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A Qualitative Study of Job Competencies for Healthcare Social Work Administrators: An Application of the Short Competency Model Process Used to Identify the Behaviors and Personal Characteristics of Exemplary Performers

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A QUALITATIVE STUDY OF JOB COMPETENCIES FOR HEALTHCARE SOCIAL WORK
ADMINISTRATORS: AN APPLICATION OF THE SHORT COMPETENCY MODEL
PROCESS USED TO IDENTIFY THE BEHAVIORS AND PERSONAL
CHARACTERISTICS OF EXEMPLARY PERFORMERS

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ABSTRACT

Job competencies are central to every organization's human resource management system. Competencies can be used to help organizations create high performance cultures, select and hire a workforce, develop leaders, and establish a foundation for training strategies. Social work, as a profession, has developed competency models for many specialized fields of social work. Health is the second most common practice area reported by social workers with a master's degree in social work, the predominant social work degree for licensed social workers. In highly structured, rapidly evolving, and complex organizations such as healthcare systems, leaders and managers require distinctively different skills and competencies than do those in other settings. Although social work administration permeates all areas of social work practice, there is only a small body of research that elaborates on the various activities, skills, and competencies that social work managers need to do their work in healthcare. The problem that this study addresses is that to date, research has not presented a competency model for 21st century healthcare social work administrators. The purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model.

Through the application of the short competency model process and qualitative research methods, this study answers a central research question: What job competencies do exemplary healthcare social work administrators demonstrate? The participants selected for this study were subject matter experts and exemplary performers in the field of healthcare social work administration. Semi-structured interviews rendered data from which to analyze the opinions of six experts and the experiences of eight exemplary performers. A thematic analysis of the interview data revealed nine competencies for healthcare social work administrators: (a)

achievement orientation, (b) concern for order, quality, and accuracy, (c) initiative, (d) impact and influence, (e) directiveness, (f) teamwork and cooperation, (g) team leadership, (h) self-confidence, and (i) flexibility. Results from this study have implications for healthcare organizations, social work education, and the professional development of healthcare social workers and administrators. These competencies make it possible for organizations to build a competency model with utilization for every human resource development process from hiring and selection to succession planning.

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To God, for your favor-

To my ancestors, for your tenacity and endurance-

To my parents, for your faith the size of a mustard seed-

To my husband, for allowing me the time I needed to finish this segment of my journey-

To my daughter, for your unconditional love that has changed my life-

To my village of family, friends, and sorors, for your encouragement-

To my dissertation committee, for your endorsement-

To the participants, for your willingness to participate in this study-

Thank you.

DEDICATION

To my eldest brother, for your life-

A shooting star fading across the moon-lit sky

Gone too soon

Skiping stones sinking in the blink of an eye

Gone too soon

Sandcastles washed away by the waves

Gone too soon

Coffins being lowered into graves

Gone too soon

But this time it was your coffin

You were the castle

You were the stones

You were the shooting star

This time you were being lowered into the grave

Being washed away by waves

Sinking in the blink of an eye

Fading across the moon-lit sky

This time you were the one

Gone too soon

And I didn't get to say "goodbye"

- Unknown

Freddie "Jay" Jones, Jr.
January 20, 1974 – July 3, 2013

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CHAPTER 1:

INTRODUCTION

Workforce development systems invest in human capital toward the goals of economic security and business productivity (Schrock, 2013). In organizations, workforce development activities occur within the scope of human resource development (HRD) and other human resource management systems (Jacobs & Hawley, 2008; Schrock, 2013). Identifying competencies is a critical step in creating HRD initiatives in an organization because “competencies are the primal root element of all human performance” (Dubois & Rothwell, 2000, p. 2-5). Given the powerful role of competencies in organizational and individual worker performance, the identification of competencies and the construction of competency models should be central to every organization’s human resource management system (Dubois & Rothwell, 2000).

Competency models have been used throughout the business sector (Rothwell & Lindholm, 1999) and competencies are typically linked to organizational objectives and strategies (Campion et al., 2011). The organizational objectives of health and human service organizations are unlike those in the business sector and for-profit worlds (Files, 1981; Patti, 2003) because the objectives of these organizations involve preventing or resolving health, mental health, social, or environmental problems that afflict individuals, families, and specific groups (Furman & Gibelman, 2013). As it follows, health and human service organizations make unique demands of their administrators that distinguish them from administrator roles in other sectors (Files, 1981). Thus, studies of managerial competencies within the context of business and industry have limited relevance for understanding the skills necessary for health and human service managers to perform effectively (Files, 1981).

A majority of social workers are employed by human service organizations (Furman & Gibelman, 2013) and almost three-quarters of social workers report management and administration as one of their job responsibilities over the course of their careers (NASW Center for Workforce Studies, 2006). Social work administrators often ascend the ranks of an organization after having worked in direct service (Spitzer, Silverman, & Allen, 2015; Wimpfheimer, 2004). Administrative roles rise with years of employment, but the detail on the competencies exercised at various career points is lacking (NASW Center for Workforce Studies, 2006).

In the late 1970s and early 1980s there was a “hoped-for growth and expected development” of social work administration (Perlmutter, 2006, p. 5). Empirical studies on the competencies and skills of social work administrators (e.g., Cashman, 1978; Files, 1981; Patti, 1977; Patti, 1985; Wolk, Way, & Bleeke, 1982) were added to the social work literature. In tandem, Johnson and Forest (1983) sought to determine whether organizational factors had an effect on the administrative activities of health and human services administrators. They found that industry and organization type have significant effects on the administrative tasks performed by health and human services administrators. Furthermore, in his study surveying public managers responsible for three types of county-based human service agencies, Preston (2008) makes the case that managerial role competencies vary across fields of social work practice. As a result, social work competency models have been developed for general human service management (Menefee & Thompson, 1994; Wimpfheimer, 2004), as well as specialized fields of social work practice such as gerontology (Geriatric Social Work Competency Scale), child welfare (Drake & Washeck, 1998), mental health (Hoge, Tondora, & Marrelli, 2005), clinical

social work (American Board of Examiners in Clinical Social Work, 2002; CSWE, 2008a), and substance abuse (CSWE, 2008b), to list a few.

The Council on Social Work Education (CSWE) is responsible for ensuring that baccalaureate and master's degree social work programs meet the accreditation standards that define competent preparation (CSWE, 2016). The Council for Higher Education Accreditation, the recognition body that oversees CSWE and other accrediting organizations, requires a competency-based approach to professional education. In response, in 2008 CSWE launched its educational policy and accreditation standards (EPAS): an initiative to work with accredited social work programs to provide resources for crafting advanced-level competencies and practice behaviors specific to specialized areas of social work practice (Spitzer et al., 2015). However, both Patti (2003) and Perlmutter (2006) agree that social work administration is also a specialized area of social work practice.

In their national study surveying social work practice areas, Whitaker, Weismiller, Clark, and Wilson (2006) discovered that health is the second most commonly reported practice area of licensed social workers, to vie with child welfare. In highly structured, rapidly evolving, and complex organizations such as healthcare systems, leaders and managers require distinctively different skills and competencies than do those in other settings (Burns, Bradley, & Weiner, 2012; National Center for Healthcare Leadership, 2005-2010; Spitzer et al., 2015). Healthcare is “an industry and environment that calls for additional competence” (National Center for Healthcare Leadership, 2005-2010, p. 2), yet there is only a small body of research that elaborates on the various activities, skills, and competencies that social work managers need to do their work in healthcare (e.g., Ezell, Menefee, & Patti, 1989; Janssen & Simmons, 1984; Patti & Ezell, 1988). Despite the significance of these studies, 21st century healthcare is considerably

distinct from what it was in the 1980s. It is different in its philosophy, priorities, and approaches, as well as the knowledge, skills, and attitudes of its care providers (Dhooper, 1997).

Statement of the Problem

The competencies and skills of social work administrators are critical to the growth and development of the profession (Perlmutter, 2006) because social work administration permeates all areas of social work practice (Ginsberg, 2001). Menefee and Thompson (1994) recommend future scholarly research on the social work administrator with respect to practice settings, specializations, and auspices, to identify management competencies that are unique to specific environments. Since administrative competencies are unique to fields of social work practice (Johnson & Forest, 1983; Preston, 2008) and healthcare is a prominent practice setting within the profession (Whitaker et al., 2006), a competency model is needed for healthcare social work administrators. The problem that this study addresses is that to date, research has not presented a competency model for 21st century healthcare social work administrators.

Purpose of the Study

Competency models are the result of identifying the job competencies of exemplary performers (Decker, Strader, & Wise, 1997; Dubois & Rothwell, 2000). Because there is no competency model for present day healthcare social work administrators, the purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model.

Significance of the Study

Competency studies are significant because (a) they prepare the field's newcomers by informing education programs, (b) they are linked to individual worker performance, and (c) they provide scholarly contribution to the field (Rothwell, Sanders, & Soper, 1999).

Workplace realities can be translated into meaningful curriculum content (Redmann, Lambrecht, & Stitt-Gohdes, 2000). For that reason, this study has the capacity to influence the educational preparation of healthcare social workers seeking a career in administration by serving as a partial basis for informing decisions about the content incorporated into social work programs of study. In fact, Patti (1977) stressed that understanding the tasks, functions, and competencies that characterize social work administration has implications for designing educational curricula.

This competency study can be linked to worker performance. When researchers study exemplary performers in an organization or industry, workers have the ability to “raise the performance bar to a new level” by replicating what exemplars do (Dubois & Rothwell, 2000, p. 1-23). Competency identification studies for existing jobs, such as a healthcare social work administrator, are meaningful because identifying competencies is fundamental to the development of a competency model (Dubois & Rothwell, 2000; Rothwell & Lindholm, 1999). Organizations can link these models to their human resource management objectives and use the models to design, develop, and administer competency-based assessment tools to measure employee performance (Dubois & Rothwell, 2000). Furthermore, this study is significant because it contributes to the body of social work literature that lacks research on competencies for healthcare social work administrators.

Research Questions

1. What job competencies do exemplary healthcare social work administrators demonstrate?
 - a. What behaviors of healthcare social work administrators are related to exemplary performance?

- b. What personal characteristics of healthcare social work administrators are related to exemplary performance?

Conceptual Framework

The foundational concept used for framing this study is Spencer and Spencer's (1993) concept of competence. Spencer and Spencer (1993) conceptualize job competencies as characteristics that *cause* or predict behavior and performance as measured by a standard of minimally acceptable and/or superior performance. "This means that there is evidence that indicates that possession of the characteristic precedes and leads to effective and/or superior performance" (Boyatzis, 1982, p. 23). Because competency methods give emphasis to "what actually causes superior performance in a job" (Spencer & Spencer, p. 7), the crux of this study lies within the causal relationship between competencies and performance.

Boyatzis' (1982) "theoretical prediction as to the causal relationship between a characteristic and job performance" (p. 23) notes that certain personal characteristics or abilities enable an individual to demonstrate specific behaviors. "These characteristics or abilities can be called competencies" (Boyatzis, 1982, p. 12). The demonstrations of these competencies lead to specific behaviors that cause specific outcomes in performance (Boyatzis, 1982). In short, competencies predict behavior, which in turn predict job performance (Spencer & Spencer, 1993).

This study aims to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model. The causal relationship between competencies and performance is the foundation upon which this study rests. "The underlying theoretical model of managerial competence looks for those characteristics that lead to or result in outstanding and superior performance as a manager or

executive” (Boyatzis, 1998, p. 103). Through this conceptual lens, job competencies are identified by working backward from exemplary performance to identify the behaviors and personal characteristics of workers who perform at this level.

Definition of Terms

The following list is comprised of key terminologies used within this dissertation:

Competency/job competency. Boyatzis (1982) used the term *competency* synonymously with *job competency*. According to Spencer and Spencer (1993), “a [job] competency is an underlying characteristic of an individual that is causally related to criterion-referenced effective and/or superior performance in a job or situation” (p. 9).

Competency identification. “Competency identification is the process of identifying job competencies” (Rothwell & Lindholm, 1999, p. 91).

Competency model. A competency model is the result of competency identification. It is a narrative description of the job competencies for an occupation. It describes the key characteristics that distinguish exemplary performers from other performers (Rothwell & Lindholm, 1999).

Exemplary performer. “Exemplary performers are best-in-class or most productive workers” (Rothwell & Lindholm, 1999, p. 91). The term *exemplary performer* (Gilbert, 2007) is often used synonymously with *superior performer* (Spencer & Spencer, 1993), *star performer* (Froiland, 1993; Kelley, 1999), *strong performer* (Zwell, 2000) and *outstanding performer* (Lucia & Lepsinger, 1999).

Healthcare social work administrator. Healthcare social work administrators are social workers employed in hospitals, health clinics, hospices, home health agencies, public health agencies, nursing homes, employee assistance programs, case management agencies, insurance

companies, social service agencies, and governmental healthcare agencies (Whitaker et al., 2006). Often used synonymously with management (Barker, 1999; Ginsberg, 2001), the term *healthcare social work administration* references social workers that serve as managers, directors, or administrators for specific healthcare programs or departments (NASW, 2011). Within their respective organizations, they have administrative responsibility such as determining organizational goals, acquiring and allocating resources, and monitoring, assessing, and making necessary changes in structure and processes for the benefit of an organization (Barker, 1999). Social workers in the healthcare field are often called *medical social workers* (Ginsberg, 2001).

Assumptions

In this study the following assumptions were made:

- The expert panel is representative of a group of individuals with expertise (having more knowledge about the subject matter than most people) on the job competencies required for exemplary performance in healthcare social work administration.
- The job competencies that emerged during data analysis are an accurate representation of the competencies needed for today's healthcare social work administrators.

Limitations

The limitations inherit of this study are as follows:

- This study was conducted within the naturalistic research paradigm; a standard that advocates for the use of small research populations. No claim is made that these experiences and opinions are generalizable, as in the quantitative research tradition.

However, this study attempts to reach the qualitative construct of transferability by using rich, thick description and applying purposive, nonprobability sampling techniques.

- The results of this study hinged on participant responses to semi-structured interview questions. Research methods in which participants are asked to provide their perspective or recount events using their own words are known as self-report methods (Barker, Pistrang, & Elliott, 2002). Self-reporting methods carry fundamental weaknesses that limit research findings because participant reports are subject to error due to inaccurate recall and/or deception ensued from social desirability biases.
- As customary in qualitative data collection, the interviews conducted in this study were audio-recorded and transcribed. However, Polkinghorne (2005) makes mention that transcribing has inherent limitations because the way in which things are said, the emphasis in speech, and the participant's intonation are often lost in the conversion from oral to written data.
- Because social work, as a profession, has not defined key performance parameters for healthcare social work administration, there were no measurable criteria that could be used to identify exemplary performers in the field. As a result, this study was limited by the nominations of exemplary performers and the ability of experts and other exemplars to identify exemplary performers with the work experiences to yield meaningful data for the Behavioral Event Interviews. The nomination of exemplary performers rests on opinion, rather than measures of actual performance (McClelland, 1998). These opinions threaten the internal validity of this study because while peer nomination has the highest validity and reliability among other peer assessment methods (Kane & Lawler, 1978), it remains open to bias.

Chapter Summary

This chapter provided background information to support the presumption that the gap in social work literature concerning competency models for 21st century healthcare social work administrators is problematic. It detailed the purpose and significance of this study in addition to the research questions that guide this study. Spencer and Spencer's (1993) concept of competency was described and presented as a conceptual framework for which this study rests. Next, the terminologies used throughout this study were defined. Finally, this introduction concluded with the assumptions and limitations of the study. A review of the literature focusing on competencies and exemplary performance is presented in the next chapter, in conjunction with a description of research findings related to healthcare social work administration.

CHAPTER 2:

REVIEW OF RELEVANT LITERATURE

The purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model. This chapter supports this study by integrating the literature relevant to job competencies and other research findings related to healthcare social work administration. The first section of this chapter illustrates concepts related to job competencies, exemplary performers, and competency models. The latter section details social work history and practice, social work administration, and the tasks and functions of administrative practice in social work, as well as a historical overview and description of social work in healthcare.

Job Competencies

David McClelland is credited for introducing the occupational concept of competency in psychology (McClelland, 1973). This concept of competence has been used in the context of workforce development including training and development, professional development, and personnel management (Mulder, 2001). All too often, the term *competency* is misused when referring to *skill* (Zwell, 2000). A competency is a characteristic of an individual that causes or predicts behavior and performance as measured by a standard of minimally acceptable and/or superior performance (Spencer & Spencer, 1993). Similarly, Brownell (2006) defines competencies as “specific descriptions of the behaviors and personal characteristics that are required to be effective on the job” (p. 311). Corporate human resource professionals generally define competency as “an underlying characteristic of a person which results in effective and/or superior performance on the job” (Lucia & Lepsinger, 1999, p. 5).

Competencies can be conceptualized into two categories: *threshold* and *differentiating*. Threshold competencies are exhibited by average performers. They are the essential characteristics needed to be minimally effective at a job (Spencer & Spencer, 1993). Differentiating competencies, on the other hand, are the behaviors that distinguish exemplary performers from average performers (Spencer & Spencer, 1993; Rothwell, 1996; Zwell, 2000). Therefore, the competence of an individual can be obtained by comparing the best instance of a performance with what is average (Gilbert, 2007).

Skills, on the contrary, predict neither behavior nor performance (Zwell, 2000). In fact, Spencer and Spencer (1993) explain that skills predict what a worker has the *ability* to do, not what she or he will actually do. When describing skills, Zwell (2000) assigned this definition: “skills generally refer to the mastery of techniques and knowledge that apply to a specific area or profession” (p. 22). Skills are important and necessary to do a job but assuming that skill determines successful performance is a common and costly mistake (Zwell, 2000). Whereas competencies are hidden, internal capabilities that workers bring to their jobs (Rothwell, 1996), skills tend to be visible and easy to develop. In other words, if a worker has not mastered a particular skill, she or he can be trained to acquire the ability but competencies are much more difficult to develop (Spence & Spencer, 1993).

Exemplary Performance and the Exemplary Performer

Gilbert (2007) defines exemplary performance as “the worth of the historically best instance of the performance” (p. 30). It is “one standard deviation above average performance” (Spencer & Spencer, 1993, p. 13). Performance at this level is key to an organization’s increased profitability because star performers are those that produce the best outputs in contribution toward the business goal (Froiland, 1993). Rothwell and Lindholm (1999) find these star

performers to be the most productive workers. In project execution, average performers aim for predetermined results, while exemplary performers aim for better than expected results. Upon project completion, exemplary performers are energized and wistful as opposed to being exhausted and relieved (Fletcher, 1993).

Exemplary performance is more about strategy than it is knowledge (Froiland, 1993). Although performance tends to accompany knowledge, exemplary performers may not be the performers with the most knowledge (Schack, 2004). What sets exemplary performers apart from average performers is their ability to use their unique strategies more effectively (Fletcher, 1993). These characteristics and strategies are what exemplars bring to their job roles (Marrelli, Tondora, & Hoge, 2005) and what hiring managers should assess for (Zwell, 2000) because workplace training is not suitable to build the strategies and competencies necessary for exemplary job performance (Lucia & Lepsinger, 1999; Rothwell & Lindholm, 1999). “It is most cost-effective to select for these characteristics” (Spence & Spencer, 1993, p. 11).

Studying the strategies and behaviors of exemplary performers is historic in human resource development (Froiland, 1993). The idea dates back to the momentous study of McBer and Company on predicting job performance.

McBer and Company’s study of the U.S. State Department. In the 1970s McBer and Company (associated with David McClelland) abetted the U.S. State Department with the process of selecting Foreign Service Information Officers (FSIOs). The U.S. State Department had been using an exam to select their FSIOs but had discovered that the exam lacked validity and its scores did not predict job performance. McBer and Company sought a criterion sample of exemplary performers and compared their work to a sample of average performers using a technique called the Behavioral Event Interview (BEI). The Behavioral Event Interview has

both sample groups provide detailed, short-story accounts of their peak successes and failures. Next, the interview transcripts from the sample groups were analyzed by comparing the competency characteristics of the exemplary performers to the average performers. Finally, they tested the validity of their competency model by administering the Behavioral Event Interview to new samples of exemplary and average FSIOs to see if they exhibited the competencies that emerged in the first analysis. They concluded that their model was an accurate predictor of the competencies required of FSIOs to do their job well. McBer and Company defend that their competency-based method of selection can be used as a human resource tool to predict job performance (Spencer & Spencer, 1993). The McBer and Company study on FSIOs is significant because it uses the competency characteristics of exemplary performers to identify competencies.

Competency Models

Competency models are the result of competency identification, which traditionally involves identifying job competencies by comparing the best instance of a performance with what is average (Gilbert, 2007; Rothwell & Lindholm, 1999). They are what Rothwell and Lindholm (1999) and Van Velsor, McCauley, and Ruderman (2010) cite as frameworks created to summarize the competencies that describe the key characteristics of exemplary performers in a given role. Many (e.g., Derven, 2008; Lucia & Lepsinger, 1999; Mansfield, 1996; McLagan, 1996) describe competency models as decision tools designed to illustrate the behaviorally specific descriptions of the knowledge, skills, and personal characteristics required for outstanding performance.

