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Enhancing Clinical Manager Self-Efficacy through a Change Management Academy

Chet Hurley Doering III
University of New Mexico, cdoering@unm.edu

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Enhancing Clinical Manager Self-Efficacy through a Change Management

Academy

BY

Chet Hurley Doering III

A Scholarly Project submitted to the College of Nursing
in partial fulfillment of the requirements
for the degree

Doctor of Nursing Practice

University of New Mexico
College of Nursing
Albuquerque, New Mexico

Scholarly Project Chair: Dr. Angeline Christine Delucas

Scholarly Project Member   Dr. Kim McKinley

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"Enhancing Clinical Manager Self-Efficacy through a Change Management Academy"

Chet Hurley Doering, MSN

Christine Delucas, DNP, MPH, RN, NEA-BC (Chair)

Kim McKinley, DNP, ACNP, INS-BC (Member)

ABSTRACT

Enhancing Clinical Manager Self-Efficacy Through A Change Management Academy

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Healthcare systems are facing increased pressure to develop their clinical managers' abilities and competencies leading change. Clinical managers that are equipped with these capabilities can influence greater quality and safety outcomes for patients. Literature and industry findings both strongly suggest that leaders who possess increased self-efficacy are more effective leading change. This is demonstrated at the unit and system level through improved project management, successfully executing strategic initiatives, retaining staff, and being more fiscally responsible. There are significant clinical and business advantages for healthcare systems that foster change management skills for their clinical managers.

When organizations do not provide support, guidance, and systematic leadership development processes, they are more apt to fail when leading change. This scholarly

project focused on designing and implementing an applicable leadership academy, particularly focused on developing change management competencies for clinical managers. This project utilized the Change Acceleration Process as the core framework for content delivery, instructed techniques, and methodology for successfully leading change. During the 8 week academy, participants were surveyed via the General Self-Efficacy Scale (GSE) instrument, a 10 item Likert scale questionnaire which evaluated participants' self-efficacy. A quantitative, descriptive statistical analysis was conducted that analyzed the GSE results both prior to the participation in the academy, as well as post-participation. Additionally, collected descriptive information contributed demographical information regarding participants.

Results of the study demonstrated statistical improvements following participation in the academy. Additionally, this study suggested that clinical managers who participate in learning based academies have a greater chance of increasing their self-efficacy. In turn, this can improve the healthcare organization's care delivery goals, as well their overall business performance.

DEDICATION

My scholarly project work is dedicated to my family, and the faith that creates and forms all great things. My family's encouragement and continual support pushed me to start this program, as well as find courage to surmount obstacles along the way.

My wife, Alison, offered me immense love, faith, and understanding the past two years. She encouraged me to chase this dream, and kept me energized during moments when I questioned my talents and overall abilities. Additionally, during earlier moments of the DNP program we were blessed with the love of our life, our baby daughter, Evelyn. While I've tried to successfully juggle professional responsibilities, DNP student, and new fatherhood, she was the one who ensured our home and family stayed intact. I will always be indebted to her for these sacrifices.

Additionally, my mother, father, sister, and brother in-law also kept me excited and committed to this goal through their words and time. Each of their roles were very different, yet instilled me a sense of great pride, grit, and determination to complete this terminal degree. A special acknowledgement to my sister, Megan, who has been a trusted mentor, confidante, and someone that embodies purpose and excellence in everything she does. This accomplishment would not have been possible without her unending love and support. For anyone who has a dream, yet has not found the confidence to pursue this vision, I end with this quote.

"Go confidently in the direction of your dream. Live the life you have always imagined."

-Henry David Thoreau

ACKNOWLEDGEMENTS

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LIST OF ACRONYMS

CAP   Change Acceleration Process

IRB   Institutional Review Board

REDCap   Research Electronic Data Capture

SCT   Social Cognitive Theory

UNM   University of New Mexico

CHAPTER 1

INTRODUCTION AND BACKGROUND

Evolutionary changes in the healthcare industry have challenged traditional leadership development processes for healthcare organizations (American Organization of Nurse Executives, AONE, 2010). Nurse leaders should be adept with such industry changes and feel competent when managing diversified projects and initiatives. Providing a systematic process where clinical managers obtain the technical and theoretical knowledge of change management is vital (Hess, 2013). For numerous reasons, a leadership academy that focuses on specialized skills, such as change management, is critical for clinical managers. The role of the clinical manager across healthcare organizations is expanding, with these leaders overseeing specialized services throughout their operational teams, achieving department and strategic goals, and persevering through continual change.

