mission, vision, and values. And I start it off by basically saying that you will see around the organization the mission, vision, and values up on the wall, and you probably think it's a bunch of words. Well let me tell you, it's not. To me, it's everything. To me, I now want you to understand what each of these words mean. (Participant O)

Aligned: Stakeholder Values must be Complementary

Another theme that emerged was that, in order for values to drive behavior effectively at an organizational level, the system or organization has to have a shared set of values that are aligned both internally and externally. Participants saw one of their roles as shifting culture towards an aligned value-system. Internally, CEOs aligned values by ensuring the right people are employed and shaping culture. Externally, CEOs aligned values through involvement in and lobbying of health-system decision-making.

Trying to influence change and influence the culture. And by no means is it easy, man is it hard. And I think I underestimated how hard it is. But I think what's helping us succeed is the outcome of the shift we're asking people to make is taking us to a place where they want to go anyway. (Participant Z)

When we do a search for senior leadership positions, we ensure that the values are part of the executive search firm's questions. Executive search firms really do a thorough job in interviewing candidates, getting references on candidates. If you set these values out, they're not going to bring someone to you who they've clearly identified doesn't share those values. (Participant K)

I think first, healthcare and health systems are very different concepts. Healthcare can be seen to be simply transactional. It does not necessarily have to be values-based. But, if you have a healthcare system, or healthcare service delivery, then there really does need to be some integration of the

values of the system of the values of the patient and consumer otherwise you have a mismatch and a dissatisfied client. (Participant J)

Deliberate: Values are Driven

Participants thought that a value-driven culture does not occur naturally. It requires constant measurement and evaluation, and represents a journey towards an ideal state which is never reached. Many participants had operationalized value management into regular processes and evaluation measures.

We certainly have had comments from patients and visitors that they're very happy to see the values posted, and they will actually come up the odd time and talk to a supervisor on the unit and say, I don't think you're, you know your staff member was living these values today with my mother or whatever, so it's giving tools and language for our patients and their families to be able to hold us accountable for meeting those values as well. (Participant A)

We've introduced tactics - we call every med./surg. patient now 24-48 hours after their discharge to make sure that they got their prescriptions and they know when they're next appointment is. And we ask them did anybody stand out for you during your stay. We do our shift reports at the bedside so the patient is part of the shift report. We keep the white boards or care boards at the bedside completely filled up to date, up to the minute, so everybody knows what's happening, including the anticipated date of discharge. We have the nurses go round every hour on their patients and tell them, 'I'll be back within the hour, is there anything I can do before I leave?' And we have this professional saying, introducing themselves and saying 'I'm going to take really good care of you.' We've introduced a lot of that, and it's making a huge difference. What the next big step will be is to take out the low performers who don't get it and never will. And I think that's where, I can tell you, that you can't instill new values on someone at this stage in their life. You can maybe strengthen their values or help minimize their negative values, but you can't instill new ones. (Participant K)

Actionable: Values Dictate Behavior

Values are not being lived unless they are shaping behavior. Participants acknowledged that having a set of organizational and personal values was not enough, but that they had to be integrated into decision making and behavior.

I think most people are well-aligned with the best of hospital values. Unfortunately, I don't always think that our values translate adequately to actions and that our reward system reinforces our values. Very few people would say 'I'm against evidence-based, patient-centred care'. But then you look at behaviors it makes you wonder, if you believe that, why are you doing this? (Participant I)

We made the commitment to these 5 guiding principles, how they would be reflected in our behaviors and actions every single day. So we put our orientation of you know, everything in our orientation in our policies, everything is linked to these 5 guiding principles because it's my fundamental belief that you express, the values of the organization are only as good as they day to day behaviors of individuals, every moment, every day and especially what happens when nobody is looking. (Participant W)

If you looked at the websites of all the hospitals across Ontario, many of the values like honesty and integrity, you'll find them there. It's really those values that patients tell us they need to see. I think what's different about our organization is our commitment to them and the way we live our values. (Participant J)

4.3.3 Measurement and Management of Values

Measurement and management of values varied extensively across hospitals and CEOs. When asked how participants knew they were delivering on their organizational and personal values, participants offered many different evaluation methods from basic walkabouts to operationalized performance reviews.

Intangible Signs

Many CEOs, particularly those from faith-based hospitals, discussed the “feel” of the organization, and its link to value. CEOs gauged the culture of an organization through simple cues such as staff facial expressions and patient encounters. This likely works in smaller faith-based hospitals for their size and longevity of culture. However, it is perhaps less effective in larger hospitals, many of which had more rigorous evaluation metrics.