Approaches to Building Competency Models

A review of the literature reveals three traditional approaches to building a competency model: (a) the borrowed approach, (b) the borrowed-and-tailored approach, and (c) the tailored approach. The borrowed approach (or Generic Model Overlay Method) to building a competency model involves adopting an existing competency model from a reputable source. The borrowed-and-tailored approach (or Customized Generic Model Overlay Method) modifies a model adopted from another source so that it becomes tailored to fit a different occupation or organization's needs. The tailored approach involves creating a model from scratch by employing numerous data collection methods to arrive at some agreement about the most important competencies (Dubois, 1993; Lucia & Lepsinger, 1999; Rothwell & Lindholm, 1999; Van Velsor et al., 2010).

Dubois (1993) and Rothwell and Lindholm (1999) describe several approaches to building job competency models by way of the tailored approach. The oldest and most rigorous is the Job Competence Assessment (JCA) process developed by the staff of McBer and Company (Boyatzis, 1982). The JCA process (or process-driven approach) is a rigorous, empirical research process that, through observation and interviewing, creates competency models grounded in the behavioral differences between exemplars and averages (Dubois, 1993; Lucia & Lepsinger, 1999; Rothwell & Lindholm, 1999). Once the competencies have been determined, they are used to construct a competency model. When a JCA process is applied, it produces competency models that distinguish the competency attributes of exemplary performers (Dubois, 1993).

Building meaningful competency models is central to planning, integrating, and improving human resource management systems (Dubois & Rothwell, 2000; Rothwell &

Lindholm, 1999). Whatever approach is used, the goal is to build valid competency models with practical applications for organizations to use when staffing its positions with employees who demonstrate the characteristics and behaviors that predict exemplary performance (Rothwell & Lindholm, 1999).

Background on Social Work

Social work: a historical overview. Formally, social work began in England in the late 1500s and early 1600s under the Elizabethan Poor Laws that defined the way the government would provide for those whose families could not support them. Much of what U.S. social workers do comes from two of England's historical practices: charity societies and the settlement movement. Charity organizations in England usually sent wealthy people to disadvantaged homes to help them overcome personal problems and poverty through counseling and resource allocation. This movement was chiefly concerned with helping individuals and families adapt to their environment. The settlement movement, on the other hand, took a different perspective and sought to change the larger society rather than the individual. This movement positioned social reformers and university students in impoverished neighborhoods so they could live among the disadvantaged and create a centralized *settlement house* of educational services, job skills, and cultural opportunities to help people help themselves (Ginsberg, 2001).

It was out of these two great traditions that social work, as a single profession, began to emerge. Direct practice or case work was the contribution of the charity organizations.

Group work, community organization, social planning, and social change emanate from the settlement movement. (Ginsberg, 2001, p. 14)

Professional social work practice. Fast forward to the 21st century, social work is a legitimate profession. It is no longer a team of wealthy philanthropists, university students, or

idealists. It is not a job or an occupation. Social work is a profession, according to Ginsberg (2001), because it has: (a) a body of knowledge that its members must know about, (b) a distinguishable set of skills that its members use in practice, and (c) a set of shared ethics and core values its members must adhere to. The foundation of the profession is rooted in its core values: service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence (NASW, 2008).

Professional social work practice is defined and regulated differently in all state jurisdictions across the United States (Whitaker, Weismiller, & Clark, 2006). A major drawback to defining social work is that individuals and organizations make their own determination of what a social worker is based on particular duties and practices (Barth, 2003). The term *social worker* has been used loosely to refer to anyone offering social assistance. Be that as it may, *The Social Work Dictionary* defines social work as “the applied science of helping people achieve an effective level of psychosocial functioning and effecting societal changes to enhance the well-being of all people” (Barker, 1999, p. 455). While the National Association of Social Workers (NASW) defines social work as “the professional activity of helping individuals, groups, or communities enhance or restore their capacity for social functioning and creating societal conditions favorable to this goal” (NASW, 1973, p. 4).

Aside from these theoretical definitions, the *application* of social work has also been explicated:

Social work practice consists of the professional application of social work values, principles, and techniques to one or more of the following ends: helping people obtain tangible services; providing counseling and psychotherapy with individuals, families, and groups; helping communities or groups provide or improve social and health services;

and participating in relevant legislative processes. The practice of social work requires knowledge of human development and behavior; of social, economic, and cultural institutions; and the interaction of all these factors. (NASW, 1973, pp. 4-5)

Social work is executed through its foremost fields of professional practice: child welfare, gerontology, healthcare, mental and behavioral health, substance abuse, clinical social work, public welfare and community development, school social work, criminal justice, and international social work (NASW, 2013).

Social Work Administration

Social workers that manage or direct social programs are said to practice in one of social work's specialized areas: administration. Often referred to as *macro social work* due to its reference to administrative functions within larger systems, social work administration is about efficiently and rationally directing social service organizations or programs. There are many fields of administration, especially in human services (e.g., public administration, hospital administration). Similar in nature to any other management role, social workers in administration often direct and supervise the work of others to ensure that the organization reaches its objectives (Ginsberg, 2001).

Social work administration includes hiring and dealing with personnel; supervising some staff and making sure other supervisors oversee their staffs; working with and managing the agency budget; ensuring that there is an adequate flow of clients from referrals, self-referrals, and outreach to the community; and making certain that the agency missions are pursued. (Ginsberg, 2001, p. 160)

Activities and tasks of social work administrators. In the early 1970s, a number of schools of social work assumed responsibility in developing curricula for management practice

in social welfare. As their master's degree social work students were being prepared for administrative roles, it became evident that the nature of the work actually performed by social work administrators had not been pragmatically examined (Patti, 1977). The literature presents two empirically grounded studies (i.e. Patti, 1977; Files, 1981) aimed at understanding the tasks and functions of administrative practice in social work.

Rino Patti's study on patterns of management activity in social welfare agencies.

Patti's (1977) study sought to determine which activities social work managers considered most significant to effective job performance. Hoping to arrive at a qualitative analysis of the tasks and activities essential to social work administration, Patti (1977) interviewed 90 managers responsible for social service programs. He found that although his sample of managers engaged in an array of activities, they could be classified into 13 functional categories: (a) planning, (b) information processing, (c) controlling, (d) coordinating, (e) evaluating, (f) negotiating, (g) representing, (h) staffing, (i) supervising, (j) supplying, (k) extracurricular, (l) direct practice, and (m) budgeting. Of these activities, the managers spent most of their time supervising (6.7 hours per week), information processing (6.2 hours per week), and controlling (5.4 hours per week).

The participants were then asked to rank the activities they considered most significant to the effective performance of their jobs. These most significant activities were controlling (74.4%), supervising (67.7%), and planning (67.7%) – indicating that a correlation exists between the amount of time spent on an activity and its significance to effective work performance. Patti (1977) deduced that the activities associated with supervising and controlling are the most essential management tasks for social work administrators as judged by the amount of time consumed on the task and the significance that the managers ascribed to them.

Laurel Files' study on time allocation for human service management tasks. Files' (1981) study focused on the managerial tasks of social work administrators in human service organizations. Her study was based on the questionnaire responses of 103 directors of health, mental health, and social service programs. The participants were asked to indicate the amount of time spent on 14 management tasks: (a) goal setting, (b) needs assessment, (c) program planning, (d) developing and improving services, (e) securing funds, (f) budget management, (g) recruiting clients, (h) securing manpower, (i) supervision and development of staff, (j) program monitoring and evaluation, (k) working with agency governing boards, (l) interagency relations, (m) community relations, and (n) intergovernmental relations. Of the aforementioned management activities, the largest amount of time was spent on intergovernmental relations (13.1%), supervision and development of staff (11.5%), and budget management (11.4%).

Next, Files (1981) compared the result of her study on human service administrators to three earlier studies on the key management functions of industrial and commercial managers (Mahoney, Jerdee, & Carroll, 1965), construction managers (Penfield, 1974), and bank managers (Haas, Porat, & Vaughan, 1969). She concluded that there are significant differences between human service administration and management in the business sector.

Although pivotal to the profession in their own right, these studies do not provide a foundation for a competency model. Patti (1977) and Files' (1981) studies resulted in what Boyatzis (1982) describes as *task and function analyses*. Task and function analyses are “detailed descriptions of what activities must be performed” in a given job (Boyatzis, 1982, p. 8). These analyses do not speak to “the characteristics that enable or increase the likelihood of a person’s performing those activities” (Boyatzis, 1982, p. 8). It is more critical to know what it takes to perform the activity than the activity itself (Lagdon & Marrelli, 2002). Because

competency models describe the key characteristics required for effective performance (Marrelli et al., 2005), a competency model based on tasks and functions denies the causal link between characteristics, competencies, and performance (Boyatzis, 1982).

Social Work in Healthcare

Social work in healthcare: a historical overview. Dating back to 1905 when healthcare was first introduced as a social work field of practice, Richard Cabot, a physician, and Ida M. Cannon, a social worker, piloted the inclusion of social workers to physician teams to address the social problems that impeded patient health (Caputi, 1978; Dhooper, 1997; Spitzer et al., 2015). Dr. Cabot believed that the effectiveness of medical treatment was contingent on a patient's home and family condition (Caputi, 1978; Dhooper, 1997).

Ida M. Cannon is credited with defining the role of medical social work and establishing the first organized hospital social work department (Spitzer et al., 2015). Her nascent social work department at Massachusetts General Hospital became a model for other hospitals and within a decade, social workers were employed in over 100 hospitals across the U.S. In the years to come, medical social work would spread throughout the healthcare system (Dhooper, 1997).

Social work in healthcare: a contemporary synopsis. Today, medical social work continues to be an integral component of the clinical teams designed to comprehensively evaluate and treat patients (American Hospital Association, 2013). Healthcare is now a distinct specialty within the social work profession, requiring social workers practicing in this setting to have a master's degree in social work from a program accredited by the Council on Social Work Education (NASW, 2005; NASW 2011). In fact, Whitaker et al. (2006) found that "health is the second most common practice area reported by social workers with a master's degree in social work" (p. 10).

The Bureau of Labor Statistics (2015) reports that social workers held 649,300 jobs in 2014. Of those, 160,100 (24.66%) were in healthcare (excluding those practicing in mental health and substance abuse). Healthcare social workers are employed in general medical and surgical hospitals, specialty hospitals, outpatient health clinics, hospices, home health agencies, public health agencies, skilled nursing facilities, and insurance companies (BLS, 2015; Whitaker et al., 2006). In their national study surveying social work practice areas, Whitaker et al. (2006) discovered that the most common employment setting for social workers practicing in healthcare are hospitals (56%).

Social work in healthcare: presence, purpose and practice functions. Essentially, hospital social work departments are staffed with professionally educated social workers. In some cases, social work departments also embrace nurse-trained discharge planners/utilization review specialists, interpreters, and other patient-centered personnel sensitive to the social issues associated with illness and disease (Bixby, 1995; Ginsberg, 2001). As within many fields of social work practice, healthcare social workers operate within an ecosystem described by Spitzer et al. (2015) as a “host setting” (p. 197). In host settings, the primary domain of attention is not the provision of social services but because of their system-oriented perspectives, hospital social workers are suitably effective in addressing health issues that span the continuum of care (Spitzer, 1995). As a result, they have a presence throughout their hospital’s emergency department, med/surg units, maternal and child health units, and other inpatient care units (Blumenfield, 1995; Spitzer, 1995).

“The mission of social work within healthcare settings is to contribute to high quality patient outcomes” (Bixby, 1995, p. 18). Further explained by Mayer (1995) and Rosenberg and Weissman (1995), the primary purpose of medical social work is to attend to the environmental

and psychosocial problems affecting patients and their families. The National Association of Social Workers (2011) outlined four general purposes of healthcare social work: (a) to promote behaviors that contribute to the physical and emotional health of patients, (b) to address psychosocial conditions that adversely affect patient health and well-being, (c) to intervene to ensure patients receive services that maintain or improve their health and quality of life, and (d) to help patients manage and adjust to their health condition(s) in order to realize maximum social functioning. These objectives are satisfied through the implementation of diverse and complex practice functions.

In general, the central function of a hospital's social work department is discharge planning (Bixby, 1995; Blumenfield, 1995; Ruster, 1995). Discharge planning is focused on helping patients, families, and caregivers plan for the post-hospital care of patients (Ginsberg, 2001; NASW, 2011). Particularly, this function refers to the characteristic activities of assessment, case management, and information/referral management (Bixby, 1995; Ruster, 1995; Spitzer, 1995). When resources are insufficient, financial assistance accompanies discharge planning activities in effort to help indigent patients find the means to pay for expenses associated with their medical treatment (Bixby, 1995; Dhooper, 1997; Ginsberg, 2001). For cases in which patients present with psychosocial problems that impact the discharge plan, medical social workers deliver in-depth psychosocial evaluations and interventions ranging from supportive counseling to clinical social work services that include individual or group treatment (Mayer, 1995; Spitzer, 1995).

Other practice functions of social work in healthcare are advocacy (Blumenfield, 1995; Ruster, 1995), crisis intervention (Spitzer, 1995), and case coordination in violence, abuse, and neglect situations (Ginsberg, 2001; Ruster, 1995). In some markets, practice functions include

the provision of stress debriefing services and employee assistance counseling (Bixby, 1995; Blumenfield, 1995; Spitzer, 1995). With the Affordable Care Act's emphasis on prevention (Burns et al., 2012), many medical social workers educate patients about the prevention and spread of illness and disease (Ginsberg, 2001).

Healthcare Social Work Administration

Social work, like other practice-based professions, promotes clinicians into management positions as a result of successful line work (Scesny, 1991; Spitzer et al., 2015; Wimpfheimer, 2004). However, for medical social workers, line work is not the ideal training ground for administration because the management of healthcare social work programs requires additional competence (Scesny, 1991). The shift from line worker to manager in the field of human services requires a different set of competencies (Spencer & Spencer, 1993).

Generally, healthcare social work administrators have leadership responsibilities within their department as well as the organization at large (Bixby, 1995). Within their department, healthcare social work administrators are responsible for program planning, the staffing and personnel-related tasks of hiring, termination, and performance reviews, fiscal management to include budgeting and revenue production, social work policies and procedures, maintaining community partnerships, and leveraging resources through negotiation and collaboration (Blumenfield, 1995; Scesny, 1991; Spitzer, 1995).

Aside from their department responsibilities, healthcare social work administrators are expected to participate in hospital-wide task forces and maintain multi-departmental committee involvements (Bixby, 1995; Spitzer, 1995). These extracurricular involvements may hinge on hospital setting. For example, university hospitals are more likely to be driven by research so social work administrators in this setting are likely to have research or teaching responsibilities.

Community-based hospitals are driven by state government, causing social work administrators in this setting to be involved with state and federal legislative processes (Scesny, 1991).

Chapter Summary

The former section of this chapter presented a review of competencies and thoroughly profiled the exemplary performer. The concluding section considered past competency studies on social work administration and attended to findings relevant to social work in healthcare.

Although these supporting studies describe the evolution of competencies and their presence in the field of social work administration, there remains a lack of research on job competencies for healthcare social work administrators. The integration of the concepts presented here support the methods of the study that are detailed in the following chapter.

CHAPTER 3:

RESEARCH METHODOLOGY

The purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model. Beginning with an illustration of the seven-step research process exercised in this study (Figure 1), this chapter provides a thorough rationale for the methodology chosen for this study. Through a qualitative methodological approach, this study applied Spencer and Spencer's (1993) short competency model process (Figure 2) as a research method to identify the job competences of exemplary healthcare social work administrators. This process involved interviewing experts and current exemplary performers in the field. The research population from which the participants were selected is thoroughly described followed by the methods of data collection. Finally, the chapter concludes with detailed information on the procedural steps of data analysis and an explanation of the verification procedures employed.

Methodological Approach

The factors most important in determining the link between the research question and the methodological approach are related to exactly what the researcher is interested in and seeking to address (Creswell, 2003). This study seeks to answer: *What job competencies do exemplary healthcare social work administrators demonstrate?* The conceptual framework, as explicated by Spencer and Spencer's (1993) concept of competence, leads to the following sub-questions:

- a. What behaviors of healthcare social work administrators are related to exemplary performance?
- b. What personal characteristics of healthcare social work administrators are related to exemplary performance?

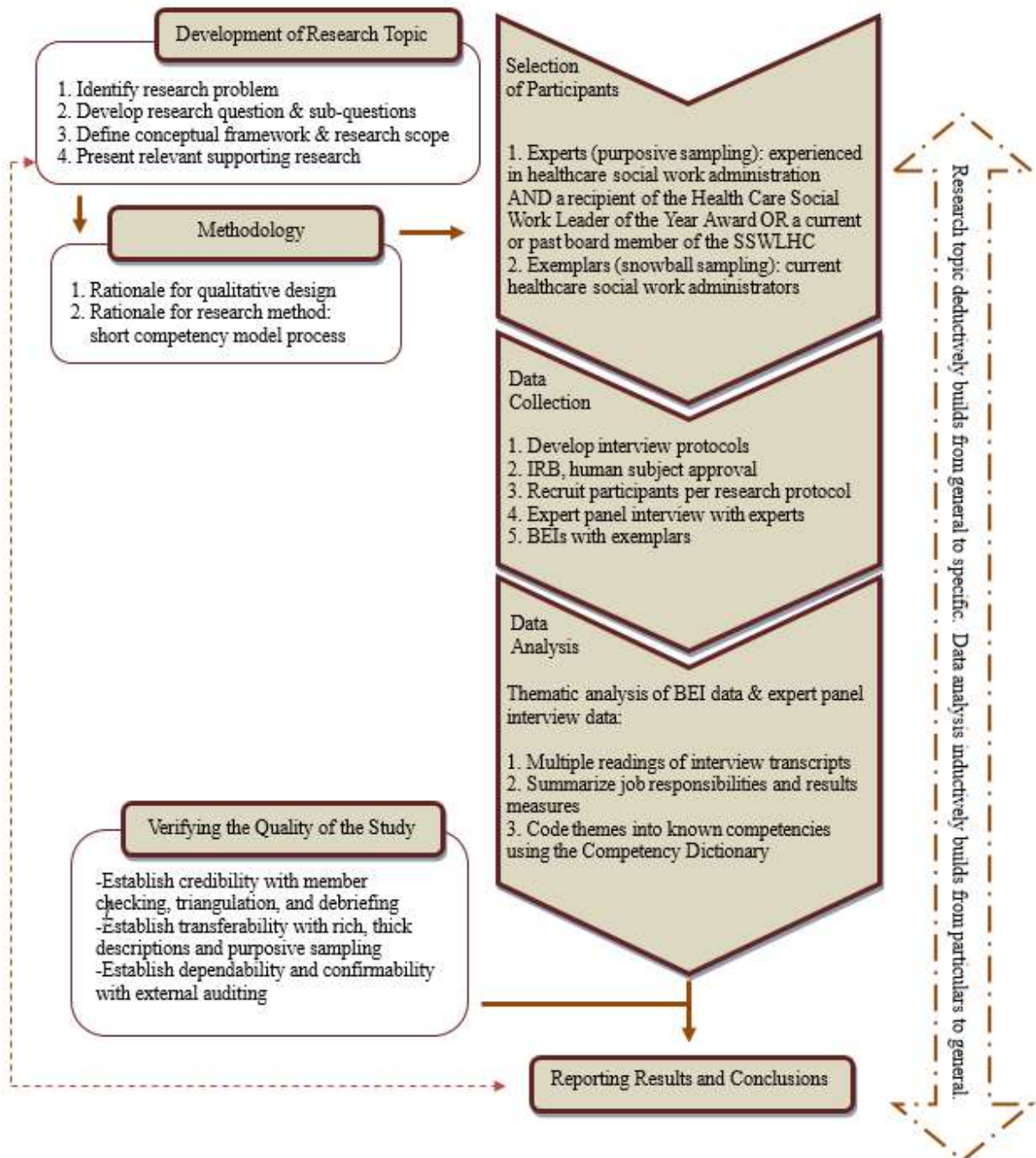


Figure 1. Seven-step research process.

These research questions seek to explore exemplary performance among healthcare social work administrators by generating meaning from their work-related behaviors and characteristics. The work-related behaviors and characteristics of exemplary healthcare social work administrators germinated from Behavioral Event Interview (BEI) data. BEIs provide short-story accounts of an exemplar's peak successes and failures. When BEIs are used in this fashion, they have an exploratory purpose for constructing competency models (McClelland, 1998). Research that is exploratory and research questions that are open-ended and intent on obtaining detailed understanding about a phenomenon among a specific group are characteristic of qualitative inquiry (Redmann et al., 2000).