From the outset the development of leaders in healthcare traditionally has been initiated through organic, undefined processes (Sanford, 2011). Hence, frontline nurses who are clinically strong and exhibit good leadership skills have higher probabilities of being tapped for formal leadership roles, without formal processes to develop their leadership skills (Sanford, 2011). This has the potential to create knowledge gaps for new clinical managers who are responsible for managing diverse groups and consistently surfacing problems. Without grooming or adequate preparation for leading change healthcare organizations are perpetuating poor outcomes for nurse leaders (Hess, 2013).

One valuable skill possessed by effective clinical managers is their ability to retain staff, with frontline nurses attributing the quality of leadership they receive as a

key determinant for the satisfaction in their role (Sanford, 2011). Furthermore, inept clinical managers can erode healthcare organizations' overall operations, illustrated by staff disengagement, obsolete processes that lack innovation, unsafe and high-risk care, and overall financial losses (Hess, 2013). When clinical managers do not receive tailored, prescriptive pathways for new skill sets, such as learning fundamental business skills, they are susceptible to failure. Organizations should provide clinical managers with opportunities to leverage their fundamental clinical expertise into other business sectors via their organization, such as managing budgets, establishing fiscal metrics and targets, identifying cost variances, and supply chain analysis (Woods, 2007). If these opportunities are not available, the clinical managers' skill set can be underdeveloped, and financial risk can ensue.

The financial losses can represent staggering and crippling consequences to healthcare organizations, especially as organizations rely on nursing managers to possess sound fiduciary competencies (Buzachero, Phillips, Phillips, & Phillips, 2013). Contrarily, an effective, modern-day leadership academy can empower nursing managers with tools, techniques and business savvy, in turn creating opportunities for cost savings, identifying new revenue sources and helping the organizations' financial goals (Buzachero et al., 2013). It is incumbent on healthcare organizations to design leadership opportunities where clinical managers can augment their business, financial assessment and project management skills.

One ideal platform for fostering these competencies has been the establishment of leadership academies. Over the years leadership academies have morphed from simply informal, unorganized gatherings to more structured, strategic learning environments

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(Hess, 2013). Companies such as General Electric, Nokia, and Proctor & Gamble have contributed valued resources and energy toward the creation of leadership academies (Burke, Hajim, Elliott, Merot, & Tkacyzk, 2007). Although identified as a method to accelerate competency acquisition, many factors impact the development of an effective leadership academy (Stevenson, 2014).

Avoiding classic pitfalls is tremendously important when constructing such academies. Deterrents include not measuring outcomes, failing to focus on competitive-edge competencies, and not treating competency development as a process (Stevenson, 2014). Additionally, focusing on granular competencies is another key strategy when instituting such academies. By magnifying competencies, such as change-management skills, healthcare systems can provide context to the training model (Hart & Donde, 2014). This equates in practical gains when leaders critically identify opportunities, connect logic with application, and begin examining their own behavioral approaches to skill development (Hart & Donde, 2014). Curriculum and learning milieu must complement the aim of the academy, by emphasizing engaging speakers, applicable projects, and grounded theory (Hess, 2013).

Problem Statement

Both healthcare and non-healthcare organizations are facing intensified pressure to meet increased operational demands, particularly with changing reimbursement structures, new complexities with regulatory demands, increased competitive globalization, and greater stringent quality assurance expectations. To successfully meet these new challenges organizations have looked to augment their leaders' skills and expertise through nontraditional educational pathways,

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particularly with integrating leadership academies into their learning milieu. Successfully designing and executing such leadership academies can render incredible value for organizations, and can simultaneously create a highly rewarding experience for clinical managers.