Many people will say to me, you know when I come to [our hospital] I can feel the difference in the hallways you know, when you walk around you walk in, you know, maybe your mother is in the hospital so you come in to visit her, you know, people smile at you in the hall, you know staff will smile at you in the hallway, if you look, all you have to do is look like you're lost for about 10 seconds at [our hospital] and one of our staff will stop and say, can I help you; you are probably lost. (Participant Y)

I don't know if you've ever felt this before, but there's some places you walk in and it's very busy and very hurried, there's other places you walk in and you think things here just don't feel right and it feels a little toxic or angry or mean. And then there's places you go into that feel very friendly and warm and caring and open. (Participant Q)

You know the number one thing I look for, is people smiling. If I walk onto a unit and everybody smiles at me, or if I say hello and they smile back, I know that the respect, compassion, and commitment to quality is there. (Participant K)

Unprovoked Feedback

The second method of evaluation of values was through unprovoked feedback. Without operationalizing a method of gaining feedback directly, many participants relied on patients, community members, staff, and other health-system stakeholders to provide feedback on an ad hoc basis, which was used to gauge culture and value delivery.

I've been told that when people come in to the hospital that they can feel the positive energy, I can't describe that, I can't describe what that feels like except that staff are interacting with each other, they're interacting with patients and they go out of their way to help individuals. Whereas maybe before they were not. (Participant H)

We were recently accredited with distinction from Accreditation Canada, so that's their highest level of performance, so that's something we're proud of and we're building on it, we're not complacent on it now that we've achieved that, it just takes us to a new level and allows us to advance that piece. (Participant B)

Value Scorecard

The third method of value delivery evaluation was through operationalized measurement processes. Some strategies included embedding value delivery into management and staff performance reviews, developing quantitative metrics to track value delivery objectively, and formalized staff feedback. These methods allowed for value-tracking over time and demonstrated to staff and management that value-based decision-making is an organizational priority.

One thing we stand for as an organization is you can't manage what you can't measure. So if you can't measure something there's no way of managing it. So we have 14 core indicators that we manage that focus on patient safety and patient quality, and its various methods of trying to get feedback, both

clinically and non-clinically, on how we're doing, so we're comparing ourselves to local, national, and international peers, and getting feedback from our patients directly on how we're doing and listening to them. (Participant S)

I will be able to show you how we have migrated on the journey of each of these values since 2011 because we have a tool in place which measures the values in survey of the team, not the entire hospital, but just the management team, and how those values have changed over those years. And I'm very surprised if there are many other organizations that do in fact have metrics associated with their values and can pull them out and show you from the CEO's desk. But we do. (Participant O)

We've moved on a scale of 1-10 from respect to 6.5 up to 6.9 now up to 8.0. Teamwork is somewhat stagnated over that time. Compassion has really taken a great big leap from 2011. Now remember I just came to this organization in 2010 when the first measure that was registered at 6 went up to 6.4 now up to 8.1. Trust has gone from 5 to 6.1 up to 7.5. (Participant O)

What we introduced after that was, every employee and every manager, including physicians, at their annual performance review, they're evaluated on how they live their values. So the values are part of the performance reviews and evaluation for every member of the staff. In addition, when we do 360 degree evaluations of staff and management, there are key questions around who they live the values around the hospital. (Participant K)

4.3.4 *Impact of Value-Driven Behavior*

Several participants commented on the tangible impact of value-driven behavior. Many stated that value-driven organizations were more productive and had improved performance, though what performance entailed was ambiguous.

Values based organizations, or organizations where the employees know and practice the values of the organization, are anywhere 4, 5, 6 times higher performing than those where the values aren't known in that practice. (Participant O)

Improved Staff Satisfaction

Participants felt that those organizations that used values to drive decision making contributed to a positive workplace culture. A common value set allows staff and management to have a common objective, and therefore improves collaboration and cooperation. Some

participants also extrapolated this effect to suggest that an improved employee culture yields improved patient satisfaction.

Values-driven organizations probably tend to provide a better environment for staff and patients and families. I surveyed for Accreditation Canada so I go across the country and internationally and you get a pretty good feel for an organization, you only get a week at a time, but you get a pretty good feel given the tone that's in place. To me, if I look at the top performing organizations, those that are very much driven by their values are the ones that over time tend to be at the top of the list more than not. (Participant C)

People can relate to it and if we all practice just that one, alone, it should create a better work force for our employees and I believe a better workforce for our employees is going to result in better patient care for the patient and certainly a better patient experience, so to me they're all very intertwined and they start with your values. (Participant A)

Unifying Goal

When making difficult decisions, values act as a unifying objective. Points of contention in any given decision can be weighed against a common set of values in order to come up with a group conversation about the impact of value tradeoffs. Rather than debating over an ideal state, value tradeoff discussions force all involved stakeholders to recognize that the ideal state is sometimes unattainable, and concessions have to be made.