The problem this study emphasizes is that previous research hasn't presented a competency model for 21st century healthcare social work administrators. According to Creswell (2009), "if a concept or phenomenon needs to be understood because little research has been done on it, then it merits a qualitative approach" (p. 18).

Competencies are unique to fields of social work practice (Johnson & Forest, 1983; Preston, 2008), hence this study gathered data that are specific to the context of social work administration in healthcare organizations. Qualitative research strives to develop a body of knowledge unique to the individual(s) being studied by inductively building from particulars to general themes (Creswell, 2009; Redmann et al., 2000). "The data obtained in qualitative research can only be considered in the context of the environment in which it was gathered" (Redmann et al., 2000, p. 136). In other words, the purpose of qualitative research is not generalizability (as with quantitative research), rather contextualization and interpretation (Glesne & Peshkin, 1992).

Therefore, the methodological approach to this inquiry was qualitative because (a) the research questions are exploratory, (b) little research has been done on the problem, and (c) the data interpretations were specific to the individuals and environmental context in which the data was gathered.

Research Method

Research methods are the forms of data collection, analyses, and interpretations that researchers propose for their studies (Creswell, 2009). In competency studies, the forms of data collection (e.g., behavioral event interviews, expert panel interviews, surveys, observations) vary according to the design of the study (Spencer & Spencer, 1993). For those engaged in the process of identifying competencies, a single, one-size-fits-all design that can be applied to every competency identification project does not exist (Dubois & Rothwell, 2000). However, Spencer and Spencer (1993) propose three tailored approach designs for building a competency model from scratch: (a) the classic competency study design using criterion samples, (b) the short competency model process using expert samples, and (c) the single incumbent or future job study.

Spencer and Spencer (1993) suggest a criterion sample of 20 participants (12 exemplary and eight average performers) for the classic competency study design. This competency study does not apply the classic design because if “the goal of qualitative research is enriching the understanding of an experience, it needs to select fertile exemplars of the experience for study” (Polkinghorne, 2005, p. 140). Both Lucia and Lepsinger (1999) and Marrelli et al. (2005) argue that when feasible, it’s best to select a sample of outstanding performers, not average performers, to contribute data in competency research. “You always learn the most from your superstars” (Spencer & Spencer, 1993, p. 97).

Management positions are typically single-incumbent jobs in which the manager is responsible for the performance of an organizational unit (Boyatzis, 1982). Similarly, social work administrator jobs within healthcare settings are typically single incumbent positions. Although the single incumbent or future job study design can be employed when there are not enough jobholders to offer samples of exemplary performance, Spencer and Spencer (1993) recommend using the short competency model process with Behavioral Event Interviews even in the case of single incumbent jobs. For these reasons, this competency study applied the short competency model process.

The short competency model process. The short competency model process is a tailored approach by way of a rigorous Job Competence Assessment process using data from an expert panel and BEIs (if possible) (Spencer & Spencer, 1993). Spencer and Spencer (1993) describe this process in four steps. I have modified this process to support the purpose of this study, as illustrated by Figure 2.



Figure 2. Short competency model process, as applied to this study.

Step 1, convene an expert panel. The short competency model process begins with the convening of a panel of individuals knowledgeable about the position being studied. Expert panels are advantageous to competency studies because they can provide researchers with a great deal of valuable data in a short time (Spencer & Spencer, 1993). Dubois and Rothwell (2000) assert that assembling a panel of experts within a profession is a sound competency identification method because ultimately, the competencies receive an extensive review from knowledgeable experts in the field. Boyatzis (1982) upholds that through discussion of what is needed to perform a management job competently, these panels can be a calculable source for competency studies.

Expert panel interview protocol. Asking the appropriate interview questions is paramount to the quality of any study (Creswell, 1998). In an effort to capture the desired data, the interview protocol applied to the experts in this study mirrored Spencer and Spencer's (1993) semi-structured expert panel interview questions.

The expert panel interview is a semi-structured interview with a total of three questions organized into five sections: introduction and explanation, job responsibilities, results measures, competencies, and summary and conclusion (see Appendix D). In the introduction, the objective is to explain the purpose of the interview and confirm demographic information for each expert. The job responsibilities section aims to pinpoint the most important job tasks and responsibilities. In the results measures section, the objective is to identify the hard outcome measures and results outputs that indicate exemplary performance. Ideally, experts establish performance measures that can be quantified and later used to judge exemplary performance (Dubois & Rothwell, 2000).

In the subsequent section, the expert panel brainstorms personal characteristics and behaviors that employees need to perform at threshold and exemplary levels (Spencer & Spencer, 1993). Because the focus of this study rested exclusively on the job competencies of exemplars, the expert panel was only asked to identify the competencies that healthcare social work administrators need to perform their job at an exemplary level. The final section of the protocol is purposed to summarize the key findings discussed and conclude the interview.

Step 2, conduct Behavioral Event Interviews. The purpose of this step is to obtain narrative accounts of competencies and provide an understanding of how competencies are expressed for superior performance. Although this step is optional, Spencer and Spencer (1993) make the case that short competency model processes completed without Behavioral Event Interviews “lack the richness and validation” of those conducted with Behavioral Event Interviews (p. 109).

Background on Behavioral Event Interviews. A Behavioral Event Interview is a technique developed by McClelland and consequent of Flanagan’s (1954) Critical Incident Technique (CIT) (McClelland, 1998; Spencer & Spencer, 1993). The Critical Incident Technique uses a set of observation procedures to collect data on an incumbent’s behavior, which, according to some criterion, has been of significance (Andersson & Nilsson, 1964; Flanagan, 1954).

Although Flanagan’s work was not narrowly focused on competencies, CIT laid the foundation for examining the significant behavioral events associated with exemplary performance (Rothwell & Lindholm, 1999). Modified through the work of David McClelland and McBer and Company, the CIT method was advanced toward the development of the BEI (Spencer & Spencer, 1993). During their collection of the critical incidents that distinguish

superior and average Foreign Service Information Officers at the U.S. State Department, David McClelland developed a set of interview questions that was later regarded as a Behavioral Event Interview (Spencer & Spencer, 1993). Competencies were identified through “face-to-face interviews that involve soliciting critical incidents from performers” (Rothwell & Lindholm, 1999, p. 94). McClelland’s Behavioral Event Interview expanded Flanagan’s method because the CIT lacked “probes that yield data about the interviewees’ personality and ‘cognitive style’ (e.g., what they think about, feel, and want to accomplish in dealing with the situation)” (Spencer & Spencer, 1993, p. 98). On this account, Dubois and Rothwell (2000) make the case that the Behavioral Event Interview is a leading method of competency identification.

Behavioral Event Interview protocol. Traditional interviewing practices are not appropriate for identifying competencies. Earlier studies have shown that unstructured, nonbehavioral selection interviews are an abortive attempt to reveal the most important competencies necessary to do a job well (Spencer & Spencer, 1993). The interview protocol applied to the exemplars in this competency study was patterned after Spencer and Spencer’s (1993) Behavioral Event Interview questions.

Similar to a journalistic inquiry (Boyatzis, 1982), the BEI format incorporates four semi-structured interview questions organized into five sections: introduction and explanation, job responsibilities, behavioral events, characteristics needed to do the job, and conclusion and summary (see Appendix E). The protocol begins with an introduction and explanation of the study to establish a mutual trust between the interviewer and the exemplar and to encourage participation. Demographic information is also reviewed during the introduction. The purpose of the job responsibilities section is to get specific information about what the exemplary performer actually does on the job. This section has four probing questions about the exemplar’s

current job title, who the exemplar reports to, who reports to the exemplar, and the exemplar's major responsibilities. Thereafter, in the behavioral events section, star performers describe three detailed and complete stories of job-related critical incidents. Questions in the behavioral events section are designed to detail the operant thoughts and actions associated with success and failure in management occupations (McClelland, 1998). For each incident response, five probing questions are asked to describe (1) the situation, (2) who was involved, (3) the exemplary performer's thoughts and feelings about the situation, (4) what the exemplary performer did, and (5) what the outcome was. Through the use of extensive probing, interviewers elicit descriptions of behaviors that were actually performed in the event (Klemp, 1979).

Asking people to focus on the most critical situations they have faced produces data on the most important skills and competencies. Interviewees tell vivid "short stories" about how they handled the toughest, most important parts of their jobs, and, in doing so, reveal their competencies to do the job. (Spencer & Spencer, 1993, p. 98)

In the next section, the aim is to get additional critical incidents and ascertain, from the exemplary performer, the characteristics, knowledge, skills or abilities needed to do the job. The last section of the protocol, titled conclusion and summary, is purposed to conclude the interview and summarize the key findings.

Step 3, analyze data and develop a competency model. The data collected in steps 1 and 2 of this process are analyzed in step 3, part A, using thematic analysis to generate themes and code for known competencies using the Competency Dictionary. Once competencies are identified, step 3, part B calls for the development of a competency model (Spencer & Spencer, 1993).

Step 4, validate the competency model. The competency model is then validated in step 4 by rating the criterion samples against the competencies identified in step 3 (Spencer & Spencer, 1993). Step 4 of the process and step 3, part B are not within the scope of this study since the purpose of this study is not to construct a competency model. Instead, I've identified the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model.

The identification of competencies required for exemplary performance is a complex and sophisticated endeavor (Marrelli et al., 2005). In fact, Dubois and Rothwell (2000) describe the identification of competencies as “the most challenging and critically important step” toward a competency model (p. 2-5). However, the actual development of a competency model typically requires a substantial time commitment in addition to a considerable amount of money and an exorbitant amount of energy (Mansfield, 1996; Spencer & Spencer, 1993). Developing and validating a competency model is quite labor intensive and usually takes several months for the experienced practitioner and as long as several years for the novice researcher (Mansfield, 1996; Rothwell & Lindholm, 1999).

Therefore, in summary, this modified short competency model process included an expert panel interview (step 1), Behavioral Event Interviews (step 2), and thematic data analysis (step 3, part A) in effort to identify the job competencies of exemplary healthcare social work administrators.

Research Population

Redmann et al. (2000) affirm that in qualitative research, the research population generally consists of insider informants. Hence, the research population for this competency study was social workers that because of their work experiences, qualify as insiders due to their

proximity to the field. Marrelli et al. (2005) avow that it is essential to collect data about required competencies from both job incumbents and others familiar with the work. To capture this population, I used purposive sampling to “identify credible respondents as information sources for competency identification” (Dubois & Rothwell, 2000, p. 2-35). Purposive sampling involves selecting participants that are representative of the research population (Glesne & Peshkin, 1992). Rea and Parker (2005) describe purposive sampling as a type of “nonprobability sampling” in which judgment (not randomness) is used in the selection of respondents based upon their knowledge in the subject area (p. 264).

Society for Social Work Leadership in Health Care. Because professional societies are highly representative of a profession, Dubois and Rothwell (2000) find that using these associations to assemble informants for the purpose of competency identification generally yields quality data. In view of their judgment, I recruited and purposively selected expert participants from the Society for Social Work Leadership in Health Care. A long established professional association of social workers in healthcare, the Society for Social Work Leadership in Health Care (SSWLHC) has over 1200 members nationwide and is governed by a nine-member board of directors (SSWLHC, 2014).

Each year the SSWLHC presents the Health Care Social Work Leader of the Year Award to a social work leader in healthcare who develops and implements creative and innovative ways to improve the delivery of social work services (SSWLHC, 2014). This award is relevant to this competency study because it is the single award that recognizes SSWLHC members who (a) are responsible for the day to day supervision of staff, (b) lead a healthcare social work program within a healthcare setting, and (c) demonstrate excellence in leadership and skill as a clinician, supervisor or consultant (SSWLHC, 2013). Recipients of this award reflect the research

population because they have demonstrated exemplary performance in healthcare social work administration.

Dubois and Rothwell (2000) posit that formal and informal leaders with allegiance to their profession/organization are also appropriate respondents for competency identification studies. Members of the SSWLHC's board of directors are required to "have achieved substantial professional accomplishments in administration and social work in the healthcare field" (SSWLHC, 2014, p. 1). Therefore, because their board seat projects leadership, their term commitments are a demonstration of allegiance, and the prerequisite for membership requires experience in administration and healthcare social work, the board of directors is an appropriate sample of expert participants.

Methods of Data Collection

Data collection is "a series of interrelated activities aimed at gathering good information to answer emerging research questions" (Creswell, 1998, p. 110). For qualitative researchers, it is common to combine different data sources and collection methods (Creswell, 1998; Golafshani, 2003). Although interviewing was the only data collection method used in this modified short competency model process, the data sources were binary. The sources for essential and highly accurate information in competency identification studies virtually always include experts and exemplary performers (Dubois & Rothwell, 2000). Employing multiple data sources provides corroborating evidence and leads to a more valid and diverse construction of realities (Creswell, 1998; Golafshani, 2003).

Selection of expert participants. The chief criterion for inclusion on an expert panel is the member's expertise on the subject area. Murry and Hammons (1995) defend that expertise implies having more knowledge about the subject matter than most people, possessing certain

work experiences, or membership in a relevant professional association. Expert participants within the research population were all members of the Society for Social Work Leadership in Health Care and recruited for this competency study because they met one of the following inclusion criteria:

- A recipient of the Health Care Social Work Leader of the Year Award with experience as a healthcare social work administrator.
- A current or past board member of the Society for Social Work Leadership in Health Care with experience as a healthcare social work administrator.

After receiving the Institutional Review Board's approval to conduct human subject research (see Appendix A), I used the SSWLHC's membership directory to recruit expert participants. I sent recruitment emails via SurveyMonkey® to (a) current and immediate past board members, and (b) 2005-2015 award-year recipients of the Health Care Social Work Leader of the Year Award.

Dubois and Rothwell (2000) advise no more than eight experts are needed to promote the levels of discussion and interaction fundamental to an expert panel. With their advice in consideration, twenty recruitment emails with an invitation to participate in the panel were sent. Ten of those email recipients agreed to participate in the panel. A Doodle poll was sent to the 10 recipients to gain consensus of interview availability. Nine recipients participated in the poll and decided that the best available time for the expert panel was September 3rd, 2015. A Google Calendar™ invitation was emailed to each of the experts with instructions for how to participate in the panel. The consent form (see Appendix B) and demographic form (see Appendix F) were attached to the email. Lucia and Lepsinger (1999) suggest providing interviewees with their

interview questions ahead of time to facilitate focused discussion. In light of their suggestion, the expert panel interview protocol was also attached to the calendar invitation.

The experts returned their completed consent and demographic forms via fax or email. Of the nine recipients who agreed to be an expert panelist and participated in the Doodle poll, six were present for the expert panel interview. The expert panel interview was audio-recorded. The panel convened for 55 minutes and 24 seconds via Zoom: a video and web conferencing service.

Selection of exemplary participants. Gilbert (2007) reasons that measurable performance standards are a requisite for the conversion of performance into competence. In their extension of his point, Spencer and Spencer (1993) note:

Ideal criteria are “hard” outcome measures, such as sales or profit data for business managers, or patents and publications for research scientists. For human service workers, the best criteria are client outcomes. For example, for alcoholism counselors, the best measure of performance is percentage of clients who are still “dry,” regularly employed, and have had no arrests for drunkenness in the year following counseling. (pp. 94-96)

Social work, as a profession, has not established measurable performance standards for healthcare social work administrators. It is recommended that in the absence of objective performance data, an alternative method for defining exemplary performance is to identify a homogenous subset of workers that have demonstrated exemplary performance and get a detailed account of how they go about doing their work (Dubois & Rothwell, 2000; Freeman-Smith, 2009; McClelland, 1998; Spencer & Spencer, 1993). This subset is often identified through a snowball sampling technique referred to as peer nomination (Dubois & Rothwell, 2000; Freeman-Smith, 2009; Spencer & Spencer, 1993).

Snowball sampling is a strategy for purposeful sampling in which the researcher asks participants to recommend others for the study because the participants are knowledgeable about what individuals are information-rich (Creswell, 1998; Rea & Parker, 2005). The peer nomination technique, according to Kane and Lawler (1978), is consistent with snowball sampling because it entails having members of a group designate other group members as being above average on particular dimensions of performance. In competency studies, peer nomination involves soliciting nominations for exemplary job incumbents from knowledgeable judges (McClelland, 1998). It is a “method of establishing the level of [exemplary performance] exhibited by a person, as judged by the members of a well-defined group to which he or she belongs” (Kane & Lawler, 1978, p. 557). Because the SSWLHC is a professional group of social workers in healthcare, members that belong to the group are professional peers. Professional peers are knowledgeable about who the exemplars are in their field (Dubois & Rothwell, 2000). “Exemplary performers stand out” (Dubois & Rothwell, 2000, p. 2-36) so “this approach is used because people agree more readily on who is outstanding than on what makes them outstanding” (McClelland, 1998, p. 332). Exemplary participants within the research population were recruited for this competency study because they met the following inclusion criterion:

- A current healthcare social work administrator nominated as an exemplary performer by an expert participant or another exemplary performer.

To reach saturation for a qualitative research methodology involving in-depth interviews, Creswell (1998) recommends a small and manageable number of participants. In like manner, McClelland (1998) notes that identifying BEI competencies in nominated samples of job incumbents is a method in which samples should be small (McClelland, 1998). More

specifically, Dubois and Rothwell (2000) suggest researchers conduct three to five BEIs to determine the appropriateness of competencies already identified by the expert panel.

Snowball sampling was used to generate a pool of 29 exemplary performer nominees to participate in BEIs (12 nominations from expert participants and 17 nominations from other exemplars). Twenty-nine invitations to participate in a BEI were emailed via SurveyMonkey®. After reviewing the responses to the invitation, I discovered that seven of the nominees were ineligible to participate in the BEI because they did not meet the inclusion criterion: five were retired and two were not healthcare social work administrators according to the definition applied to this study. Consequently, these seven nominees were excluded. Sixteen of the nominees who met the inclusion criterion accepted the nomination and agreed to participate in a BEI. A Doodle poll was sent to each of the 16 nominees to determine their individual BEI availability. Thirteen nominees participated in the poll and were emailed a Google Calendar™ invitation confirming the agreed-upon date and time of their interview. The consent form (see Appendix C), demographic form, and exemplary performer interview protocol were attached to the calendar invitation. Instructions of how to participate in the interview were also included. I received each exemplary performer's completed consent and demographic forms via email.

Of these 13 nominees, eight actually participated in a BEI. The duration of each BEI ranged from 43 minutes and 27 seconds to 92 minutes and 24 seconds. The BEIs commenced on October 22nd, 2015 and terminated on December 8th, 2015. BEIs were audio-recorded to preserve the words of the participants. Each BEI was conducted via Zoom: a video and web conferencing service.

Methods of Data Analysis

Spencer and Spencer's (1993) short competency model process, as modified and applied to this competency study, concludes with an analysis of competency data derived from experts and exemplary performers. Figure 3 depicts the data analysis methods within the context of this modified short competency model process.

Data conversion. Creswell (1998) and Seidman (2006) agree that the primary method for transforming an interview into written text for analysis is to transcribe it. Therefore, after receiving a signed transcriber confidentiality agreement, I submitted nine audio files (one expert panel interview and eight BEIs) to a transcriber for transcription. Because researchers are prohibited from disclosing “confidential, personally identifiable information concerning their...research participants”, some aspects of the data were disguised so that “neither the subject nor third parties (e.g., employers) are identifiable” (American Psychological Association, 2010, p. 17). Once the transcripts were returned, they were edited to eliminate confidential information. Participants were assigned pseudonyms and the particulars of their geographic location, workplaces, job titles, and other identifying information were omitted.

Member checking, in process. Next, as an exercise in verification to establish credibility, I deployed the first round of member checks. In member checking, data and interpretations are referred back to data sources for correction and verification (Lincoln & Guba, 1985). Thus, the transcribed interviews were returned to the participants to be checked for accuracy and to “ensure that inadvertent speaking errors” are corrected (Stitt-Gohdes, Lambrecht, & Redmann, 2000, p. 66). The participants were given one week to submit any revisions. With the exception of punctuation and spelling corrections, no significant errors were reported.