Study Purpose

The primary purpose of this study is to determine the feasibility of a change management leadership academy for clinical managers. The skills clinical managers need are to assess self-efficacy for leading organizational change among participating managers, and to evaluate participants' overall satisfaction with the content and quality of this educational activity. Participants had an opportunity to attend a highly informative and customized educational academy geared toward enhancing their change management skills. The research project was conducted at an upper Midwest healthcare system, which recognizes the skill disparities within their clinical managers. To address this, an academy was constructed to improve the managers' ability to direct change and improve their self-efficacy. The aim of this project is to analyze academy effectiveness by measuring the participants' self-efficacy before and after academy participation. Scope of this project focused on clinical managers at a level II healthcare system in the upper Midwest who have operational responsibilities in both the outpatient and inpatient settings. All participants were employees of this healthcare organization.

Objectives and Goals

Objectives and goals of this study were to determine the feasibility of a change management leadership academy for clinical managers, assess self-efficacy for leading organizational change among participating managers, and

evaluate participants' overall satisfaction with the content and quality of this educational activity. This academy was approved by the organization and would have been conducted if the student was not conducting research to evaluate its overall feasibility.

Scope and assumption of study

Participants were designated as an inpatient unit or outpatient unit clinical manager at GHS when the study commenced. Participants included inpatient and outpatient clinical managers at a large healthcare system in the Midwest. The population for this study was eligible to all participants who met these study requirements. Providing a systematic, organized change-management leadership academy tailored to clinical managers will increase the individual's self-efficacy when leading change management activity, projects or initiatives. The study's Population, Intervention, Comparison, Outcome and Time (PICOT) included: Do clinical managers who participate in a change-management leadership academy have greater self-confidence (self-efficacy) when leading teams through change compared to clinical managers who do not participate in this program over a six month period?

Significance of Study

This research evaluated the effect a change management leadership academy has on the self-efficacy of clinical managers participating in the academy. An exhaustive review of the literature has been conducted, with a noted dearth of substantive evidence surrounding leadership academies, particularly with developing change-management skills for clinical managers in the healthcare setting. When clinical managers are not given opportunities to foster change-management skills, negative ramifications can occur.

Illustrated by skill deficits, leaders who lack both the soft and hard skills essential to modern day healthcare management, and ineffective project management abilities. Furthermore, these findings can erode healthcare organizations' overall operations, illustrated by poor staff retention, obsolete processes that lack innovation, unsafe and high-risk care and overall financial losses. Data gathered helped contribute to a gap in the literature related to the effectiveness of leadership academies, focusing on change management competencies for clinical managers. Additionally, this study addressed the essential resources that constitute a change-management academy, such as quality assurance, effectiveness of speakers, overall feasibility, and satisfaction from participants.

Chapter 2

REVIEW OF THE LITERATURE

A systematic review of the literature was conducted utilizing many academic databases, including CINAHL, Academic Search Complete, and Business Source Complete. Certain key search words included the following: nurse empowerment, leading change, leadership development, organizational change, transformative change, leadership academy, and manager self-confidence, change management skills. A strategic review of the literature was conducted using a robust, and in-depth syntheses pertaining to the scholarly focus. This included looking at traditional academic healthcare information sources, as well as non-healthcare leaders operating in the business, corporate, and non-healthcare sectors. This review included 14 articles that were most relevant to healthcare system leadership academies, and will be discussed with this submission. Primary topics included leadership development frameworks in the

healthcare setting, universal change-management competencies across industries, self-efficacy's influence on leadership effectiveness, leadership development and fostering a culture of continual improvement.

Leadership development frameworks in healthcare and non-healthcare settings

The Cleveland Clinic is a top-tier, upper echelon healthcare institution, particularly due to its innovative reputation, renowned research practices as well as excellent clinical outcomes (Hess, 2013). The clinic espouses distinguishing characteristics and reputability in the development of its leaders, focusing on challenging the status quo, on long term success, and on the application of pragmatic skills (Cleveland Clinic, 2016). A catalyst that has helped promote these noteworthy accolades has been the Cleveland Clinic Academy (CCA) (Hess, 2013). The CCA originated in 2006 and has been responsible for more than 285 leadership academies in national and international organizational programs (Hess, Barss, & Stoller, 2014). Due to this geographical dispersion the CCA curriculum has influenced approximately 43,000 employees, with distributed learning being integrated, accessible, and complementary to its employees (Hess, 2013).