The values help remind everyone in the organization of the commitment of the organization and what's important in the organization. (Participant P)

Well, if you don't have a policy and procedure, and people don't know the values that drive the organization, they will either nothing will happen, or wrong decisions could be made. But if you've got the organization knowing it's values and were all aligned in that regard, then I can go home and sleep at night and know that whoever's out there needing to make a decision will make the right decision because it's based in the values of the organization. And out of it will come some new protocol or policy, but it's a value-driven decision and likely, most likely, no different than it would be if I was there to make it myself. (Participant O)

Correct Default Response

Healthcare workers are faced with new, unpredictable situations every day simply due to the nature of the industry. As a result, rules and regulations to guide decision-making are difficult to develop because they can never fully cover all possible scenarios. The traditional

method of overcoming this was to develop detailed procedure documents which often went unread by many staff. By using value-based decision-making processes, hospital leaders can simply teach staff the organizational values they wish to deliver upon, and these values become a tool to critically evaluate decisions. Staff become empowered to develop their solutions, and management can be confident that these solutions will be appropriate as long as the values are deeply embedded into the organizational culture.

So before they get into the hospital doing things and acting out, they have heard from the president and CEO what the mission, vision, and values are, and why they are important, and how each and every thing you do today can be governed by this. And when you're in the corner, and don't know what to do, count on your values. (Participant O)

I think the second thing is about living your values, and ensuring that your decision-making and the way in which the executive team and the board conducts itself is representative of the organization's values, mission, and that there's consistency and clear role modelling that happens, so that people know what's expected of them, they know what it looks like, they know when they've achieved it, and there really is no ambiguity in the organization about what that looks like. (Participant J)

5 Discussion

This study sheds new light on the nature of values and how they are used to drive decision-making in hospitals. Hospital Chief Executive Officers (CEOs) in Ontario have two value sets; a set of core values that are established at a young age and are largely non-negotiable, and a set of practical values that are established throughout the career journey and are specific to the leadership role. Practical values come with an intended purpose, and are used as tools to shape culture and behavior for a desired effect. For example, practical values such as transparency and patient engagement can be used to lead by example and establish community relationships respectively. These practical values align closely with the functional values identified in the literature review. The concept of functional value varied slightly between the philosophy, business, and healthcare literature, with the business literature aligning most closely with participants' responses. The practical values of transparency, impact, and engagement that participants discussed were all used as tools to achieve a desired outcome, similar to the utilitarian nature of functional values described in the business literature (Sheth, 1991). Additionally, the social and emotional values described in the literature can be seen in CEO's core values as well as each hospital's organizational values. These values, including integrity, compassion, and empathy, were often included in the chosen hospital values, and were a given expectation for CEOs which were non-negotiable. The way in which practical and core values were used differed slightly. Practical values were used primarily by the CEO and leadership team, in order to drive culture change and patient/community satisfaction. Conversely, core values were intended to be used by the entire hospital staff. Core values were also less negotiable than practical values during decision-making.

Participants in this study spoke extensively of healthcare as a system. Linking back to Porter's (1985) value chain, hospital CEOs confirmed that they are often placed in difficult situations where their responsibilities to the health system and patients conflict. All participants had a rich understanding of the health-care system and its various players, including organizations on the periphery of the system such as housing or social assistance groups. Many participants expressed frustrations with the nearsightedness of many stakeholders in the system, and suggested that hospital CEOs were primarily responsible for aligning sometimes conflicting perspectives. This supports the proposed value chain that places hospital CEOs in the value delivery stage of Porter's (1985) value chain.

There was some misalignment in values identified at a variety of levels in healthcare. However, it is important to realize that the values themselves are not significantly different across organizations, but rather their prioritization of values is different. It is clear from the literature review that the prioritization of values is important to decision-making, particularly in a health-care context. It is also clear that the prioritization of values is inconsistent across stakeholders, both within and across organizations, causing conflicts. By acknowledging differences in personal values and being open and transparent about individual priorities and agendas, value negotiations can take place when making contentious decisions. CEOs have already demonstrated this at an organizational level. Through open communication methods, many CEOs are able to debate and implement difficult decisions and gain staff buy-in so that the process is accepted and respected, even if the outcome is not agreeable to everyone.

The largest value conflict highlighted by participants is with the Ministry. Participants expressed a need and desire for increased hospital CEO involvement and consultation for high-level policy decisions. Many participants felt that hospitals, particularly outside of the Greater Toronto Area, have been increasingly removed from policy decision-making in recent years. Participants also expressed a need for longer-term planning with fewer rapid changes in strategic direction in order to sustainably impact these priorities. Participants proposed a shift in incentive structures so they directly correlate with health system values and strategy. The literature review showed that CEOs were very infrequently compensated for improvements in patient outcomes or community impact, but CEOs and health systems both placed significant emphasis on the importance of community engagement and impact. Better-aligned incentives may help to increase the level of decision-making driven by values.