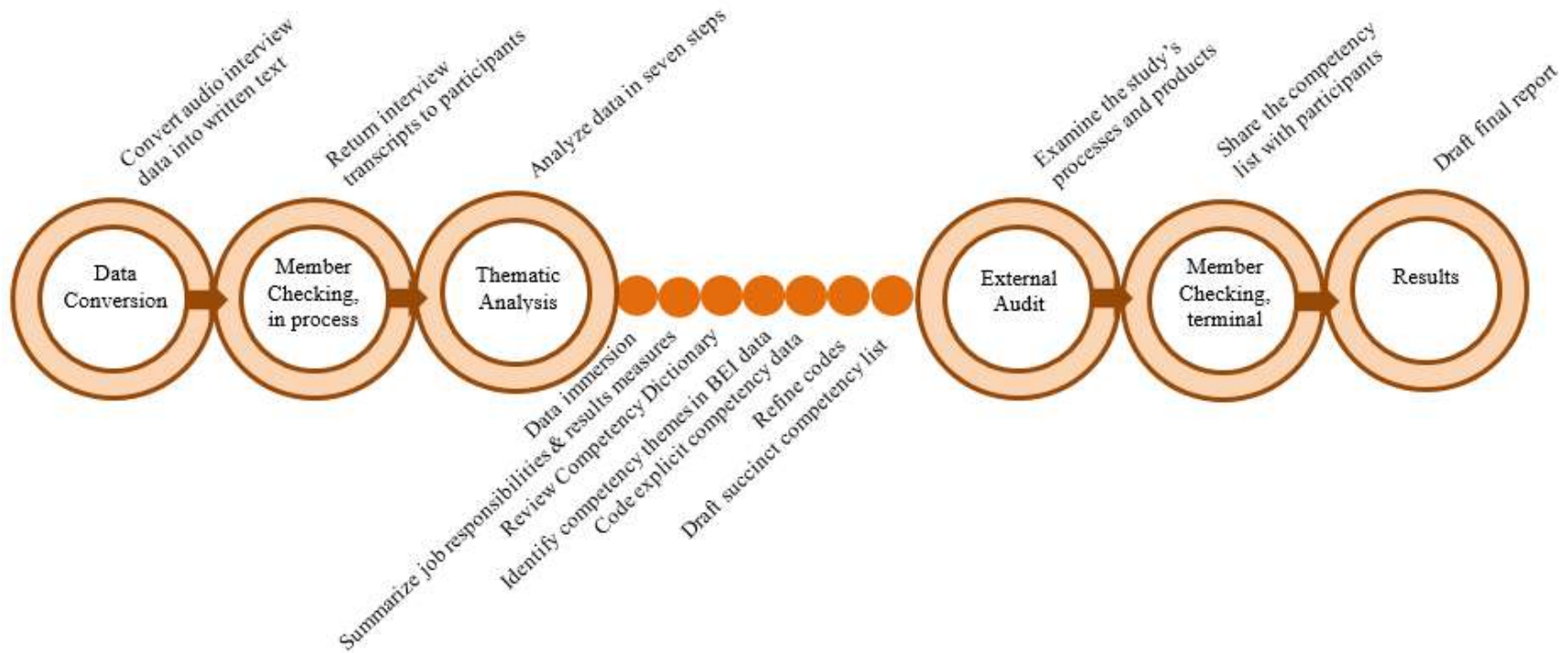


Figure 3. Methods of data analysis.

Thematic analysis. Spencer and Spencer (1993) and Boyatzis (1982) agree that for competency research designs and methods, thematic analysis is the favorable approach to systematically code for competencies. Thematic analysis is “a way of analyzing qualitative information” (Boyatzis, 1998, p. 4) by “identifying themes or patterns in raw data” (Spencer & Spencer, 1993, p. 135). A theme is a pattern found in raw data that interprets aspects of the researched phenomenon (Boyatzis, 1998; Vaismoradi et al., 2013). Through the method of thematic analysis, themes in the data reflect the underlying characteristics of exemplary performers (Boyatzis, 1982). Because Spencer and Spencer (1993) describe competencies as the underlying characteristic of an individual, these themes can be translated into competencies through coding.

In sum, thematic analysis was applied to the data to identify the behaviors and personal characteristics demonstrated by exemplary healthcare social work administrators, as well as their job responsibilities and results measures for which they are critiqued. Due to the voluminous nature of qualitative data (Creswell, 1998; Polkinghorne, 2005), the transcribed expert panel interview and BEI text were analyzed using MAXQDA, a software for qualitative data analysis.

Step 1, become immersed in the data. Qualitative data analysis commences with an immersion in the data (Boyatzis, 1998; Vaismoradi et al., 2013). Raw material from each unit of analysis is read through several times so that the researcher gets an overall sense of the data (Boyatzis, 1998; Elo & Kyngas, 2008; Marshall & Rossman, 1999). Accordingly, I began the data analysis process by simultaneously listening to each interview and reading through its corresponding transcript, twice, to become completely familiar with the data.

Step 2, summarize job responsibilities and results measures. Taking into account the participants’ revisions issued forth from the first round of member checking, I summarized the

job responsibilities and results measures. In the short competency model process, the experts' question: *What are the most important duties, responsibilities, and service outcomes of a healthcare social work administrator?* complements the exemplar's probing question: *What are your major tasks or responsibilities?* Using MAXQDA, the responses to these questions were highlighted in the text and categorized by responsibility type. Then, the responsibilities were simply summarized for the final report. Next, transcript data from the panel's response to the question: *What are the performance indicators for these duties and responsibilities that can be used to identify exemplary performers in healthcare social work administration?* was highlighted in the transcripts and also summarized for the final report.

Step 3, read the competency dictionary to become familiar with competencies. Spencer and Spencer (1993) developed a Competency Dictionary of common competencies using Behavioral Event Interview-based studies of the characteristics of outstanding performers. The Competency Dictionary is a constellation of 286 competency models for “technical/professional, human service, entrepreneur, sales/marketing/trading, and managerial jobs in industry, government, military, healthcare, education, and religious organizations” (p. 20). Organized into six clusters, the dictionary describes 20 common competencies and lists 19 unique personal characteristics and competencies. Each competency is defined by one or more dimensions and each dimension includes a scale of behavioral descriptions of the competency. Applying thematic analysis, competencies are identified in raw data by coding “interview transcripts for known competencies using the Competency Dictionary” (Spencer & Spencer, 1993, p. 135). Cognizant of this coding method, I became familiar with the Competency Dictionary by thoroughly reading the competencies, their definitions, and the behavioral indicators several times in preparation for identifying competency themes and labeling categories.

Step 4, identify competency themes in behavioral event data. After becoming familiar with the interview data and the Competency Dictionary, Spencer and Spencer (1993) recommend analysts highlight the exemplar's behaviors and personal characteristics described in the behavioral event data that may suggest a competency theme. The intent is to let the information from the interview drive thematic formation (Freeman-Smith, 2009). Spencer and Spencer (1993) suggest searching the behavioral events to organize data into three general categories: motivational, interpersonal, and cognitive skills. For this reason, I used MAXQDA to create these initial categories and sort highlighted text. The motivational, interpersonal, and cognitive-related categories encompassed many of the competencies and proved to be helpful when diagnostically analyzing the behavioral event data.

Next, I further sorted the text by creating competency categories using the six competency clusters: achievement and action, helping and human service, impact and influence, managerial, cognitive, and personal effectiveness. Following the categorization of competency themes, I then further refined the themes by creating sub-categories for each cluster and labeling each sub-category with a specific competency from the Competency Dictionary. I re-organized the highlighted text and each theme was coded into a competency by assigning the text to a sub-category. "Any competency recognized by the Competency Dictionary is noted or coded" (Spencer & Spencer, 1993, p. 143). Some themes were coded for more than one competency because competency combinations are common among exemplary performers. "Superior performers' stories often include competency 'molecules'- several competencies used together to accomplish a task or deal with a difficult situation" (Spencer & Spencer, 1993, p. 145).

Step 5, code explicit competency data. After coding for competencies among the behavioral event data, I then searched the expert panel interview and BEIs for key words and

phrases that explicitly suggested a competency theme. Whereas competencies are inferred by coding for behaviors and characteristics from the behavioral events described in BEIs (Boyatzis, 1982; McClelland, 1998), they are explicitly presented in the interview data by way of the experts' interview question: *What competencies do healthcare social work administrators need to perform their job at an exemplary level?* and by way of the exemplars' question: *What characteristics, knowledge, skills, or abilities do you think are needed to do your job?* Therefore, the responses to these questions were also coded into competencies using the Competency Dictionary. I used MAXQDA to sort and add this competency data to the previously created categories.

Step 6, refine codes. Finally, I reviewed the categories and prudently judged each theme against the Competency Dictionary. Spencer and Spencer (1993) counsel analysts to thoroughly weigh and integrate data coded against the Competency Dictionary. When necessary, I refined the codes by reorganizing themes into more suitable categories.

Step 7, convert codes into a succinct competency list. Spencer and Spencer (1993) suggest that in judging the inclusion and exclusion of competency data, researchers must consider if the theme(s) is/are present in most of the exemplary performers, or just a few. To prepare for this assessment, competency codes were marked for frequency of occurrence within each data source. In other words, I made note of each time an exemplary performer inferred a competency and each time an expert mentioned a competency. Moreover, I also noted competency frequencies across data sources. "If the resulting data obtained from one source is similar to the data collected in a second source, there is greater credibility and greater assurance that required competencies have been accurately identified" (Marrelli et al., 2005, p. 544). "Analysts' highest confidence can be placed in those competencies that all data sources indicate

are important to doing a job well” (Spencer & Spencer, 1993, p. 151). In contrast, few occurrences of a codable phenomenon diminishes significance (Boyatzis, 1998) thus rarely seen competencies should be omitted (Spencer & Spencer, 1993). So before developing a concise competency list, I reviewed each competency and its frequency pattern to omit those in rare appearance and evaluate each competency against its source.

Each identified competency was then weighted according to its data source. Spencer and Spencer’s (1993) confidence in BEI data is five tenths greater than that of panel data. Therefore, competencies found in BEI data were assigned a weight of two and those found in expert panel data were weighted 1.5. These designated weights were used to calculate an overall weighted score for each competency (see Appendix G).

Spencer and Spencer (1993) advise against long lists of competencies. On accord, Dye and Garman (2006) suggest a short, effective list. Spencer and Spencer (1993) recommend analysts “boil down” competency themes and develop a “focused list” with five to nine of the most important competencies (p. 148) (see Kelley, 1999). Therefore, as justified by an evaluation of overall weighted scores for each competency, thematic analysis culminated with a succinct list of nine competencies for healthcare social work administrators. This list is inclusive of those competencies that were assigned the nine highest overall weighted scores (ranging from eight to 17).

External audit. With thematic analysis complete, I then sought to verify my findings and interpretations by utilizing an additional verification procedure Creswell (1998) describes as external auditing. “An external auditor examines the inquiry to establish that the process was carried out in ways that fall within the bounds of good professional practice, and the products are consistent with the raw data” (Lincoln & Guba, 1985, p. 109). Over the period of a week, the

auditor examined this study and its audit trail files such as a copy of Spencer and Spencer's (1993) Competency Dictionary, interview transcripts, and MAXQDA notes. After his examination, the auditor and I met to discuss his critique. He believed that four competencies were mismarked for frequency of occurrence and thus the overall weighted scores for these competencies were not an accurate reflection of the raw data. After returning to the interview data and reevaluating the competencies in question, I agreed with the auditor's assessment. Although the frequency of occurrence for these four competencies were modified and their overall weighted scores recalculated, the external audit did not result in the inclusion or exclusion of competencies from the list drafted beforehand.

Member checking, terminal. Once the competencies were identified and the study verified, I executed the final round of member checks. In competency studies, it is imperative that researchers share their results with the panel of experts and also with the exemplary job performers who were interviewed as a validity check (Dubois & Rothwell, 2000). For this reason, a copy of the succinct competency list, along with each competency's definition, behavioral indicators, and corresponding anecdote examples from the BEI data were sent to the participants as a final measure to verify my interpretations of the data. Again, the participants were given one week to judge the accuracy of accounts and share their views of the research findings. The terminal round of member checking concluded with no amendments to the results.

Trustworthiness of the Study

To achieve worthy outcomes, Marshall and Rossman (1999) insist that "all research must respond to canons of quality" (p. 191). Because conventionalist quality approaches are not congruent with naturalistic inquiry, reliability and validity perspectives that would otherwise describe the quality of quantitative research should be redefined for their use in a naturalistic

approach (Golafshani, 2003; Redmann et al., 2000). Researchers have sought qualitative terms that parallel quantitative approaches to reliability and validity (Creswell, 1998).

To start with, the term *trustworthiness* was used by Lincoln and Guba (1985) to describe quality in naturalistic inquiry. Furthermore, they present the terms *credibility*, *transferability*, *dependability*, and *confirmability* as “the naturalist’s equivalents” for validity and reliability (p. 300). While they fall short of guaranteeing balance and fairness, the techniques used to operationalize these terms and establish trustworthiness nevertheless provide a system of procedural checks and balances that occur throughout data collection and analysis (Creswell, 1998; Lincoln & Guba, 1985).

Naturalistic quality approaches. Because the researcher serves as the instrument in qualitative research, verification rests on the diligence of the researcher (Golafshani, 2003). Creswell (1998) advises that “qualitative researchers engage in at least two [verification procedures] in any given study” (p. 203). Therefore, member checking; triangulating; rich, thick description; purposive sampling; external auditing; and debriefing were the verification procedures applied to this study.

Lincoln and Guba (1985) believe member checks to be “the most critical . . . for establishing credibility” (p. 314). Member checking “involves taking data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account” (Creswell, 1998, p. 203). Two rounds of member checking were applied to this study. During member checking in process, interview transcripts were taken back to the participants following data conversion to check for inaccuracies. As a terminal member checking procedure, I provided the participants with a draft of the identified competencies and their corresponding examples from the BEI data.

Triangulation involves cross checking data and interpretations by using multiple data sources, methods, and/or data collection techniques. In naturalistic studies, researchers validate one source or method against another to increase the probability of credibility (Creswell, 1998; Lincoln & Guba, 1985). This study employed three data sources: experts, exemplary performers, and the Competency Dictionary, thus adding to the study's credibility. "No single item of information should ever be given serious consideration unless it can be triangulated" (Lincoln & Guba, 1985, p. 283).

"To make sure that the findings are transferable between the researcher and those being studied, thick description is necessary" (Creswell, 1998, p. 197). Transferability requires the study's findings to be useful to others in similar situations and with similar questions of practice (Marshall & Rossman, 1999). Thus, to establish transferability, I provided anecdotes of the participants' behavioral events in rich detail to illustrate how exemplary performers express each competency. "Effective thick description brings the reader vicariously into the context being described" (Erlandson, Harris, Skipper, & Allen, 1993, p. 33).

Purposive sampling is also a strategy to facilitate transferability. Because the foundation of transferability is a rich description of participants' views, the search for data must be guided by a sampling procedure that purposively seeks to maximize the range of specific information about what is relevant to the study (Erlandson et al., 1993). Since I employed purposive sampling as a data collection technique to identify credible information sources, the purposive selection of expert and exemplary participants supports trustworthiness.

In an attempt to minimize prejudice and partiality, an external audit was conducted of this study. In external auditing, a qualified external consultant with no connection to the study establishes dependability by determining the acceptability of the process, and confirmability by

attesting that the research product is supported by the data (Creswell 1998; Lincoln & Guba, 1985). The external auditor of this study holds a Ph.D. in social work, has over 30 years of experience in healthcare social work administration, six years of experience as a director of human development, and has had two associate professor academic appointments. The auditor has 27 years of experience in designing, conducting, and analyzing research. He has authored four textbook chapters and written over 11 published journal articles on medical social work, including six grounded in qualitative research methods.

In addition to these verification procedures, debriefing was also applied. Naturalistic researchers engaged in debriefing periodically converse with a professional who has a general understanding of the study in effort to explore methodological steps, analyze materials (Lincoln & Guba, 1985), and allow the debriefer to ask “hard questions about methods, meaning, and interpretations” (Creswell, 1998, p. 202). Over the course of this study, I met with an experienced workforce development researcher to talk through my research design, research decisions, and research significance. After the themes were coded into competencies, the debriefer reviewed the study in its entirety and critiqued its research method, data analysis, and conclusions. The debriefing process establishes credibility for qualitative research studies (Erlandson et al., 1993; Lincoln & Guba, 1985).

Conventionalist quality approaches. As the quantitative concepts of validity and reliability pertain to the data collection methods applied to this study, both expert panel interviews and BEIs have been appraised. McClelland (1998) concedes that the method of identifying competencies through the use of expert panels has face validity. Behavioral Event Interviews have also been thoroughly studied (Andersson & Nilsson, 1964; Levine, Ash, & Bennett, 1980; Ronan & Latham, 1974). According to Andersson & Nilsson (1964), the Critical

Incident Method (from which the BEI was derived) is both reliable and valid. McClelland (1998) posits that “coding competencies from Behavioral Event Interviews...produces assessments that are reliable and validly associated with success as an executive” (p. 331).

The objective of BEIs is to determine which behaviors and personal characteristics are causally related to job success (Spencer & Spencer, 1993). Because “the interview obtains a sample of the person’s actual behavior in the job,” Behavioral Event Interviews have validity (Boyatzis, 1982, p. 51). “Behavioral Event Interview outcomes have high face validity” for specific jobs within specific settings (Dubois & Rothwell, 2000, p. 2-42). Thus, the BEI and expert panel interview contributed to the quality of this study.

Additionally, the nonprobability sampling procedures applied to this study also contributed to its quality, from a conventionalist perspective. Spencer and Spencer (1993) state that nominations or ratings by peers have “high criterion validity, that is, they do predict hard job performance outcomes” (p. 96). Kane and Lawler (1978) add that when comparing peer assessment methods, peer nomination has the highest validity and reliability, thus minimizing the threat to internal validity.

Chapter Summary

This chapter began by defending the case for applying a qualitative methodological approach to this study. Following a rationale for adopting Spencer and Spencer’s (1993) short competency model process as the research method, this chapter described the criteria for participation in the study and data collection methods. The latter section of the chapter delivered a detailed explanation of the data analysis approach as well as a description of quality measures undertaken. The research findings for this study are presented in the next chapter.

CHAPTER 4:

RESULTS

The purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model. The preceding chapter offered a detailed description of how Spencer and Spencer's (1993) short competency model process was applied to this study and how the interview responses of experts and exemplary performers were analyzed. This chapter opens with a description of the research participants, after which the results measures and job responsibilities of a healthcare social work administrator are summarized. Nine competencies are then identified and described in terms of behaviors and personal characteristics. Lastly, the chapter concludes with an epitome of the research findings organized as answers to the research questions.

Profile of Expert Participants

The panel of expert participants consisted of five females and one male. One participant was in the 40-49 age range, four were in the 60-69 age range, and one was in the 70-79 age range. Five participants identified themselves as White and one identified with the Asian racial category. Expert participants' educational background ranged from licensed clinical social workers with Master's degrees in Social Work to Ph.D.s. Five experts were employed in hospital settings and one was employed in a health clinic/outpatient facility. The expert participants held sundry job titles such as senior vice president of psychosocial services and community affairs, director of patient and family services and community health services, director of social work and interpreter services, and director of clinical social work services. One expert participant was the manager of patient and family counseling, utilization review, and care coordination and one was a retired director of social work and community services. All six experts were recipients of

the Health Care Social Work Leader of the Year Award and published authors with material on social work in healthcare. Half of the expert participants taught a social work course(s) at a post-secondary institution and five of them had experience on the SSWLHC's board of directors. The following table summarizes the expert participants' demographic information:

Table 1

Expert Participants' Demographics

Characteristic		N=6	Percent
Sex Category	Female	5	83.33%
	Male	1	16.66%
Age Range	40-49	1	16.66%
	60-69	4	66.66%
	70-79	1	16.66%
Ethnic Category	Not Hispanic or Latino	6	100%
Racial Category	Asian	1	16.66%
	White	5	83.33%
Education	MSW + LCSW	2	33.33%
	MSW + additional master's degree	2	33.33%
	MSW + Ph.D.	2	33.33%
Employment Setting	Hospital	5	83.33%
	Health Clinic / Outpatient Facility	1	16.66%
Experience	Recipient of the Health Care Social Work Leader of the Year Award	6	100%
	Instructor of social work	3	50%
	Current or past member of the SSWLHC's board of directors	5	83.33%
	Author with published material on social work in healthcare	6	100%

Profile of Exemplary Participants

The exemplary research participants were made up of six females and two males. Two participants were in the 40-49 age range, two were in the 50-59 age range, and four were in the 60-69 age range. All eight of the exemplary participants described themselves as White. Exemplary performers' educational background ranged from a licensed social worker with a Master's degree in Social Work to those holding two master's degrees. Five exemplars were

employed in hospital settings, two in health clinics/outpatient facilities, and one was employed in a hospice setting. In terms of geographic location, there was one exemplar who worked in a rural setting, five in metropolitan settings, and two who were responsible for the oversight of social workers in satellite offices with varied geographic settings. Four exemplars were recipients of the Health Care Social Work Leader of the Year Award and four taught a social work course(s) at a post-secondary institution. Seven exemplary participants had experience on the SSWLHC's board of directors and six of the eight were authors with published material on social work in healthcare. The exemplary research participants in this study maintained job titles such as director of clinical social work services, national director of social work, director of social work, social work director, and director of social services. Two exemplars occupied the title of director of social work and case management and one held the title of manager of patient and family counseling and care coordination. An individual profile of each exemplary performer can be found in Appendix H. A summary of the exemplary performers' demographic information is outlined in Table 2.