The Cleveland Clinic leadership development philosophy is grounded in immersion, acquiring real life strategies and techniques, a first-hand look at clinical and operational innovations, face time with organizational leaders, and consistent networking opportunities (Cleveland Clinic Education Institute, 2017). Although participants can enroll in two different tracks through either a leadership or management focus, the CCA maps out diverse competencies that will complement participants' development goals (Hess, 2013). Additionally, the CCA is geared toward multiple organizational roles,

including nurses, physicians, administrators, and other senior executives, in turn supporting the organizations' multidisciplinary vision (Hess et al., 2014).

This passion for continual enrichment was evidenced through a six-year quantitative descriptive design study spanning 2006-2012, which evaluated participants' overall satisfaction with the CCA (Hess, 2013). It also identifiable transferrable competencies (Hess, 2013). Participants were also surveyed on improvements or enhancements with their own emotional intelligence after attending CCA through a 5-point Likert scale, with attendees rating their level of course satisfaction a 4.8 on the 5-point scale (Hess, 2013). Between 2006 and 2012, course satisfaction and overall attendance steadily increased each year, with this experience representing the largest attended leadership development program in a healthcare institution (Hess et al., 2014). Furthermore, course participants have also produced applicable and viable business plans, with 61% of the business plans providing a positive organizational impact (Hess et al., 2014). However, this study did lack a control group, and the findings were based on experience in a single institution, which would require replication in other settings to ensure generalizability (Hess, 2013).

Comparably, the Cleveland Clinic also designed a similar leadership academy named Leading in Health Care (LHC) in 2006, which is tailored to nominated physicians and research scientists who demonstrated excellent potential. The objective of the LHC program is to provide these individuals with distinct skills for optimum business plan development, healthcare finance, and understanding the regulatory environment of medicine (Stoller, Berkowitz, Bailin, 2007). The LHC participants were compared against other historical leadership development models offered via the Cleveland Clinic

through a quantitative pre-test and post-test survey design, with their different features being reviewed for effectiveness and applicability. LHC performed better in every category, which included physician throughput, customized curriculum, cost to institution, administrator interaction, interval of time, and networking possibilities (Stoller et al., 2007).

The LHC program has provided the Cleveland Clinic an outcome orientated, skill development leadership program that continues to produce diverse and valuable business plans. Examples of business proposals generated through LHC include the following: proposal of new service or program (24%, n = 12), proposal of a multi-disciplinary clinic or service (10%, n = 5), proposal of a new facility (8%, n = 4), service line expansion (24%, n =12), marketing programs (14%, n = 7), and process enhancement (18%, n = 9) (Stoller et al., 2007). The Cleveland Clinic's ability to capitalize on human capital assets allowed for greater economies of scale, illustrated through the mentioned business plans, the innovative ideas that have caused market disruption, all while reinforcing new leadership behaviors (Harvard Business Review, 2010).

Other healthcare systems are designing leadership academy models that emphasize experiential learning, versus the more common, traditional competency-based development framework. Kolb posits "that learning is the process whereby knowledge is created through the transformation of experience" (Kling, 2010, p. 7). This 2010 study at Brigham and Women's Hospital in Boston sought a deeper understanding of experiential learning and the acquisition of knowledge for the nursing manager. This qualitative, phenomenological study investigated the lived experiences of new managers (Cathcart, Greenspan, & Quin, 2010). The structure of this academy centered around the essential

nature of phenomenology, also reflected through intuition or grasping descriptions through one's own consciousness (Powers, 2015). This study provided a framework for nurse managers to articulate their experientially acquired knowledge via narration (Cathcart, et al., 2010). The nurse manager practice can be challenging and requires resilience and persistence with skill acquisition; however narration provides new nurse managers with a vehicle to synthesize and collect their thoughts (Cathcart et al., 2010). Nurse managers used Benner's methodology of practice articulation, in turn allowing them to interpret their own practice by better understanding their own narrative (Cathcart et al., 2010).