The results from this study support the literature findings that CEO values are more heavily weighted on organizational performance, rather than on delivering value to patients (Wilson-Stronks & Mutha, 2010). This study also found that this weighting is not necessarily a reflection of CEO values, but rather a reflection of the mandate given to CEOs. Many participants described challenges in focusing externally when most of their accountabilities and responsibilities lie internally. Some participants suggested that including more external metrics in CEO performance reviews would yield increased attention to community engagement and health outcomes.

The results from this study also confirm the findings of Teke et al. (2010) suggesting that patient value-driven decisions result in more effective hospital management. All

participants recognized the need for value-driven decision-making in healthcare, and all believed that this would ultimately result in better patient care. Furthermore, participants indicated that value-based decision-making yielded improved employee culture and satisfaction. Participants also felt that value-driven decision-making empowered employees to make their own decisions, while management could remain confident that the choices made align with the organization's values.

Finally, the research showed that values are generally not a focus of attention by CEOs in Ontario health-care institutions today. Participants typically did not evaluate or consciously think about their personal values until later in their careers, but all emphasized the importance of conscious thought. Embedding values exercises into hospital employee onboarding and clinician education may be an approach to spreading the awareness of values across the health system.

By developing an understanding of hospital CEO values, this research contributes to the growing body of evidence supporting value-based health systems, and hopes to act as a catalyst for value-based reform by aligning leadership values with consumer values. "The big question is whether we can move beyond a reactive and piecemeal approach to a true national healthcare strategy centered on value. This undertaking is complex, but the only real solution is to align everyone in the system around a common goal: doing what's right for patients." (Porter, 2009, p. 112).

5.1 Limitations

The findings from this study improve our understanding of how values are understood and used in the Ontario health system. However, there are some limitations to this research.

Many of the participants indicated their excitement of the topic of value-based leadership when responding to the initial interview requests. Several commented on the need for such research and their interest in the topic. The sample that did participant in the interviews could have potentially been biased towards adopting value-based leadership. Without knowing the perceptions of the other CEOs in Ontario who did not participant in this study, this research potentially omits dissenting viewpoints on the role of values in healthcare.

Capturing the true personal values of individuals is a complex task which requires a great deal of personal reflection from the participant and a trusting relationship between interviewee and interviewer. Multiple interviews with the same participant, over a period of

time to allow for regular reflection, would allow for a deeper understanding of each individual's true values. Different methods were used to mitigate this limitation, including reflexivity practices, constant comparative analysis, member checking, and active coding. However, in some cases, only a superficial level of understanding was reached.

The study was limited to the perspectives of hospital CEOs in Ontario. Participants' self-reflections of their personal values were assumed to be true. In order to verify whether or not the stated values match CEO behavior and hospital decision making, interviewing other hospital staff could provide added reliability. Furthermore, understanding the values of other stakeholders in the system, including staff and clinicians, would further strengthen the findings.

5.2 Implications and Future Research

The findings from this study suggest a need for some specific changes in health policy and hospital leadership. Recommendations arising from this research include:

- Promote collaboration between hospitals and community service organizations by aligning organizational accountabilities to system-level impact
- Align CEO performance metrics with their personal and organizational values by including more external, community-focused metrics related to engagement and health outcomes
- Acknowledge that many health-care decisions require values tradeoffs, and educate stakeholders how best to make these decisions
- Involve interested hospital CEOs in health-system decision making at the LHIN and Ministry levels, particularly related to health-system strategy and structure
- Provide hospital CEOs outside of the Greater Toronto Area more opportunity to contribute to policy decisions
- Embed reflective value practices in educational and workplace programming to allow for open discussions about values, particularly tradeoff discussions
- Reduce the frequency of policy and health-system strategy changes to allow for long-term planning and evaluation
- Clarify and distinguish the definitions of value, mandate, accountability, etc. and discuss how they are related and prioritized

Additional research on this topic should seek to answer the following questions:

- How can practical values be developed or guided over time? What role does professional mentorship play in the values of hospital CEOs?
- How do system-level thinkers manage siloed stakeholders with conflicting individual values and priorities?
- How do different health-system stakeholders prioritize similar values? Where do differences in prioritization originate?
- How does changing the structure of CEO mandates and accountabilities affect value-driven behavior?
- How does transitioning to a value-driven leadership style affect hospital organizational performance?
- How do other health-system stakeholders (hospital staff, patients, community) perceive CEOs delivering and managing values? Does behavior match stated values?

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