Summary of Job Responsibilities and Results Measures

“A responsibility is an action or a result for which one is accountable” (Rothwell, 1996, p. 26). In competency studies, jobs are usually described in terms of responsibilities that reveal what the job occupant is expected to do and outcomes she or he is expected to produce in contribution to the organization's performance (Boyatzis, 1982). Because competency identification projects require a thorough understanding of these key parameters, competency studies typically begin with work activities, or action statements that describe what the worker is responsible for (Dubois & Rothwell, 2000).

Table 2

Exemplary Performer Participants' Demographics

Characteristic		N=8	Percent
Sex Category	Female	6	75%
	Male	2	25%
Age Range	40-49	2	25%
	50-59	2	25%
	60-69	4	50%
Ethnic Category	Not Hispanic or Latino	8	100%
Racial Category	White	8	100%
Education	MSW + LSW	1	12.5%
	MSW + LCSW	5	62.5%
	MSW + additional master's degree	2	25%
Employment Setting	Hospital	5	62.5%
	Health Clinic / Outpatient Facility	2	25%
	Hospice	1	12.5%
Experience	Recipient of the Health Care Social Work Leader of the Year Award	4	50%
	Instructor of social work	4	50%
	Current or past member of the SSWLHC's board of directors	7	87.5%
	Author with published material on social work in healthcare	6	75%

The results of the BEIs concluded that healthcare social work administrators direct departments staffed with diverse disciplines and educational backgrounds. Many healthcare social work administrators have direct reports that are not only master-level social work clinicians, but also nurses, interpreters, clerical personnel, and other bachelor-level social science staff that assist with logistics and patient navigation. Additionally, the BEIs revealed that healthcare social work administrators are not typically involved in direct patient care unless associated with patient and family complaints or ethical issues. They are, however, chiefly responsible for

- financial management - preparing, defending, and monitoring the department's budget; managing and leveraging resources; expanding fundraising capacity and maintaining donor relations;
- resource management - seeking, acquiring, and governing technical resources for patients and families (e.g., meal vouchers, emergency food, clothing assistance, transportation);
- conflict management and problem solving - mediating and resolving grievances among subordinate staff, between patients and families, and between medical practitioners and the organization;
- patient experience - conceiving and/or participating in department and organization-wide quality improvement initiatives; assessing and improving patient satisfaction outcomes;
- program development - designing and directing special projects, initiatives, and programs for patients, subordinates, other medical practitioners, and/or the community; evaluating program outcomes;
- planning - developing strategic plans for the department; forecasting staffing and resource needs;
- education - planning learning and educational opportunities for patients, subordinates, and superiors;
- management control - overseeing the supervisory structure of the department; ensuring that the department and organization policies and procedures are maintained; safeguarding clinical standards and making certain that social workers are operating within their scope of practice;
- evaluation - monitoring and evaluating service delivery for efficiency and effectiveness; directing service delivery to meet the organization's objectives;

- human resource management - hiring subordinates, orientating and training subordinates, measuring retention and turnover; reviewing work assignments, staffing, and ensuring adequate coverage; and
- performance management - providing and/or overseeing clinical supervision, internal audits, and plans of correction.

Before competency identification can proceed, responsibilities should be defined in terms specific to results measures and standards that can be quantified for judging performance (Dubois & Rothwell, 2000). According to the expert participants, performance indicators are tied to the department's business plan, the organization's objectives, and its strategic plan. Although specific results measures may vary by organization, the general outcome measures that can be used to distinguish exemplary healthcare social work administrators are

- financial management - directing a department or managing a program that operates under its forecasted budget; increasing the amount of revenue generated for the department or organization;
- conflict management and problem solving - decreased number of patient and staff grievances; decreased response time toward the resolution of patient and staff grievances;
- patient experience - high patient satisfaction scores;
- program development - increased number of newly initiated or modified services/programs; increased number of internal and/or external accolades for the department's services/programs;
- evaluation - low overall patient readmission rates; low readmission rates among distinct patient populations (e.g., homeless, diabetics); decreased frequency of emergency

department visits among distinct patient populations; low rates of avoidable days (evidence of service efficiency); low average rates for length of stay; and

- human resource management - high employee engagement scores; high employee retention rates; low employee turnover rates; high percentage of tenured staff.

Competencies for Healthcare Social Work Administrators

As recommended by Spencer and Spencer (1993), the format for competency reports begins with a presentation of the competencies by dictionary cluster. Next, each competency is listed along with a description of the competency in terms of behaviors and personal characteristics (see Appendix I for a quick reference). Ideally, for each competency listed, there should be a description of the relevant behavioral indicators and one or more verbatim examples of the competency from the BEI data. Only the rich examples illustrating the most compelling evidence of the competency were included in this competency report. These anecdotes are included to make the competency “come alive” because they “convey the nuances of *how* a competency is used” (Spencer & Spencer, 1993, p. 154). The thematic analysis of the interview data resulted in the identification of nine competencies. Figure 4 depicts these competencies by dictionary cluster. The most important competencies for healthcare social work administrators are

- achievement orientation;
- concern for order, quality, and accuracy;
- initiative;
- impact and influence;
- directiveness;
- teamwork and cooperation;

- team leadership;
- self-confidence; and
- flexibility.

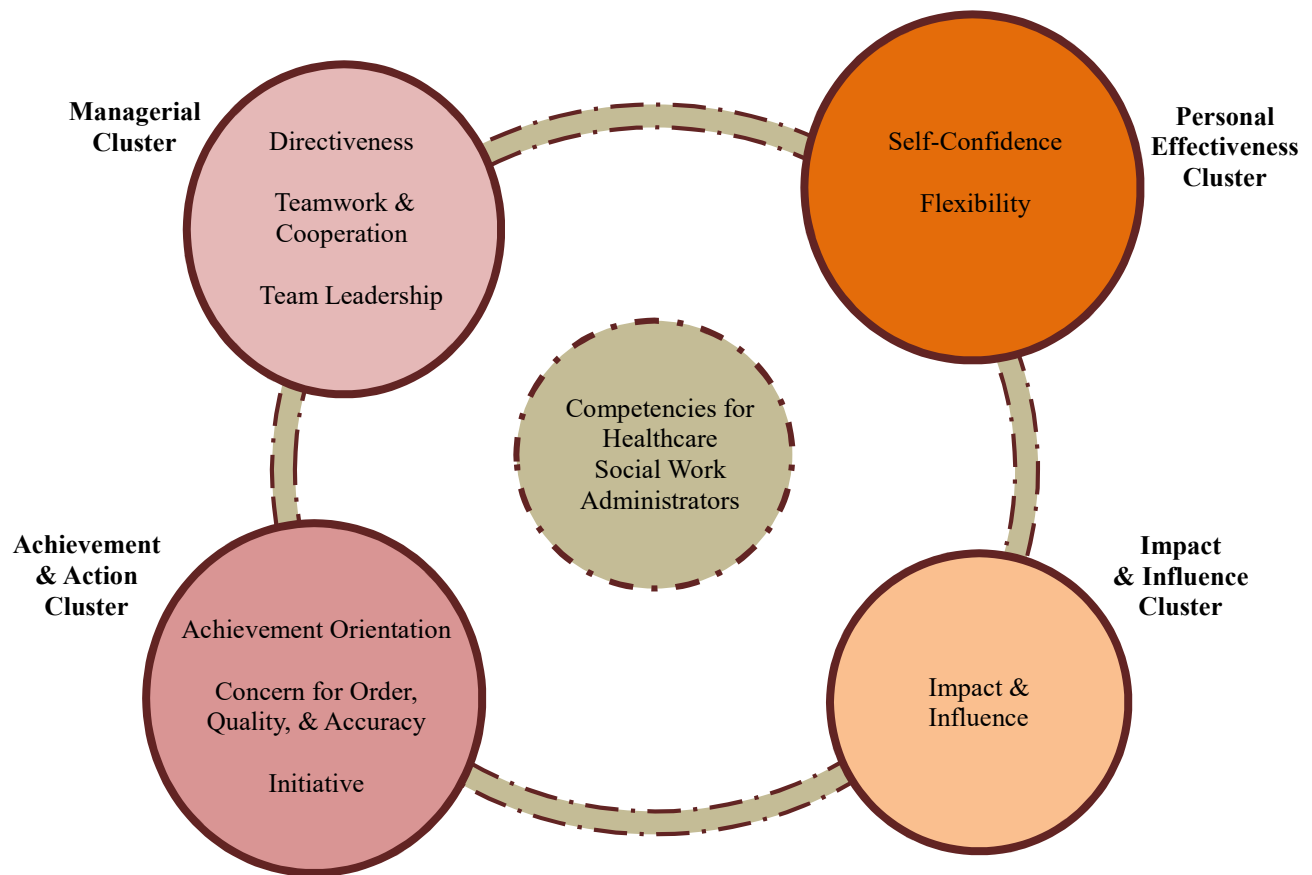


Figure 4. Competencies for healthcare social work administrators.

Achievement Orientation. Achievement orientation is setting, striving, and achieving challenging goals to vie with one's own performance (striving for improvement), the performance of others (competitiveness), or what anyone has ever done (innovation) (Spencer & Spencer, 1993; Zwell, 2000). Behaviors expressing achievement orientation are (a) working to

meet management or industry standards, (b) setting challenging goals to improve performance, (c) making cost-benefit analyses, and (d) taking entrepreneurial risks (Spencer & Spencer, 1993). This competency “proves to be one of the competencies that most differentiates superior performers” (Zwell, 2000, p. 26).

Neena expressed achievement orientation by working to meet her organization’s standards:

*As one of the problems that confronted me as soon as I got [here] was we had all of these, what we call, open reqs, which are postings that are out there to fill and we had something like 41 of them, which means you’ve got work that 41 people should be doing but you haven’t found the right people to do it. **So one of my goals right away was to try to get the number of open reqs down.** . . . Now, our number of open reqs is well below 20, probably in the mid-teens.*

Achievement orientation was also made manifest by supporting data in Cressy’s BEI. After considering potential profits, she modified the work methods of her staff to reach budgetary standards:

*We’re now beginning to bill for our services . . . in the emergency department and in our ambulatory clinic setting. We’re actually now billing for our assessments and interventions. So for all my evaluations, I’m now billing and recouping revenue, which is **helping me come under budget** because I’m now reimbursing the hospital for my time and my social workers’ time.*

Achievement orientation also includes setting goals and working to make system changes to improve performance, efficiency, or quality (Spencer & Spencer, 1993). Neena further

demonstrated this competency when she decided to improve the hiring process for her department:

When we were looking for new staff, all the managers were looking at all the applicants separately. People were talking to the applicants separately. Sometimes one manager didn't know another manager had talked to an [applicant]. There was a history of the front line staff being involved in interviews which are sometimes two and three interviews before we selected a candidate. [There was] no template to interview the candidate with, you just sort of talked to them and then no timeframe for when you get back to candidates or what questions you asked when you actually checked their references. So, I found this all quite distressing because hiring people is so critical to having a strong department. . . . I went through all of the workflow around hiring and we established some very different practices; very structured practices for recruitment and hiring. One of these was that we would not bring people here for more than one interview. We needed to be able to make our mind up based on one interview and reference check and in order to make the process timely, we could not set up interviews involving front line staff. . . . Last week [the new hires] told us they've never been so warmly welcomed in such a structured way and they feel so confident, where things are so organized, and they are just so grateful for the hiring process and the orientation process that we use here. They said, too, this is so efficient, like I applied, you contacted me, you interviewed me, you made a decision, I got here, it went exactly as I would have wanted it to go.

Thalia set challenging goals for her staff when she was asked by her CFO to develop a charity care application process for the entire hospital system:

*I knew we needed to get a charity care app for people [because] we had people who were not opting for treatment because they didn't have an ability to pay for it. . . . But the turnaround time had to be fast. . . . So people are not waiting to find out [whether or not their application had been approved]. **Our turnaround time had to be two days. That was our goal.** [I said] "We're going to get these processed and we're going to get them processed now and get people in for treatment." We made it happen and we are processing probably 80 applications a week and gosh, that's unheard of.*

Ferris set his work priorities based on a return on investment analysis when he worked to achieve national acknowledgment for his hospital vis-à-vis lesbian, gay, bisexual, and transgendered patient equality:

*I took on responsibility for a hospital-wide effort to gain or to achieve national recognition. . . . Sort of an acknowledgement . . . created by the Human Rights Campaign. . . . My hospital . . . is in the middle of [the city] and right smack in the middle of a very large LGBT population [and] a very active, but at-risk, transgender population. . . . The hospital was providing and is providing really amazing services to this specific population and so I [thought] this is just such a good thing. . . . If we were able to show, you know, and have our patients who are impacted by this, have something to be very proud of. But also really, **when you look at things like market share and we're fighting for patients among other children's hospitals** in the area and none of them have this certification, by the way. . . . So . . . I put together a group of people . . . I think there were only six or seven of us. I kept it pretty small as the task group and we lobbied, actually, some key folks in the organization including the Chief Nursing Officer, the Chief Operating Officer, the Chief Medical Officer, and who else, oh, the head of HR. . . .*

*[because]there was a business impact as well as community relations. Employees [would be] so proud if they really felt that the organization took a step forward in representing its workforce in a much more genuine way. [So] if we were to get it that would be very good for us. . . . If we were to get this it would, **it would be well worth the investment.** I really saw it as a win/win.*

The Competency Dictionary asserts that when star performers take calculated entrepreneurial risks, they “commit significant resources and/or time (in the face of uncertainty) to improve performance, try something new, or reach a challenging goal (e.g., starts new products or services, takes on ‘turn around’ operations)” (Spencer & Spencer, 1993, p. 26). Cressy demonstrated achievement orientation when she created a medical respite program for homeless patients:

*I have a very key interest in the homeless . . . but **homeless was a population that I kept struggling with. I could not figure out what it is that I could do and be impactful from a hospital perspective.** Knowing that they kept showing up in the ED but I didn’t know how to change that. . . . It was a very frustrating population because I was not able to really get a vision for what I needed to do. . . . So we did a full analysis of what the impact of the homeless patient is on our hospital . . . and it did take us two years. . . . **So we did many, many, many presentations to our key legislators. I did many presentations to [my] hospital administration.** I got the support from the hospital administration to convene a task force within the hospital of very key people, which isn’t easy to do because there’s so many priorities at the hospital. But they designated a finance person to work with me, a data person to work with me, an ED person to work with me so I had this key taskforce. . . . And then we went to key legislators to try to see if*

*we could get state funding to actually fund this program. **We determined we needed about \$450,000 a year to run this program. We got a key legislator to agree to have Medicaid fund this program as a 3-year pilot to see whether or not we're going to say we saved Medicaid funding. . . . We had to actually build a program** and we had to look at what services, what staffing, what resources were needed, who is the population we're actually going to be able to see. So, you know, we went through a lot of that kind of discussion and we came up with, you know, operational manuals, and personnel manuals, staffing guidelines. It was like creating a mini hospital. So that's what we had to do and I had to bring the right people to the table because obviously I don't have the knowledge of all those areas. But I was the lead to convene, facilitate and push the vision. **Two years of work lead up to that ribbon cutting and it is one of maybe a dozen medical respite programs around the country for homeless. So it's the only one in [the region]** and we did a lot of work trying to set this program up. So what it is, it's a place that I can discharge homeless patients, instead of having them go to a shelter or go back to the street or live in a car. I discharge them to a facility [located within a community shelter] that can keep them up to 30 or 60 days. . . . **We've had a major impact on reducing . . . ED utilization. . . . [And] reducing readmission [rates among] homeless patients.***

Concern for Order, Quality, and Accuracy. The concern for order competency reflects a desire to reduce uncertainty (Spencer & Spencer, 1993). At its highest level, this competency is exhibited by influencing large systems within the organization to adopt new processes and procedures to safeguard accuracy and quality (Zwell, 2000). Superior performers manifest concern for order, quality, and accuracy by (a) monitoring data or others' work, (b)

clarifying roles, tasks, and functions, and (c) developing new and complex systems to keep track of information (Spencer & Spencer, 1993).

Cressy confirmed her proficiency in the concern for order, quality, and accuracy competency when she explained how she monitors the documentation of her social work staff to keep track of children who've been poisoned by lead exposure:

*You know a leader, especially a social work leader. . . . You have to be really a guru of documentation and collecting accurate data. . . . Up until a couple months ago [my social workers] weren't articulating in their documentation that this child had a lead exposure and that there was certain interventions that were unique to this child around a home assessment and a home evaluation. So I had to change the documentation so that it can be very specific, but I had to get into the weeds on that because **I need to be able to pull that data out when I look at, you know, what is the overall improvement to this population.** . . . So, I'm a stickler at accurate documentation and you know, garbage in-garbage out. **It does not help me if my staff does not document accurately, one hundred percent of the time.** I get in the weeds on that because it's so important in order for me to articulate any kind of project plan [because] I need to rely on the data.*

Abigail also demonstrates the concern for order, quality, and accuracy competency when she checks to ensure documentation procedures are followed by monitoring information:

*I put together a readmission prevention program to focus on our home health patients. . . . Really looking at patients that are at high-risk for re-hospitalization. **I'm responsible for keeping people accountable and making sure we're tracking these patients.** We have a database that shows us how many patients have been readmitted to the hospital off of our care and **I keep track of those percentages.***

When Derrick was leading the roll out of a new social work initiative within his organization, he knew that the initiative had to have a data monitoring component that would keep track of social work interventions:

*One of the first things that we worked on was how do you get metrics around what us social workers do. **We developed a virtual site to capture all the data and the data points of the interventions.** That's why I think [this initiative] is so important because it's giving us hard numbers about the impact we are having on patient quality of life.*

When she decided to split her department in half, Cressy extended her expression of concern for order, quality, and accuracy when she insisted on clarity of roles and functions between social work and case management:

*There is a separate case management department in the hospital and it's, you know, side by side with the department of social work and they, you know, they do traditional case management. But social work does clinical social work. . . . In the terms of nursing home placement or, you know, medical equipment, post-acute care services. . . . No, they don't do any discharge planning. . . . **There's a very clear line that defines them** and the strength is we continue to increase the skill level of the social workers [as] clinicians. So they're working on MI interventions and, you know, CBT. They're the ones who are actually working with homeless patients and substance abusers and drug abusers and they're the ones working with all the kids and domestic violence cases. So we've carved out a clinical role in the hospital. **I was able to draw a very strong line between what a case manager does and what a social worker does.***

Cressy developed a new, multifaceted system to identify homeless patients in her hospital:

*It's very difficult to identify homeless patients. I'm looking at reducing their length of stay and readmission [rates] and ED utilization and sort of getting them back to a higher quality of life when they leave [but] they don't self-identify. . . . We did some systems changes. **We did significant systems changes within the hospital and even in the social services community** so that everybody is more attuned to the health care plight of the homeless in the community and everyone in the hospital is much more attuned to identify the homeless population. We created a number of different entry points of where people can ask certain questions to a patient to determine whether or not they have a safe place to live when they leave the hospital and **we have physicians incorporating certain key questions in their assessment, we have our registration people involved.** You can't ask a person if they are homeless in other words. You can't ask if they live in the shelter. You have to be much more careful about the way you ask people: Do you have a safe place to go once you leave here? [and] tell me and describe the place you're going to go to once you leave here. So, you know, **we redefined and scripted how we approach every patient and the hospital says that we can now identify those patients.** Before this project we identified 350 homeless patients on an annual basis. Now, since this project is in place we identify on an average 800 patients a year who are homeless. So we more than doubled our identification, which means we're in a better place to help those folks.*

Initiative. Often referred to as proactive, the initiative competency is a preference for taking action without being asked or required to do so (Spencer & Spencer, 1993; Zwell, 2000). It is doing more than what is required or expected for the job. Behavioral descriptions for this competency include (a) persisting in the presence of obstacles, (b) acting on opportunities, (c)

performing more than the job requires, and (d) preparing for opportunities or problems in a way that is not obvious to others (Spencer & Spencer, 1993).

When asked what she believed to be some of the critical characteristics necessary to do her job as a healthcare social work administrator, Thalia simply replied “***Persistence to stay the course, despite adversity.***” Exemplary performers proficient in this competency seize opportunities and perform more than the job requires, such as working extra hours, taking on extra tasks, or starting new projects (Spencer & Spencer, 1993). For example, Maxine was one of three key people in her hospital responsible for implementing a customer service training program, mandatory for both new and existing employees. In her BEI, she recalled how this leadership opportunity began with an invitation from her vice president to go to Disney Institute for customer service training.

I think my ability to be at the right place at the right time and raise my hand and say I can do this or I want to do this ended up being really good for my career in the organization. . . . I was willing to put in lots of extra time beyond work hours to make it happen. . . . We were doing lots of training and lots on our own time at night or on weekends.