This study emphasized the importance of nurse manager introspection, in turn allowing nurse managers to feel connected to patients and staff, feel less burdened by constant administration tasks, and improve cognitive recall during stressful events (Cathcart et al., 2010). Overall results suggested that complex leadership challenges can be a source of significant experiential learning (Cathcart et al., 2010). To ensure rigor and credibility, investigators provided structure guidance around the overall study, including discussing theoretical underpinnings of reflective practice. It has been shown that experiencing and reflecting on these concepts equips nurse managers with concrete skills, particularly in effectively managing time, delegating, giving and receiving constructive feedback, and objectively assessing team performance (Kling, 2010). The study also incorporated the Dreyfus Model of Skill Acquisition as a framework, underscoring the fact that nursing leadership expertise is a situation-driven practice (Cathcart et al., 2010).

Leadership academies have also placed an importance on psychological empowerment for nurse managers, with evidence suggesting that empowerment strategies

help foster safer work environments and better nursing outcomes (MacPhee, Green, Bouthillette, & Suryaprahas, 2011). A qualitative descriptive, methodological study in British Columbia evaluated the importance of psychological empowerment through a formal leadership development academy; the study included a theoretical empowerment framework (MacPhee et al., 2011). The study sample consisted of 27 individuals, and data collection methods were organized through telephone interviews, including separate qualitative researchers who reviewed, coded, and transcribed obtained information.

Findings suggested that nurse managers who participate in an empowerment-based, leadership academy might improve their confidence and overall performance (MacPhee et al., 2011). There were noted limitations with this study regarding leadership's role in evaluating nursing staff, mentor, and superiors (MacPhee, et al., 2011). Moreover, using a mixed-methods study with a validated assessment tool would have allowed greater reliability and validity of leader interview statements (MacPhee, et al., 2011). The student researcher found similar commonalities with this study and the proposed scholarly project. This study attempted to enhance clinical managers' self-confidence in a complex work environment, evaluated participants with varying demographic characteristics, and linked didactic training to practical application.

Similarly, developing competencies and fostering a rich pipeline of successive personnel has long been standard practice in non-healthcare industries (Hess et al., 2014). The need to develop managers for future executive roles is a critical objective for businesses competing across the globe. Business analysts estimate that Western European companies are struggling to establish effective leadership development processes at the manger level (Pulcrano, 2013). Consequently, these companies are forced to promote

untrained personnel into complex roles, consequently leading to poor outcomes and compromised services (Pulcrano, 2013).

Certain progressive companies have been steadfast and deliberate in developing promising managers, hoping that these individuals develop broader and more robust leadership competencies. General Electric, Disney, and Colgate-Palmolive have also shown to be industry leaders with the development of their own company institutes (Pulcrano, 2013). In turn, this has equipped companies with a rich pipeline of successive leaders who have demonstrated intent to become executives. Outcomes have shown to be positive, with employees gaining specific executive-level competencies (Pulcrano, 2013). Furthermore, companies that endorse such frameworks have shown improved employee engagement and enthusiasm toward the mission of their work (Pulcrano, 2013).

Universal change management competencies across industries

The Healthcare Leadership Alliance (HLA), a consortium of six major professional membership organizations, conducted broad syntheses evaluating critical healthcare management competencies, ultimately producing the highly reputable HLA competency development model. A primary goal of developing this model was to substantiate, validate, and legitimize the credentialing and certification processes of healthcare organizations.

The HLA study attempted to determine if synonymous, transferrable healthcare management competencies found throughout the participating professional organizations. The professional healthcare organizations were comprised by the American College of Healthcare Executives, American College of Physician Executives, American Organization of Nurse Executives, Healthcare Financial Management Association, and

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Healthcare Information and Management Systems Society (Stefl, 2008). Vitally

important were the relevancy and transparency of competencies throughout this study,

with a strong emphasis on academic preparation, continuing professional development,

and ensuring a modernization of acquired skills (Stefl, 2008).

Using a quantitative, descriptive study, participating healthcare organizations

were queried about their own leadership competency development models (Stefl, 2008).

A reliable psychometric firm ensured accuracy and validity through an extensive

analysis, in turn identifying five generalizable competency domains through all

participating organizations. This was demonstrated through communication and

relationship management, professionalism, leadership, knowledge of healthcare

environment, and overall business knowledge (Stefl, 2008). Moreover, the HLA engaged

in a process where subsuming elements of these domains were delineated, such as

distinctive abilities, skills, and knowledge (Stefl, 2008). Identified outcomes included

determining competency domains, the creation of an HLA competency directory, and a

healthcare leadership competency assessment tool (Stefl, 2008).