Individuals with the initiative competency not only put in extra effort and exceed their job description, they also get others involved in their extra efforts on a volunteer basis (Spencer & Spencer, 1993). A pronounced expression of this competency is when Cressy created an off-shift executive role at her hospital:

We are a 24/7 organization but you know, after hours . . . after 5:30, 6:00 [p.m.] and on the weekends most of the administrative staff leave the hospital and who's left running the hospital? . . . The patients are not being neglected, but they don't have the same level

of attention that they do during the day. . . . They did an analysis of patient satisfaction scores, our quiet scores, our cleanliness scores, our communication and . . . the biggest problem was on the off-shift time. That's when the patients said that, you know, things weren't cleaned overnight, that they couldn't get a good night's rest, nobody was available to answer their questions or concerns. [Then there was] the employee engagement survey, where the employees said, you know, there's nobody available to support us or assist us. We feel like we're isolated on the off-shift. . . . So **I created a proposal [for an] off-shift executive and an off-shift nurse leader.** This two-person partnership would actually be available anytime [and] would be onsite now from 7:00 p.m. to 7:00 a.m. every day and then they would be onsite 24 hours starting Friday night through Saturday and Sunday and they would actually . . . do all executive types of problem solving and decision making. . . . [I was given] enough money to hire three off-shift executives and three off-shift nurse leaders . . . but until [I could] hire these people [I was] going to have to figure out who can staff it. . . . So **I actually had to go to all the administrative people in the organization- department heads and nursing directors- and ask them to actually take shifts for six months** until I can actually hire and put staff in place. . . . So **I had people who took, you know, the Monday night shift every week, I have people that took the Tuesday night shift and people took the Saturday day shift.** So I was able to fill out the shifts for six months. . . . Then six months into the program I hired the staff. It has been hugely successful. . . . **I still fill in that shift** because [I feel] very strongly about this program that I actually take a shift once a month.

When the norm is to hope that the problem will resolve itself, exemplary performers with the initiative competency are decisive and seize opportunities that are not obvious to others (Spencer & Spencer, 1993). Abigail presented an example of this competency in her BEI:

*I remember a few years ago it was particularly tough. We had a lower census than usual. . . . It was bad for a few months. So we were having to look at cutting back some of the [social work] staff. . . . So I thought, ok, how can we . . . keep our social workers busy when our census goes down? . . . I remember **I was just like really digging in and thinking outside the box.** . . . A friend of mine worked for [a disease-specific society]. . . . [She] mentioned to me that she was struggling to get [social work] coverage because she was short staffed. . . . I approached her with a plan to contract services [using] our **full-time social workers** to cover the [disease specific] assessments for the patients in her agency. . . . It was a win/win. . . . We would pay our social workers, the [disease-specific society] would pay us, and it would keep [the social workers] busy so we wouldn't lose money on productivity and we avoided cutting staff, which was pretty remarkable.*

Noel recalled when her hospital hired a consultant firm to streamline costs and reduce spending. In her BEI she demonstrated an ability to not only anticipate and prepare for problems, but also take action to avoid future crisis:

*I saw the handwriting on the wall when the consultants came and I heard they were coming. As [my staff] would resign or move to other [departments] . . . **I never asked to fill their positions and that way I kept my staffing low, knowing that more than likely I would get cut because I had already researched this consultant firm and they are known for cutting social work.** So I knew not to fill those positions so I kept my numbers low so*

I never had to lay anybody off. You know, you have to do your homework and figure things out.

Impact and Influence. Impact and influence is also a competency that, according to Zwell (2000), segregates exemplary performers from average performers. The impact and influence competency, also called strategic influence, refers to an individual's effect on others. It is "an intention to persuade, convince, influence, or impress others" in effort to gain their support or adopt a specific course of action (Spencer & Spencer, 1993, p. 44). Those strong in the competency of impact and influence act to persuade others by (a) appealing to reason, (b) using concrete examples and visual aids, (c) adapting presentations to appeal to audience interests, (d) deliberately giving or withholding information, and (e) building behind the scenes support of ideas (Spencer & Spencer, 1993).

Ferris exhibited this competency when he used reasoning and market data to gain support from his CEO to lead a hospital-wide effort to be nationally recognized as a hospital that provides excellent care for the lesbian, gay, bisexual, transgender population.

*[I received] word . . . that the CEO didn't think that this was really a project that deserved any of our focus. . . . So I did something that I had really never done before in seven years of leadership of the departments I oversaw, which is that I went to him directly just one on one and booked, **I booked fifteen minutes of time with him and laid out exactly why I thought this was a good business decision.** I didn't even really talk about why it was good for our patients, or why the community would look favorably on this if we were to get this certification. **I really just focused on market share and he responded very well to that** and was able to see that . . . if we were to get this it would be well worth the investment. . . . You know, you have to know who your audience is right? . .*

. Right, and so when I came to him and . . . **I framed the discussion** around how this could potentially be a market share gain for us and pointed out the fact that, hey [Hospital A] across town does not have this and [Hospital B] does not have this for pediatrics. You know, we would be the only one in the region who did. That sort of put a sparkle in his eye.

Derrick exhibited impact and influence when he explained how he used visual aids and concrete examples to persuade his COO to develop a national social work role:

I took a chance and put together a PowerPoint and presented what I wanted to do. I listed what I could bring to [the organization], how we could standardize our new hire training, how we could develop our team. . . . [In our regularly scheduled meeting] I said, you know, I'd like to talk about [the need for a national position] and his response to me after I did my presentation is, he said Derrick I was prepared to tell you no but because you organized this and you are so passionate about the need for this, we'll give you a chance. I was organized and I was prepared to defend what I really wanted to do.

Moreover, behaviors associated with impact and influence also include adapting a presentation to appeal to the interest and skill level of others (Spencer & Spencer, 1993). In her BEI Cressy argued for this behavior:

[Healthcare social work administrators] have to be able to articulate and communicate very complex strategies and very complex analysis to anyone and everyone. So if [I'm] talking to the financial people of the hospital, I have to be able to articulate the analysis in terms that they understand. If I'm talking to hospital administrators, I have to be able to articulate in words and theories and philosophy that they understand. If I'm articulating the same thing to my staff, I need to be able to communicate it in such

a way that they understand and agree and support whatever it is I want them to do. . . .

You have to be able to speak to the audience in front of you and speak differently depending on who they are.

Abigail's BEI also revealed the impact and influence competency: ***"I know my audience and what language to speak. [I] know what's important to other people. So I know my audiences and I know how to read them. That's a huge thing to being successful."*** Likewise, supporting BEI data yielding to impact and influence was shown by Thalia when she was asked by her hospital's administration to roll out a case management department from scratch. She describes the process as a "learning curve" in which she was required to meet with the vice presidents monthly to articulate her vision, communicate her action plan, and provide progress reports on the roll out. Impact and influence was expressed in her recount of these meetings:

*I had four vice presidents I was reporting to during this period of time. . . . They're all different personalities, it was, it was very good because it made me be prepared and I think a lot of times social workers aren't. They're just doing what feels good and they're not thinking about the business plan [and its] value to administration. **When I looked at all four of the vice presidents, value to them is totally different and each one of them is different and so you have to speak to each one of them. The business side . . . the patient care side with the Vice President of Nursing. . . . The financial side . . . I had to be able to speak to all of it.***

In Noel's BEI she conveyed the impact and influence competency when she deliberately used specific information to persuade others to adopt her agenda:

I was really down staffed. . . . So, as you know within hospitals, patient satisfaction is extremely important and, you know, we are monitored on that. . . . Our patient

satisfaction slipped and it slipped significantly. . . . I met with the head of the department that does all the patient satisfaction [surveys and analysis] for the corporation. We pulled all of the surveys and looked at patient satisfaction scores and then we tracked when I started losing staff. . . . The major [survey] question that we looked at is “Were you provided emotional support?” So we used emotional support to correlate to what my team provides and that score had dipped significantly for the hospital. So we correlated it because I didn’t have the staffing there to provide it. . . . We also . . . looked at how many, you know, child abuse cases, how many suicidal cases, everything has just escalated in this past year. . . . Whether that had any correlation or not we made it look like it did! So we painted that up, you know, put lipstick on a pig. . . . I did a one page . . . proposal asking for six new staff. . . . [I] submitted it to my new boss and her CEO. . . . It went through slam dunk, got my six [additional staff positions]!

Building behind the scenes support is another behavior supporting the impact and influence competency (Spencer & Spencer, 1993). For example, Cressy employed complex influence strategies and political maneuvering when the consulting group hired by her hospital sought to cut social work services:

It was the Vice President of Administration. He was a hard nose administrator . . . but he had a soft heart for social work and so, you know, I really took advantage of the soft part of his personality. [I knew] he was willing to support whatever the consultants decided was the final decision. So once I realized that was going to happen, I knew my work had to be with the consultants. . . . [So] I identified the strongest social workers who wanted to be clinical social workers. I worked with them very closely to help them define their work in clinical terms and then I had them meet individually with the consultants so

*that they could define their work as clinicians and **convince the consultants** that they were not case managers. **This way [the consultants] weren't taking my word for it they were meeting directly with the [social workers].***

When a consultant firm spent a year at her hospital, Noel applied a complex influence strategy when she surreptitiously used a third party to indirectly influence others:

*I was concerned for my staff, I was concerned for me, I was concerned what the outcome was going to be. [The consultants] had what they called "value added groups" and the value added group looked at how we provided our services and how discharge services were provided. I was not asked to be a part of [this group]. And that's part of the frustration. The committee kept saying "Why [isn't Noel] here?" They had no one from my profession represented on that committee. But **I had a mole. That mole then told me what was going on.** We were not allowed to talk but we took the risk of meeting secretly where **I could feed her what needed to be said.***

Directiveness. When exemplars use personal or positional power to appropriately and effectively make others comply with their wishes, they are said to be demonstrating the directiveness competency. Directive behaviors include (a) delegating routine tasks to others to free self for higher priorities, (b) saying "no" to unreasonable requests, and (c) confronting others about performance problems (Spencer & Spencer, 1993).

Ferris disclosed that he was in the process of restructuring the leadership of his social work department so that he is available for extracurricular involvement within his organization:

*So we'll move to a system where we have five team leads who each have a team of people that they oversee. . . . **They will essentially manage the day-to-day staffing needs.** So any sick calls, vacations, and day-to-day stuff they will handle. They will be the first line*

*of response for issues that might be going on [with] the staff members' service in terms of performance. . . . Once we get everything in place, then **I will spend much less of my time on those activities, which I have been doing since I got here.** . . . So I'm trying to move all those activities closer to the service delivery points. . . . **Which means that I end up sitting on a number of committees and task forces, you know, pretty much anything. . . . [To do with] program development and policy development that impacts social work and case management across the organization.** . . . I would be there at the table with those issues.*

Directiveness was inferred when Neena assertively denied the request to approve funds that she did not consent to:

*We have one area of service where we provide resources to patients and families and I assumed that this resource area was totally well run . . . then I started getting bills that I needed to approve. Expenses that I needed to approve that seemed, to me, to be kind of out of line. . . . So then I started digging a bit more with the manager where this resource area reported to in my department and it became apparent that there really wasn't an adequate structure. . . . There really was no accountability for the people in this resource area. They were just doing their own thing and then at the end of the day I was getting bills that I was supposed to approve. . . . **I'm not going to sign off on stuff that I didn't know was being approved and that I wouldn't have approved if I knew about it at the time.***

Directiveness, according to the Competency Dictionary, may be involved in incidents in which the exemplary performer found it necessary to fire or get rid of a poor performer (Spencer & Spencer; 1993). Noel's BEI revealed just that:

*I hired someone too quickly. . . . She was still on orientation and [there was an incident]. . . . It got escalated to me immediately and then I met with her. She didn't understand. She was clueless about why [what she'd done] wasn't the correct thing to do and at that point **I told her that I'm really seriously thinking this might not be the right placement for her. . . . I did not mess around. I really was very direct with her** but it just declined after that. . . . She just kept having instance after instance. . . . We tried to train her and it just didn't [work out]. . . . That's when **I told her that, you know, based on her abilities we were going to have to sever ties. . . . I had to think patients and families come first and she was definitely dangerous to have working with them. I knew I had to be gentle but firm with her when I let her go. . . . I mean, you know, I have no qualms firing somebody or letting someone go. . . . [It's] never easy but when you know you're doing the right thing for the patients and families that takes precedence over everything else.***

Neena also imparted an incident in which she felt compelled to address a performance problem:

*It seemed that this employee had been moved around several times because they did not seem to perform well in a number of the positions we had them in . . . and [I] said, you know, this isn't good enough. You can't keep moving someone around who's underperforming because it does not do our department any good. It's not good for patients and families, and it's not good for the team and it's not good for the employee either. . . . **The conclusion was reached very quickly that this employee, their skills, and abilities were not a good fit with the job we were asking them to do. . . . It was very counter culture, because the culture within the department had been well, you know, some people are good and some aren't and we just hang on to them all and just, you***

know, you just have to kind of work around them and I'm not big on that. . . . I had several conversations with the employee to try to help her see that it wasn't that we didn't like her or that she was a bad person, she simply was not the right person to do the jobs we had in our department.

Teamwork and Cooperation. Spencer and Spencer (1993) describe teamwork and cooperation as a managerial competency in which the superior performer has a genuine desire to work with others as part of a team. When an exemplar with formal authority acts in a participative manner among team members, she or he is baring the teamwork and cooperation competency. Behaviors held by those secure in this competency are (a) keeping people informed and up-to-date, (b) soliciting ideas from others, (c) empowering others, and (d) building teamwork (Spencer & Spencer, 1993).

Cressy keeps her team updated and seeks input from her subordinates:

I get very high employee satisfaction engagement scores in my department. . . . [Because] staff feel that they know what's happening in the hospital. They feel that, you know, I do a really good job of communicating. I have monthly staff meetings. [The staff meetings] are taped, so even if you miss it you can view the tape. . . . So there's a, you know, top down communication, but there's a bottom up feedback. I'm constantly circling the loop as far as what is the staff saying to me. I'm always looking for feedback in various ways.

Recounting the process of overhauling her hospital's on-site daycare, Thalia demonstrated teamwork and cooperation when she solicited input from daycare staff:

*I think people did feel listened to and a part of things because **I truly was interested in their viewpoints and using their viewpoints and their ideas.** I was truly interested in it and curious about it. I mean, I just, **I want to be a part of the team.***

Those conveying this competency are apt to exhibit behaviors that empower others, to wit, make them feel important (Spencer & Spencer, 1993). Derrick's BEI revealed that he empowers his team by publicly crediting them for accomplishments:

*I was really lucky about four years ago at a national meeting I received [an award]. **One of the things that I said in my presentation is that I don't accept this award for myself, I accept it for my team.** I'm the one here presenting and talking but **there's a whole team of folks that have worked to develop content and to thrive social work to the next level within [the organization].** . . . My success is not my success. My success is that I have a really strong team.*

As Derrick spoke of his team building strategies, he revealed an even broader sense of competence in teamwork and cooperation. Superiors who team build "act to promote a friendly climate, good morale, and cooperation" (Spencer & Spencer, 1993, p. 62). When he meets with his 47 divisional leads Derrick promotes team morale:

*Because we are so big and because we cover the US. . . . One of the things that I really try to do is . . . make that connection. **So one of the things we ask [the leads] in our meetings is, you know, "What is your favorite Halloween costume? What are you dressing up for this Halloween?" or "What are your kids or your pets gonna be?"** So it's being able to be very strategic and drive the initiatives within [the organization] but also maintain that element that they are part of something bigger and **they're seen as a person not just a teammate doing a job.***

Team Leadership. Executives and upper-level managers often combine teamwork and cooperation with team leadership. Simply put, team leadership is taking on the role as leader of a team (Spencer & Spencer, 1993). The team leadership competency compels superior performers to create and communicate visions aligned with the organization's mission (Zwell, 2000). Superior performers with the team leadership competency will (a) treat group members fairly, (b) inform the team when affected by a decision, (c) take care of the group's needs, (d) set a good example, and (e) ensure vision buy-in.

Thalia showed that she makes a personal effort to treat all group members fairly:

*[Exemplary healthcare social work administrators should] . . . truly, truly have respect for anyone. Doesn't matter if they are a daycare worker making eight bucks an hour or a clinical nurse making fifty, everybody is important to the whole. . . . **I've never ever felt that a person with a degree is more important than a person taking care of a baby.** I just, I'm sorry. I just don't. We're all part of this big ole fat juicy world and we need everybody.*

When she was told by her CEO that she had to cut the social work staff in her department by a third, Maxine confirmed team leadership by keeping her staff informed:

*I went to the staff and, because **I've always been transparent with staff on things that everybody needed to know, I went to them and said here's the plan.** We have to cut by this much and I don't know exactly how we're going to do it yet. But we'll be working on it.*

Thalia explained how she kept her vice presidents abreast as she developed a new case management program for her organization. "***I had a meeting once a month and I created the***

*vision first, for them. Then **explained how we were breaking it up and how we were rolling it out and why we were doing it that way.***

Strong performers with the team leadership competency “make sure the practical needs of the group are met” (Spencer & Spencer, 1993, p. 65). Thalia obtains needed resources for her group:

*You know it's kind of, it's humbling, I mean, I guess I lead them. . . . I guess it's weird I don't feel like a boss. . . . I was just fortunate to hire some excellent people that became **an excellent team and I kept them going with the resources.** . . . I'm the person that's like, what do you need? What do you need? Let's create a vision and I'll find the resources. **I will talk anybody into giving us the resources we need to develop this and get it done.***

Taking care of the group's needs also includes promoting its reputation within the host organization (Spencer & Spencer, 1993). Underscoring the significance of this competency behavior among healthcare social work administrators, Spitzer et al. (2015) protested “demonstrating and effectively communicating the extent to which our services add value to the organization determines our continued presence within the system. Failing to do this has negative consequences” (p. 198). The BEI data showed that several exemplars demonstrated this behavior.

Cressy, by way of illustration, said:

*They've seen me wear many, many, many, different hats in this organization. . . . Why? Because I see it as an opportunity for visibility for me. So anything that I'm visible on reflects on my department and I, you know, **if I can get an opportunity to reach a new***

level in the organization or reach a new group that needs to understand the value of a social worker, you know, I'll take that on.

Maxine also showed that she is devoted to promoting her team's reputation:

*It's not about me but it's about [the CNO and CEO] having an awareness of what [social workers] can do and what our value is; what we bring to the organization. . . . This year has been about how do I help my senior leaders, my boss, understand the depth of what we do, the value of what we bring. **So my work . . . has been to keep educating and keep making people above me aware of what social work can do and the value that we bring to the organization.***

Abigail related:

*I think historically social workers haven't been that great at coming up with data to prove our value. . . . I'm a firm believer in showing that value. . . . [At] a social work staff meeting. . . . We decided to do a caregiver burnout inventory. . . . So on admission when the patient's family would be admitted to hospice services. . . . We would do a caregiver burnout inventory and then by the time the patient discharged, we would do a follow up and we'd look at the data to see if there was an improvement and how much of an improvement there was. . . . Here's some data that shows what we're doing and it's making a difference for these patients and families. . . . **[I was] able to speak to the president of the company and the vice president and help them understand the value that social work brings to the agency.***

Strong performers with this competency also position themselves as leaders by modeling desired behaviors (Spencer & Spencer, 1993). Neena spoke of leading by example in her BEI:

*[An administrator in my position should have] an ability to walk the walk, to **demonstrate through your behavior the things you expect of your staff** and to be extremely consistent and mindful about that. That what they see you do is what they think is okay and what they see you ignore they think doesn't matter. So you have to **be very consistent and predictable and rigorous about the way you model what it is you want them to see.***

Cressy's BEI bespoke team leadership when she explained why others buy into her vision:

*I'm always thinking one step ahead. Here's where I am today. Where do I need to be tomorrow? And then what's the future for me? . . . That's how I think and **I usually bring a whole group along with me because they trust my judgment and people like to have challenges. . . . Even if they think [I'm] going into a big hole, they will follow me.** I mean, not that I want to take them into that big black hole [but] **they will follow me because they trust my judgment and they know I'm not going to take them into a big black hole.** They know I may be a little risky, but they come along for the ride and they wait it out and see that eventually something good will come of it.*

In his discussion on team leadership, Zwell (2000) is confident that employees "want to be part of something bigger than themselves that provides a sense of meaning and purpose to their work" and those with this competency work toward responding to that need (p. 49). For example, when Thalia first met with the staff workers at the daycare she'd been asked to oversee, she tried to connect to her staff's needs:

*I had to really sit down with all of the naysayers, the staff, and start from scratch again, saying "**We get to create this vision.**" . . . I wanted them to feel that value. . . . Having*

them be a part of something bigger than themselves and being a part of something that they were creating.

Self-Confidence. Self-confidence, or ego strength, is found in most models of exemplary performance because it is demonstrated by behaviors that result in high levels of achievement (Spencer & Spencer, 1993; Zwell, 2000). It is “a person’s belief in his or her own capability to accomplish a task” (Spencer & Spencer, 1993, p. 80). Self-confidence “reflects how we feel about ourselves, how well we accept ourselves, and the degree to which we know we are okay no matter how well we do” (Zwell, 2000, p. 40). Behavioral descriptions of self-confidence include (a) stating confidence in ability, (b) making decisions in spite of skepticism and indifference from others, and (c) admitting mistakes and learning from them (Spencer & Spencer, 1993).

Superior performers adept in this competency are able to present themselves confidently. Maxine believes healthcare social work administrators should be “*Somebody with a balanced ego. Enough ego to raise their hand and say I can do it.*” Those with self-confidence trust in their own ability and see themselves as a catalyst or prime mover (Spencer & Spencer, 1993). For example, Thalia said in her BEI “*I just feel like I’m the little motor. I’m the motor. That’s the best way I can describe it. I’m like the little motor that keeps everybody moving.*”

Superiors proficient in self-confidence also present themselves forcefully by acting on decisions despite disagreement from others (Spencer & Spencer, 1993). In consonance, Abigail said exemplary healthcare social work administrators should be someone with “*A thick skin and a good sense about who they are.*” Case and point, Thalia was asked by her hospital’s administration to oversee a newly acquired on-site daycare for employees. Upon learning that

the daycare was poorly run, she initiated changes in structure, policy, and overall culture. As a result, she was met with much variance:

*Staff weren't trained, there were no policies, there were no infection controls. . . . I mean, no boundaries, no structure, it was a free for all. . . . **They hated the fact that I was putting structure to it and that I was literally enforcing that structure. . . . [But] I felt good about everything I was doing. . . . [And] very confident that I could do it. . . . I felt good about the fact that what I was doing had to happen. . . . I was like, "Stay the course whether they hate you or not."***

Exemplars with the self-confidence competency are able to admit their mistakes and take responsibility for their shortcomings (Spencer & Spencer, 1993).

Ferris recalled:

*About two years ago. . . . I got up in front of my social work department at the time. . . . So I mean, you know, in front of probably upwards of 60 people at a staff meeting and . . . **I was very honest with the group about how I think I could have been better at some things. . . . One area . . . for leadership that I have struggled with over the years has been the art of delegation. . . . So, I take, I take a lot of stuff on sometimes. . . . [There] was a department project we had all been working on . . . but I clearly had taken too much of the responsibility on myself, even to the point where I think it frustrated a couple of my staff who really wanted to do a great job on it and I kept getting in the way. . . . It was a couple of months after the project wrapped and it was done and it was finally successful, but I owned up to it. . . . In front of the staff. . . . I stood up there and said here's where I think I made a mistake. I was so honest with them about it. . . . And I was very clear with them about what I had learned from it.***

Furthermore, star performers with the self-confidence competency are also able to learn from their mistakes by analyzing their own performance to understand failures and improve future performance (Spencer & Spencer, 1993). When asked about the competencies needed to do his job, Derrick replied:

*[Anyone in this position should be] able to cut themselves some slack. What I mean by that is **we're all going to make mistakes**, we're human and, you know, **when you make a mistake how can you learn from it? What will you do differently?***

Individuals with self-confidence are “free to take more risks to try new things . . . because they are always acceptable to themselves” (Zwell, 2000, p. 40). Cressy demonstrated this competency when she explained how she conceptualizes failure in terms of discovery:

***I like to take risks.** So it doesn't matter if I thought . . . this could be a huge failure. . . . It really matters that I tried. . . . **It doesn't matter, you know, if what I did today doesn't work, but it builds, it's a building block to what I might be able to do tomorrow because I learned from it.** That's the kind of leader I am. I take a lot of risks. **Some things work out really, really well and some things just sort of muddle their way through. But I'll take that muddling and I'll build that.** I will learn from everything I do.*

Flexibility. Flexibility, or resilience, is the ability to adapt to changing circumstances by coming up with creative and innovative approaches in response to the needs of the situation (Spencer & Spencer, 1993). Behavioral indicators of flexibility include the ability to (a) see situations objectively, (b) flexibly apply rules or procedures, and (c) adapt behaviors or strategies in response to the needs of a given situation (Spencer & Spencer, 1993).

Maxine expressed flexibility when she showed she was able to understand the validity of opposing perspectives:

*Our CEO decided to use a certain narrow benchmarking program to look at our staffing models and my department was getting cut by a third in social work and a little bit in family services. . . . I had to trim lots of FTEs. . . . **We're a non-revenue generating department which hospitals always look at particularly when there's concern about finances. You know, you get rid of the people who don't bring you money first, but . . . while you can't look at the checkbook and say oh they brought in a million dollars this month, you can look to see [the costly impact] without us. What is the recidivism rate for patients who couldn't afford their medication, or didn't have a refrigerator at home to keep [their medication], or didn't even have a home to go to? So now [they're back in the hospital] again. . . . It's not that I think, I don't think we've been targeted specifically, I think it's just looking at cold hard numbers, which I completely understand.***

Spencer and Spencer (1993) note that these workers “pinch-hit by doing coworkers’ tasks as necessary” (p. 85). Thalia demonstrated her proficiency in this competency when she discussed being able to flexibly apply procedures by adapting her actions to accomplish the organization’s larger objectives:

*When I started our [home-away-from-home facility for families to stay close to their hospitalized loved ones] I changed the bed sheets. **I have no problem doing any job, none. If that's what it takes for us to get the job done** and we don't have a person to do it, I'll change sheets, I'll dust a room, I'll, you know, I don't care. It's somebody's job we just haven't figured out whose job it is yet. But I have no problem getting my hands dirty and I think that there are a lot of supervisors and leaders that say “That's not my*

job.” You know, and it’s like, oh for God’s sake maybe if you tried it out you might find ways to even improve it!

When she was faced with downsizing, to wit, eliminating staff positions, Noel made short-term organizational adaptations when she came up with a creative strategy in response to the situation:

*[Following the consultants’ recommendations] my bosses had wanted me to just fire [the social work supervisors] to just. . . . Let them go, you know. **But that’s when we got smart and I changed their titles** to “care coordination” . . . [which] was a down grade, a demotion for them. [So] I didn’t have [social work] supervisors for two years but they hung in there and I knew I could get them back as supervisors if I just kept chiseling away at it. . . . I kept working at it, working at it, and working at it and I got them re-promoted back to supervisors.*

Research Questions Revisited

The central research question that this study attempted to answer is: *What job competencies do exemplary healthcare social work administrators demonstrate?* The job competencies that exemplary healthcare social work administrators demonstrate are (a) achievement orientation, (b) concern for order, quality, and accuracy, (c) initiative, (d) impact and influence, (e) directiveness, (f) teamwork and cooperation, (g) team leadership, (h) self-confidence, and (i) flexibility. As evident in Spencer and Spencer’s (1993) concept of competence, the demonstration of these competencies leads to specific behaviors. Therefore, it was necessary to pose research sub-question (a): *What behaviors of healthcare social work administrators are related to exemplary performance?* An analysis of the data and a comparison to the Competency Dictionary unearthed the following behaviors:

- In terms of achievement orientation, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) working to meet management or industry standards, (b) setting challenging goals to improve performance, (c) making cost-benefit analyses, and (d) taking entrepreneurial risks.
- In terms of concern for order, quality, and accuracy, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) monitoring data or others' work, (b) clarifying roles, tasks, and functions, and (c) developing new and complex systems to keep track of information.
- In terms of initiative, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) persisting in the presence of obstacles, (b) acting on opportunities, (c) performing more than the job requires, and (d) preparing for opportunities or problems in a way that is not obvious to others.
- In terms of impact and influence, the behaviors of healthcare social work administrators that are related to exemplary performance are acting to persuade others by (a) appealing to reason, (b) using concrete examples and visual aids, (c) adapting presentations to appeal to audience interests, (d) deliberately giving or withholding information, and (e) building behind the scenes support of ideas.
- In terms of directiveness, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) delegating routine tasks to others to free self for higher priorities, (b) saying "no" to unreasonable requests, and (c) confronting others about performance problems.
- In terms of teamwork and cooperation, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) keeping people

informed and up-to-date, (b) soliciting ideas from others, (c) empowering others, and (d) team building.

- In terms of team leadership, the behaviors of healthcare social work administrators that are related to exemplary performance are (a) treating group members fairly, (b) informing the team when affected by a decision, (c) taking care of the group's needs, (d) setting a good example, and (e) ensuring vision buy-in.

As reported by Conca and de Juana-Espinosa (2012), these behaviors are constructs of the personal characteristics that enable an individual to demonstrate competencies. They defend that competencies formed by intrinsic personality characteristics serve to shape other competencies. In parallel, Spencer and Spencer (1993) report that self-concept characteristics cause the behaviors that lead to effective and/or star performance because they support the effectiveness of other competencies. Self-concept characteristics are those competencies associated with the personal effectiveness cluster. The matter of this conceptualization led to research sub-question (b): *What personal characteristics of healthcare social work administrators are related to exemplary performance?*

- In terms of self-confidence, the personal characteristics of healthcare social work administrators that are related to exemplary performance are (a) stating confidence in ability, (b) making decisions in spite of disagreement from others, and (c) admitting mistakes and learning from them.
- In terms of flexibility, the personal characteristics of healthcare social work administrators that are related to exemplary performance are the ability to (a) see situations objectively, (b) flexibly apply rules or procedures, and (c) adapt behaviors or strategies in response to the needs of a given situation.

Chapter Summary

This chapter began with a demographic profile of this study's participants followed by a summary of the job responsibilities and results measures for healthcare social work administrators. Ultimately, competency findings from the interview responses of experts and exemplary performers were presented. The next and final chapter concludes the study with a discussion of the research, implications for practice and social work curriculum, and recommendations highlighting the knowledge gaps that yet remain.

CHAPTER 5:

RESEARCH CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to identify the job competencies that exemplary healthcare social work administrators demonstrate in effort to provide a foundation for a competency model. Competency models are human resource management tools and when implemented astutely, these models offer significant contributions to human resource management systems. Within the context of organizations, HRD (a component of human resource management systems) is a cardinal function of workforce development. Competencies are linked to workforce development systems because through HRD, they hold the capacity to influence an individual's day-to-day workplace performance.

Research Summary

The present study sought to fill a vacuum in the literature as existing bodies of knowledge have failed to present a competency model for 21st century healthcare social work administrators. In a funneled fashion, a comprehensive review of the literature cited felicitous subject matters and revealed that much of the research on healthcare social work administration is focused on the management tasks and activities of the hospital social work director. Therefore, this investigation was the first attempt to explore and define job competencies for the healthcare social work administrator.

The data collection and data analysis methods exercised in this study were guided by a modified version of Spencer and Spencer's (1993) short competency model process, a research method based in the tradition of qualitative methodology. The conceptual framework adducing the causal relationship between competencies and performance was presented in the introduction. Through this reasoning, competencies can be identified by exploring the behaviors and personal

characteristics of healthcare social work administrators who perform at an exemplary level. On that account, I interviewed eight exemplary healthcare social work administrators and six experts with close proximity to the field to identify the competencies that define exemplary performance. A thematic analysis of the data exposed competency themes that corresponded to specific behavioral indicators catalogued in Spencer and Spencer's (1993) Competency Dictionary. These behavioral indicators were then linked to the following nine competencies: (a) achievement orientation, (b) concern for order, quality, and accuracy, (c) initiative, (d) impact and influence, (e) directiveness, (f) teamwork and cooperation, (g) team leadership, (h) self-confidence, and (i) flexibility.

Limitations of the research methods. This study considered the experiences of eight exemplary performers. Time and expense made it impractical to analyze a large number of BEIs in pursuit of greater transferability. Secondly, qualitative inquiry tends to lean towards researcher subjectivity. The American Psychological Association (2010) advises researchers set aside their prejudgments, personal biases, and opinions. In an effort to reduce the potential for bias caused by my professional experiences as a healthcare social worker, multiple verification procedures were applied to this study such as triangulation, debriefing, member checking, and external auditing. The use of self-reporting also limited the research findings because the BEIs relied on the recall of the exemplary performer. Consequently, only information that the exemplar chose to present was represented in the interview (Boyatzis, 1982).

The diversity of the participants, or lack thereof, limited the findings as well. Although the participants' gender, ethnic, and racial make-up were representative of the social work workforce in healthcare (see Whitaker et al., 2006), cultural factors undoubtedly shape an exemplar's worldviews and thus inform their workplace behaviors. A reasonably homogeneous

participant population of white, non-Hispanic, female healthcare social work administrators thus limited these research findings.

Additionally, most jobs require unique characteristics that may not be represented in Spencer and Spencer's (1993) Competency Dictionary because the Competency Dictionary only represents 21 of the most common competencies. Furthermore, the nomination of exemplary participants denotes a subjective judgment of performance rather than actual measures. This sampling strategy threatened the internal validity of this research.

Conclusion

The results of this study suggest that the job competencies of healthcare social work administrators are products of a complex set of behaviors and characteristics demonstrated by exemplars in the field. Given the business acumen required of healthcare administrators, it is paramount that social work administrative practice in healthcare organizations be predicated on job competencies. Such competencies may not be trainable; thus social workers must bring these competencies (at some level of intensity) to the management role. Therefore, instead of matchmaking, hiring managers should implement competency-based selection by assessing for the competencies that most determine exemplary performance. Incidentally, it is critical that healthcare organizations, professional associations, scholars, and researchers alike extend their understanding of job competencies beyond what has been so commonly referred to as *skills*. With an appreciation for this distinction, these research findings can be used as a foundation to build a competency model for healthcare social work administrators.

The results of this study also suggest that the competencies required of healthcare social work administrators are unique to social work. The availability of leadership competency models used throughout the health and non-health sectors is abundant. Although some may

argue that leadership competencies are the same regardless of industry, healthcare presents unique challenges. The life-and-death nature of the work, emotional demands, interminable safety requirements, and financial challenges influenced by shrinking reimbursements and complex social and political forces are very different from those in non-health sectors (Dye & Garman, 2006; Stefl, 2008).

Within the health sector, five competency models of leadership with competency definitions consistent with McClelland (1973), Boyatzis (1982), or Spencer and Spencer (1993) are conspicuously discussed in the literature. With input from an expert panel, Hilberman's (2004) model identified 35 competencies for early careerists in healthcare administration. Organized into seven clusters, Garman, Tyler, and Darnall's (2004) model identified 26 competencies that distinguish star performers from average performers. In 2006, the National Center for Healthcare Leadership (NCHL) developed a health leadership competency model that defined the competencies required for outstanding leadership in healthcare. The NCHL model captures 26 competencies, eight of which are technical (e.g., communication skills, financial skills, project management) (National Center for Healthcare Leadership, 2005-2010). Dye and Garman's (2006) leadership competency model lists 16 competencies that differentiate exemplary senior-level healthcare executives from averages. The Healthcare Leadership Alliance (HLA) developed a competency directory of 300 competency statements common among all practicing healthcare managers (Stefl, 2008).

Though exemplary healthcare social work administrators have a lot in common with and demonstrate behaviors similar to other exemplary administrators in high performing healthcare organizations, they do so in an industry in which they are the only profession that addresses the psychosocial components of health and illness. In fact, in my BEIs with the exemplary

participants, I asked: *Do you think someone without a social work degree could do your job effectively?* The exemplars responded “No.” They agreed that other disciplines lack an understanding of what social workers do and to be an effective healthcare social work administrator, one has to be familiar with social work standards of practice and possess the ability to recognize sound social work practice. Managing a healthcare social work department without a social work background is a disadvantage. With that said, the expression of job competencies for healthcare social work administrators illustrates the distinctiveness of the social work profession.

Discussion

As a social worker of 11 years, this study germinated from a personal place. My own struggle with finding a role within the social work profession that befits my career interests has led me to explore social work outside the margins of traditional practice. Through this exploration, I’ve discovered that social work practitioners across fields of practice are stretching the boundaries of social work. Healthcare social work administrators are no exception. The BEIs afforded me a rare opportunity to learn of the amazingly progressive strides that social work administrators are making in healthcare, especially those undertakings that stretch beyond conventional social work practice. Their work experiences lend to the mantra that social work skills are indeed transferrable and thus exemplary healthcare social work administrators should not find themselves immobilized with the proverbial “glass ceiling” to blame.

This consideration leads to a broader discussion on how social work is presented in the labor market. Social workers, as perceived by many, work as child welfare workers, individual and group counselors, and community organizers. However, it is critical that employers recognize the value of social work skills in corporate and business settings. Forward-thinking

MSW programs are training social workers to lead social responsibility strategies, diversity initiatives, change management efforts, and employee wellness systems. Bridging the gap between employer perception and reality calls for social workers to espouse strategic marketing approaches that emphasize talent, competency, and knowledge base (Spitzer et al., 2015). Through their expressions of the team leadership competency, the exemplary participants in this study felt an obligation to enlighten others of the value of social work and the utility of social work skills beyond the social work department. As it follows, social work skills and talents should be marketed in such a way that expands the definition and scope of social work practice and sustains the profession in a rapidly changing world.

Another acknowledgement worthy of discussion relates to applied intelligence. Systems-perspective and the principles of person-in-environment are well revered in the social work knowledge base. These pillars of practice are characteristic of the information seeking competency because social workers are not trained to accept situations at face value but rather develop their own understanding at a more complex level. From this angle, social workers are educationally prepared to be analytical thinkers, a competency used exclusively to support initiative, impact and influence, and those competencies of the managerial cluster (Spencer & Spencer, 1993).

A final point of discussion, and one that causes great lamentation, is the universal message of job insecurity among social workers in healthcare organizations. Healthcare consultants report that layoffs appeal to hospitals facing budget crisis because they offer quick results. However, layoffs can lead to increased turnover rates, a factor with detrimental consequences in a labor-intensive environment such as the healthcare industry (Evans, 2008).

Research Implications

This competency study holds the potential to guide the future direction of healthcare social work administration; however, there continues to be a gap between the generation of research findings and their implementation in real-world settings. According to Melnyk, Gallagher-Ford, Long, and Fineout-Overholt (2014) this delay can be attributed to a myriad of challenges such as (a) the misperception by practitioners that the implementation of evidence-informed practice is time-consuming, (b) academic programs focusing on rigorous research processes instead of evidence-based approaches, (c) organizational cultures that do not support evidence-informed practice, (d) lack of appropriate resources in the workplace, and (e) resistance from colleagues, subordinates, and/or supervisors. The research implications presented support the practicality of this research. Implications are proposed for healthcare organizations and social work education.

Implications for healthcare organizations. “Competency reports should conclude with recommendations for human resource applications that can add value to the organization” (Spencer & Spencer, 1993, p. 155). Job competencies are the link between individual performance and organizational success. Competencies should be used to help organizations create high performance cultures, select and hire a workforce, develop leaders, and establish a foundation for training strategies (Zwell, 2000). This study makes it possible for organizations to build a competency model with utilization for every HRD process including hiring and selection, training and development, succession planning, and performance evaluation. These competencies should be considered in the job descriptions, selection criteria, appraisal and performance management instruments, and the set of policies related to the professional development of healthcare social work administrators. Furthermore, with the job competencies

of healthcare social work administrators identified, incumbents can direct their focus toward the development of said competencies through the demonstration of specific behaviors that will allow them to pursue outstanding performance and meet the challenges of 21st century healthcare.

Because medical social workers are so often promoted to healthcare social work administrators after proven and effective direct practice in line work, healthcare organizations should use these job competencies to select for these roles rather than assuming effective line work will result in successful managerial work. This study implies that the competencies identified for healthcare social work administrators are not related to direct practice. Micro-level ideologies are inherent of direct practice social work but those principles have far-reaching negative implications in social work management. Healthcare social work administration is not concerned with the nuances of direct practice. It is, however, concerned with planning and coordinating care at the system level within the entire context of service delivery.

Implications for social work education. Workforce development systems emphasize occupational preparation. Because healthcare social work positions require a master's degree in social work and the MSW curriculum prepares graduates for advanced practice through the mastery of specialized knowledge and practice behaviors, these competencies are pivotal to rising healthcare social work administrators. These research findings have implications for the preparation of social workers through education and professional development.

There appears to be a discrepancy concerning the practicability of campus-acquired knowledge in professional social work practice. This chasm is to be filled through social work field education experiences. Field education is a signature pedagogy in social work education, designed to socialize students to the role of practitioner and ensure the integration of theory and

practice. CSWE accredited schools of social work require baccalaureate students to complete a minimum of 400 hours of field education and 900 hours for master's students. The CSWE (2015a) acknowledges that field education faces a variety of challenges, one of which is ensuring social work students develop into competent professionals. The accountability for this educational preparation should be assumed in the classroom as well as the field (Spitzer et al., 2015). This study offers a footing for meeting this challenge because the identification of job competencies and the development of competency models informs professionals in the field (field instructors, in particular) as well as social work instructors. Equipped with these job competencies, field instructors and campus-based instructors can teach social work students the scope and breadth of healthcare social work administration while promoting exemplary performance.