The HLA study provided context and targeted essential healthcare leadership

competencies, in turn providing structured and sound curriculum for graduate healthcare

administration programs and healthcare systems' leadership development processes

(Stefl, 2008). Providing additional substantiation, a web-based survey in 2007 queried

university faculty, preceptors, and healthcare leaders about the relevancy of HLA content,

with 49.2% of the respondents indicating all competencies were necessary (Stefl, 2008).

Interestingly, individual competencies from different sections were remarkably consistent

through respondents' feedback, inferring that the model could be simplified and adapted

for future use by varying organizational and academic institutions. This adaptability and application is important, especially as multi-industry statistics estimate that approximately $14 billion is spent annually on leadership development, with this figure growing rapidly each year (Stevenson, 2014).

Additionally, this study underscored that there is a common body of interdependent, dynamic knowledge related to nurse managers. Study limitations may include maintaining contemporary, modern healthcare leadership competencies in an ever-changing, volatile healthcare industry, which will require continual upgrades and competency validation (Stefl, 2008). Targeting highly relevant competencies gives nursing managers a significant edge when confronting problems, managing direct reports, and promoting a sharp vision (Stevenson, 2014). This will require an iterative approach between the HLA and previously identified professional organizations, with new and emerging information necessitating transposition onto the HLA competency directory (Stefl, 2008).

With the cited healthcare leadership competencies being integral to business and clinical success, healthcare systems are less averse to devote resources and energy to leadership development processes. Traditionally, organizations have allocated such opportunities to prominent, senior individuals with commensurate responsibility. However, this may diminish the importance of individuals with less experience and prominence, such as the clinical managers' influence over organizational performance (Ang, Koh, Lee, & Pua, 2016). There is a large body of indeterminate, unidentified evidence evaluating the development of potential, aspiring healthcare leaders (Stevenson, 2014).

To narrow this gap, a cross-sectional survey design was conducted from July 2013 until February 2014, validating the psychometric properties of a competency instrument, known as Aspiring Leaders in Healthcare-Empowering Individuals, Achieving Excellence, Developing Talents (AHEAD) (Ang et al., 2016). AHEAD was constructed through a systematic review of the literature and obtained input from relevant healthcare executives responsible for managerial competency development (Ang et al., 2016). Approximately 105 allied health professionals completed the AHEAD survey and validated the internal consistency of the instrument, with alpha values > 0.88 (Ang et al., 2016).

Additionally, AHEAD showed convergent validity with the Leadership Practice Inventory (LPI), a 30-item self-assessment that surveyed future and existing leaders' own skill development, with total and component AHEAD and LPI score correlated moderately (Spearman *P* values, 0.37 to 0.58) (Kouzes & Posner, 2014). Obtained data suggested all degrees of managerial experience can benefit from validated healthcare competency training, especially for emerging nursing managers who show leadership potential. Additionally, this study emphasized that leadership development is a process in which continual learning requires consistency, discipline, and constructive mentoring (Stevenson, 2014).

Self-efficacy and effective leadership practices

Although unquestionably rewarding, leadership can be an abstract journey that requires leaders to have conviction with their action, unwavering confidence, and strong execution capabilities (Sanford, 2011). Nurse executives have an opportunity to equip their leaders with specific tools to maximize their own efficacy when leading change.

Individuals who adhere to these experiences may experience powerful mastery with their own capabilities (Bandura, 1997). This transformational restructuring of one's own self-efficacy has the potential to manifest across different diverse realms of action and thinking (Bandura, 1997). Moreover, it has been suggested that leaders with greater self-efficacy are better and more effective leaders, this being important for nursing managers who bear complex and demanding operational responsibilities (Mesterova, Prochaska, & Vaculik, 2015).

Self-efficacy has also been a reliable measure for Clinical Nurse Leaders (CNLS's), especially as their role is requisite to successfully leading change (Gilmartin & Nokes, 2015). The CNL role was developed to prepare highly skilled nurses to focus on improvement of quality and safety outcomes for patients (Gilmartin & Nokes, 2015). A web-based survey gathered cross-sectional data that evaluated the role of self-efficacy on a CNL, postulating that CNL's with higher levels of self-efficacy are more likely to be innovative, culturally sensitive, and feel confident working with diverse populations (Gilmartin & Nokes, 2015).