This study also has the potential to inform CSWE's educational policy and accreditation standards (EPAS) for baccalaureate and master's social work programs. Initiated in 2008 and revised in 2015, the Commission on Accreditation (COA) and the Commission on Educational Policy (COEP) developed EPAS and nine social work competencies with curriculum content designed to ensure that social work students are able to integrate and apply the competencies into practice (CSWE, 2015b). However, these competencies describe the knowledge, values, and skills required for social work practice. Although critical to sound social work practice, knowledge, values, and skills have no bearing on performance. With current emphasis on the mastery of competencies related to workplace effectiveness (Stefl, 2008), competencies should be based on evidence-informed practice grounded in scientific inquiry. Similar to an expert panel, CSWE's COA and COEP revised the 2008 EPAS, resulting in three drafts issued for public review. The public review process consisted of soliciting feedback on the drafts from

various constituents such as individuals, organizations, and communities of interest (CSWE, 2015b). The 2015 EPAS makes no mention that the required competencies were identified by soliciting input from exemplary performers of the job in the organization context. In other words, the COA and the COEP did not employ BEI methods when identifying social work competencies. BEI findings repeatedly dispel false hypotheses about the competencies that job experts or others hypothesize are important for the job (Dubois & Rothwell, 2000).

Lastly, these research findings also highlight professional development needs. Continuing education can play a significant role in the development of social workers for healthcare administrative roles. Although the majority of healthcare social work students will enter the field as line workers, many of them will eventually advance to management positions. They should have an opportunity to develop new skills and job competencies through healthcare social work management courses and credentialing. Schools of social work should offer comprehensive healthcare management certificate programs to help seasoned and novice healthcare social work administrators develop the necessary job competencies and skills required for outstanding performance. Moreover, the NASW Specialty Certification Program helps social workers increase their visibility as specialized professionals. Currently, there are two healthcare-related advanced practice specialty credentials for MSWs: (a) certified social worker in healthcare, and (b) advanced certified hospice and palliative care social worker. NASW should develop an advanced practice specialty credential for healthcare social work administrators and employers should seek credentialed healthcare social work administrators to fill leadership positions within their organizations.

Recommendations for Future Research

Concerning future investigations, one critical area capable of yielding valuable data pertains to the demographic makeup of the medical social work workforce. As recorded in Tables 1 and 2, the participants of this study were overwhelmingly White and female. NASW policy statements and the NASW Code of Ethics charges social workers with the ethical responsibility to be culturally competent. As it happens, standard seven of the “Standards and Indicators for Cultural Competence in Social Work Practice” calls for a diverse workforce in which workforce demographics and client populations are aligned (NASW, 2015). According to the NASW Center for Workforce Studies (2011), African Americans, Hispanics, and Native Americans are significantly underrepresented in the health and mental health workforce. In an earlier study, the NASW Center for Workforce Studies (2006) reported that licensed healthcare social workers are less diverse than the clients they serve. Healthcare social workers are more likely to be female than male (89% vs. 11%) yet healthcare social workers are more likely to carry client caseloads that are predominantly male. Medical social workers are also more likely to be non-Hispanic whites (86%) yet the demographics of their disenfranchised client populations include a disproportionate number of people of color.

The discrepancy between the composition of the social work workforce and the demographic profile of many client groups led the federal government to support health and mental health workforce initiatives to increase diversity where it is lacking (NASW Center for Workforce Studies, 2011). For example, the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) is “the primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs” (U.S. Department of Health and Human Services, 2016,

para. 1). One of HRSA's five goals is to strengthen the health workforce by "support[ing] outreach and other activities to increase the recruitment, training, placement, and retention of under-represented groups in the health workforce" and by "support[ing] pre-entry academic advising, mentoring, and enrichment activities for underrepresented groups in order to promote successful health professions training and career development (U.S. Department of Health and Human Services, 2016, "Increase the Diversity and Distribution," para. 2-3). Investigations of these HRSA objectives and similar diversity initiatives and their impact on the healthcare workforce are worthy of scholarly consideration.

Another recommendation for future research pertains to a clear interpretation of the polarity between knowledge and skill competencies and underlying motive and trait competencies. Although social work literature may be rich with competency models, many of these models are based on skill rather than actual job competencies. Currently, there is scant literature on social work managerial job competencies by industry or employment setting. The need to develop a body of knowledge regarding social work management at this level of analysis is critical to both practice and social work education.

To end, this study offers fertile ground for future researchers to further the exploration of competencies for healthcare social work administrators in a number of ways. Scholars can use informants (Barker, Pistrang, & Elliott, 2002) and other 360-degree feedback methods to gather competency data on healthcare social work administrators. Replicating this investigation using a larger number of exemplary performers is another way to further this exploration. Ultimately, researchers can advance the application of Spencer and Spencer's (1993) short competency model process to develop a competency model. Such efforts promise to provide the field with a strong empirically-based model of administrative practice specific to healthcare social work.

Appendix A: Social/Behavioral IRB Exempt Review Letter

UNLV
Social/Behavioral IRB – Exempt Review
Deemed Exempt

DATE: January 28, 2015

TO: Dr. Cecelia Maldonado, Workforce Development and Organizational Leadership

FROM: Office of Research Integrity – Human Subjects

RE: Notification of IRB Action
Protocol Title: A Qualitative Study of Job Competencies for Healthcare Social Work
Administrators: An Application of the Short Competency Model Process Used to
Identify the Behaviors and Personal Characteristics of Exemplary Performers
Protocol # 1501-5049

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:

Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call (702) 895-2794.

Office of Research Integrity – Human Subjects
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047
(702) 895-2794 • FAX: (702) 895-0805 • IRB@unlv.edu

Appendix B: Consent Form- Expert Panel



Department of Workforce Development and Organizational Leadership

TITLE OF STUDY: A qualitative study of job competencies for healthcare social work administrators: An application of the Short Competency Model Process used to identify the behaviors and personal characteristics of exemplary performers.

INVESTIGATOR(S): Cecilia Maldonado, Ph.D. and LaShonda Moore, MSW, LSW

For questions or concerns about the study, you may contact Dr. Cecilia Maldonado at 702-895-3410.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to provide a foundation for a competency model for healthcare social work administrators. We will satisfy this purpose by identifying the job competencies that exemplary healthcare social work administrators demonstrate.

Participants

You are being asked to participate in this study because you are a past recipient of the Society for Social Work Leadership in Health Care's Health Care Social Work Leader of the Year Award, a faculty member of the Society for Social Work Leadership in Health Care, or a board member of the Society for Social Work Leadership in Health Care.

Procedures

If you volunteer to participate in this study, you will be asked to do the following:

1. Participate in an online 1 ½ to 2 ½ hour group interview.
2. Sign this consent form prior to your interview.
3. Complete a demographic form.
4. Nominate exemplary healthcare social work administrator.
5. Review a copy of the transcribed group interview to check for accuracy and provide changes, if necessary.

Benefits of Participation

There may be no direct benefits to you as a participant in this study. However, we hope to learn about the job competencies for healthcare social work administrators in a way that informs social work education programs and advances individual worker performance.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks such as uncertainty or becoming uncomfortable when answering questions. It is unlikely that you will experience physical, psychological, or social harm caused by this study.

Cost /Compensation

There will be no financial cost for you to participate in this study. The study will take up to 3 ½ hours of your time for which you will not be compensated. However, should you choose to receive a final copy of this research, one will be provided for you.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least five years after completion of this study. After the five-year storage period, paper documents will be shredded using university approved shredding services. Digital data, including any documents resulting from the transcription, will be saved on a flash drive and destroyed at the conclusion of the five-year period. All emails will be deleted and all data will be de-identified and no names will be identified on the recordings.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Appendix C: Consent Form- Exemplary Performer



INFORMED CONSENT

Department of Workforce Development and Organizational Leadership

TITLE OF STUDY: A qualitative study of job competencies for healthcare social work administrators: An application of the Short Competency Model Process used to identify the behaviors and personal characteristics of exemplary performers.

INVESTIGATOR(S): Cecilia Maldonado, Ph.D. and LaShonda Moore, MSW, LSW

For questions or concerns about the study, you may contact Dr. Cecilia Maldonado at 702-895-3410.

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to provide a foundation for a competency model for healthcare social work administrators. We will satisfy this purpose by identifying the job competencies that exemplary healthcare social work administrators demonstrate.

Participants

You are being asked to participate in this study because you have been nominated by your peers as an exemplary performer in the field of healthcare social work administration.

Procedures

If you volunteer to participate in this study, you will be asked to do the following:

1. Participate in an online 1 ½ to 2 ½ hours, one-on-one interview at a date and time of your convenience.
2. Sign this consent form prior to your interview.
3. Complete a demographic form.
4. Review a copy of your transcribed interview to check for accuracy and provide changes, if necessary.

Benefits of Participation

There may be no direct benefits to you as a participant in this study. However, we hope to learn about the job competencies for healthcare social work administrators in a way that informs social work education programs and advances individual worker performance.

TITLE OF STUDY: A qualitative study of job competencies for healthcare social work administrators: An application of the Short Competency Model Process used to identify the behaviors and personal characteristics of exemplary performers.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks such as uncertainty or becoming uncomfortable when answering questions. It is unlikely that you will experience physical, psychological, or social harm caused by this study.

Cost /Compensation

There will be no financial cost for you to participate in this study. The study will take up to 3 ½ hours of your time for which you will not be compensated. However, should you choose to receive a final copy of this research, one will be provided for you.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for at least five years after completion of this study. After the five-year storage period, paper documents will be shredded using university approved shredding services. Digital data, including any documents resulting from the transcription, will be saved on a flash drive and destroyed at the conclusion of the five-year period. All emails will be deleted and all data will be de-identified and no names will be identified on the recordings.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Appendix D: Expert Panel Interview Protocol for Experts

Introduction & Explanation

Facilitate introductions. Explain the purpose and format of the interview. Confirm demographic information on each expert.

Job Responsibilities

Question 1: What are the most important duties, responsibilities, and service outcomes of a healthcare social work administrator?

Results Measures

Question 2: What are the performance indicators for these duties and responsibilities that can be used to identify exemplary performers in healthcare social work administration?

Competencies

Question 3: What competencies do healthcare social work administrators need to perform their job at an exemplary level?

Summary & Conclusion

Summarize the key findings discussed and conclude the interview.

Spencer, L. M., & Spencer, S. M. (1993). *Competence at work: Models for superior performance*. New York, NY: John Wiley & Sons, Inc.

Appendix E: Behavioral Event Interview Protocol for Exemplary Performers

Introduction & Explanation

Facilitate introductions. Explain the purpose and format of the interview. Confirm the exemplar's demographic information.

Job Responsibilities

Probing question a: What is the title of your present job?

Probing question b: Whom do you report to?

Probing question c: Who reports to you?

Probing question d: What are your major tasks or responsibilities?

Behavioral Events

Question 1: Can you think of a specific time or situation which went particularly well for you, or you felt particularly effective...a high point?

Probing question a: What was the situation? What events led up to it?

Probing question b: Who was involved?

Probing question c: What did you think, feel, or want to do in the situation?

Probing question d: What did you actually do or say?

Probing question e: What was the outcome? What happened?

Question 2: Can you think of another time or situation on the job when things went particularly well?

Probing question a: What was the situation? What events led up to it?

Probing question b: Who was involved?

Probing question c: What did you think, feel, or want to do in the situation?

Probing question d: What did you actually do or say?

Probing question e: What was the outcome? What happened?

Question 3: Now, can you think of an instance in which you feel you weren't as effective as you could be, when things didn't go well, when you were particularly frustrated...a real low point?

Probing question a: What was the situation? What events led up to it?

Probing question b: Who was involved?

Probing question c: What did you think, feel, or want to do in the situation?

Probing question d: What did you actually do or say?

Probing question e: What was the outcome? What happened?

Characteristics Needed to Do the Job

Question 4: What characteristics, knowledge, skills, or abilities do you think are needed to do your job?

Conclusion & Summary

Summarize the key findings discussed and conclude the interview.

Spencer, L. M., & Spencer, S. M. (1993). *Competence at work: Models for superior performance*. New York, NY: John Wiley & Sons, Inc.

Appendix F: Demographic Form

Name: _____

Phone: (_____) _____ - _____

Email: _____

Note: This information will be kept confidential.

1. What is your affiliation with the Society for Social Work Leadership in Health Care?
 - ☐ A past recipient of the Health Care Social Work Leader of the Year Award
 - ☐ A member with membership in the faculty category
 - ☐ A member with membership in the management category
 - ☐ A member of the board of directors
2. What sex category best describes you?
 - ☐ Female
 - ☐ Male
 - ☐ I do not wish to respond
3. What ethnic category do you most identify with?
 - ☐ Hispanic or Latino - Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin
 - ☐ Not Hispanic or Latino
 - ☐ I do not wish to respond
4. What racial category do you most identify with?
 - ☐ American Indian or Alaska Native - origins in North and South America (including Central America) and tribal affiliation or community attachment
 - ☐ Asian - origins in the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
 - ☐ Black or African American - origins in any of the Black racial groups of Africa
 - ☐ Native Hawaiian or Other Pacific Islander - origins in Hawaii, Guam, Samoa, or other Pacific Islands
 - ☐ White - origins in Europe, the Middle East, or North Africa
 - ☐ I do not wish to respond
5. Which range captures your current age?
 - ☐ 18-29
 - ☐ 30-39
 - ☐ 40-49
 - ☐ 50-59

- ☐ 60-69
- ☐ 70-79
- ☐ 80+
- ☐ I do not wish to respond

6. What relevant professional experiences have you had, research studies have you led, and/or positions have you held that have contributed to your knowledge on exemplary performance in healthcare social work administration?

7. What is your educational background (degrees, certificates, certifications held)?

Appendix G: Competency Data Integration Matrix

Competency	BEI Data Weight	Panel Data Weight	Overall Weighted Score
Self-Confidence	7(2) = 14	2(1.5) = 3	17
Teamwork & Cooperation	7(2) = 14	2(1.5) = 3	17
Impact & Influence	7(2) = 14	1(1.5) = 1.5	15.5
Team Leadership	6(2) = 12	2(1.5) = 3	15
Achievement Orientation	4(2) = 8	4(1.5) = 6	14
Flexibility	6(2) = 12	1(1.5) = 1.5	13.5
Initiative	6(2) = 12	1(1.5) = 1.5	13.5
Directiveness	5(2) = 10	1(1.5) = 1.5	11.5
Concern for Order	4(2) = 8	0(1.5) = 0	8
Analytical Thinking	3(2) = 6	1(1.5) = 1.5	7.5
Developing Others	3(2) = 6	1(1.5) = 1.5	7.5
Interpersonal Understanding	3(2) = 6	1(1.5) = 1.5	7.5
Organizational Awareness	3(2) = 6	1(1.5) = 1.5	7.5
Unique: Sense of Humor	3(2) = 6	1(1.5) = 1.5	7.5
Information Seeking	3(2) = 6	0(1.5) = 0	6
Self-Control	3(2) = 6	0(1.5) = 0	6
Unique: Occupational Preference	3(2) = 6	0(1.5) = 0	6
Relationship Building	2(2) = 4	1(1.5) = 1.5	5.5
Unique: Accurate Self-Assessment	2(2) = 4	0(1.5) = 0	4
Unique: Visioning	2(2) = 4	0(1.5) = 0	4
Organizational Commitment	1(2) = 2	1(1.5) = 1.5	3.5

BEI Data Weight - the number of exemplary performers inferring the competency multiplied by 2 (the BEI weight assigned to each instance)

Panel Data Weight - the number of experts mentioning the competency multiplied by 1.5 (the panel weight assigned to each instance)

Appendix H: Individual Profile of Exemplary Performers

Participant Name	Years of Experience as a Healthcare Social Work Administrator	Employment Setting	Department Composition
Abigail	13	Hospice	MSW Staff: 26
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 0
			Other Staff: 0
Cressy	26	Hospital	MSW Staff: 150
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 3
			Other Staff: 8
Derrick	10	Outpatient	MSW Staff: 1800
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 1
			Other Staff: 0
Ferris	8	Hospital	MSW Staff: 50
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 0
			Other Staff: 15
Maxine	17	Hospital	MSW Staff: 34
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 2
			Other Staff: 40
Neena	19	Hospital	MSW Staff: 74
			Nurse-Trained Staff: 63
			Admin/Clerical Staff: 0
			Other Staff: 19
Noel	30	Hospital	MSW Staff: 32
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 1
			Other Staff: 1
Thalia	36	Outpatient/Hospital	MSW Staff: 12
			Nurse-Trained Staff: 0
			Admin/Clerical Staff: 2
			Other Staff: 36

Appendix I: Competencies for Healthcare Social Work Administrators

Competency Cluster	Competency	Definition of the Competency, as Described by Spencer and Spencer (1993)	Common Behavioral Expressions of the Competency, as Described by Spencer and Spencer (1993)
Achievement and Action	Achievement Orientation	A concern for working well or competing against a standard of excellence. The standard may be the individual's own performance (striving for improvement); an objective measure (results orientation); the performance of others (competitiveness); or what anyone has ever done (innovation). (p. 25)	<ul style="list-style-type: none"> ▪ Working to meet a standard set by management ▪ Setting and acting to reach challenging goals for self or others to improve performance (e.g., doing something better, more efficiently; improves quality) ▪ Making cost-benefit analyses ▪ Taking calculated entrepreneurial risks (p. 28)
	Concern for Order, Quality, and Accuracy	A bias toward action to reduce uncertainty in the surrounding environment. (p. 29)	<ul style="list-style-type: none"> ▪ Monitoring and checking work or information ▪ Insisting on clarity of roles and functions ▪ Setting up and maintaining systems of information (p. 30)
	Initiative	An underlying drive to take action. It is doing more than what is required or expected in the job and/or doing things that no one has requested in effort to improve job results, avoid problems, or create new opportunities. (p. 31)	<ul style="list-style-type: none"> ▪ Persistence, refusal to give up when faced with obstacles or rejection ▪ Recognition and seizing of opportunities ▪ Performance of far more than the job requires ▪ Anticipation and preparation for a specific opportunity or problem that is not obvious to others (p. 33)
Impact and Influence	Impact and Influence	A desire to persuade, convince, or influence with the intention of gaining support. It is concerned with having a specific effect on others. In Impact and Influence, the individual has an agenda, a specific type of impression to make, or a course of action that she or he wishes others to adopt. (p. 44)	<ul style="list-style-type: none"> ▪ Anticipates the effect of an action or detail on others ▪ Appeals to reason, data, facts, and figures ▪ Uses concrete examples, visual aids, demonstrations, etc. ▪ Assembles political coalitions, builds "behind-the-scenes support for ideas ▪ Deliberately gives or withholds information to gain specific effects (p. 45)
Managerial	Directiveness	An intent to make others comply. Directive behavior is themed with "telling people what to do." Directiveness	<ul style="list-style-type: none"> ▪ Confronts others openly and directly about performance problems

		can range from firm to demanding or even threatening. The individual uses personal or positional power appropriately and effectively, for the long-term good of the organization. (pp. 57-58)	<ul style="list-style-type: none"> ▪ Firmly says “No” to unreasonable requests, or sets limits for others’ behavior ▪ Assigns tasks to get the job done or to free self for higher priorities (pp. 58-60)
	Teamwork and Cooperation	A genuine desire to work cooperatively with others, be a part of a team, and work together. The expression of this competency requires the individual be a member of a group functioning as a team. Although the individual does not need to be in a position of leadership, someone who does have formal authority yet acts in a participative manner is using Teamwork and Cooperation. (p. 61)	<ul style="list-style-type: none"> ▪ Solicits ideas and opinions to help form specific decisions or plans ▪ Keeps people informed and up-to-date about the group process, shares all relevant or useful information ▪ Encourages and empowers others; credits others publicly for accomplishments ▪ Team builds (p. 63)
	Team Leadership	A desire to lead others or take a role as leader of a team or group. Team leadership is generally shown from a position of formal authority. (p. 64)	<ul style="list-style-type: none"> ▪ Let’s people affected by a decision know what is happening ▪ Makes a personal effort to treat all group members fairly ▪ Makes sure the practical needs of the group are met, to include both tangible and less tangible resources for subordinates ▪ Positions self as the leader by setting a good example ▪ Ensures that others buy into leader’s mission, goals, agenda (pp. 64-65)
Personal Effectiveness	Self-Confidence	A belief in one’s own capability to accomplish a task. (p. 80)	<ul style="list-style-type: none"> ▪ Makes or acts on decisions in spite of disagreement from others ▪ States confidence in own judgement or ability ▪ Takes personal responsibility for mistakes and shortcomings ▪ Learns from mistakes, analyzes own performance to understand failures (pp. 81-83)
	Flexibility	An ability to objectively perceive a situation, allowing the individual to adapt to and work effectively with a variety of situations, individuals, or groups. (p. 83)	<ul style="list-style-type: none"> ▪ Recognizes the validity of opposing viewpoints ▪ Flexibly applies rules or procedures, depending on the individual situation, to accomplish organization’s larger objectives ▪ Changes own behavior or approach to suit the situation (p. 84)

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