Participants completed the Core Self Evaluation Scale, which measured self-esteem, locus of control, emotional stability, and general self-efficacy (Gilmartin & Nokes, 2015). The mean scores (3.558) on the core self-evaluations on the 5-point Likert scale demonstrated higher self-evaluation scores, indicating positive core evaluations (SD = .432, range = 2.84 to 4.62). Additionally, participants completed the Transcultural Self-Efficacy Tool (TSET), which assessed confidence with performing transcultural nursing skills. Using a Pearson product moment correlation, the Core Self Evaluation Scale was significantly related to the TSET, particularly associated with participants' cognition (r =

.431, $p = .000$), practicality ($r = .532$, $p = .000$), and affective abilities ($r = .469$, $p = .000$) (Gilmartin & Nokes, 2015).

Comparably, in 2015, a web-based survey queried a national sample of CNLs about their own self-efficacy, through a state-specific self-efficacy scale called the CNL Self-Efficacy Scale (CNLSES) (Gilmartin & Nokes, 2015). The CNLSES consists of two parts, with items assessing self-efficacy for the CNL role, as well as a brief section on the respondents' demographic characteristics (Gilmartin & Nokes, 2015). The construct validity, reliability of the study's indices, and discriminant validity were assessed and examined. Findings from this study directly aligned with the American Association of Colleges of Nursing (AACN) core competencies, which emphasize strategic planning, fiscal acumen, creating team environments, demonstrating professionalism, and system awareness (Gilmartin & Nokes, 2015). Study limitations included a small sample size, in turn increasing the chances of Type I and Type II errors (Gilmartin & Nokes, 2015).

Moreover, a systematic review was conducted that evaluated existing theory and research specific to leadership self-efficacy (Hannah, Avolio, Luthans, & Harms, 2008). Study goals looked to develop a conceptual framework around the importance of leadership self-efficacy, in turn validating the positive effects of efficacious leadership styles in an organizational setting (Hannah et al., 2008). An exhaustive review of the literature was conducted surrounding leadership self-efficacy, focusing on individual study's targeted focus, methods, and overall results. The investigators provided both a retrospective account of LSE studies as well as a broader, more dynamic focus on what constitutes leadership self-efficacy. In turn, organizations providing LSE frameworks are more apt to produce collective efficacy across teams, are sustainable systems, and

develop resilient leaders (Hannah et al., 2008). Additionally, it was noted that goal orientation and self-awareness both have potentiating, positive factors with influencing the development of a leaders' self-efficacy (Hannah et al., 2008).

Understanding leadership development is critical, as leadership effectiveness is broad and can be identified by an array of multidimensional factors, such as organizational culture, resourcefulness, interpersonal skills, and many more. Hence, leaders operate in a very nonlinear environment where numerous factors might significantly challenge their ability to deliver on organizational goals (Griffith, 2012). Leaders who exhibit enhanced self-efficacy are more likely to positively influence their followers and the organization's culture, climate, and performance (Hannah et al., 2008). As leaders' positive self-efficacy shapes their environments with technical skills, such leaders also exhibit higher degrees of psychological resourcefulness, flexibility, and adaptability (Hannah, et al., 2008).

Leadership development and fostering a culture of quality improvement

Healthcare systems are facing increased demand to demonstrate greater quality and cost containment, all while ensuring that the customers' experience is personable, efficient, and produces the desired outcomes. To meet these increased expectations, healthcare systems are investing time, energy, and training to quality improvement training, especially for associates with operational responsibilities. Many industry analysts and experts, both healthcare and non-healthcare, have posited that adapting to change is a critical requisite for thriving organizations (Sanford, 2011). Although an organization's core values represent foundation and purpose, adapting to change ensures that organizations are innovative, creative, and maintain viability. Both the

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manufacturing and automotive industries have been pioneers with instituting change management leadership principles into their corporate culture (Griffith, 2012). In turn, systems and methodologies have been established that stress continual quality improvement, strategic foresight, and improving efficiencies (Griffith, 2012).

Clinical managers have also been tasked with cultivating systems and cultures of improvement. Clinical managers must accomplish these challenging tasks while working in diverse, heterogeneous environments. (Black & Morrison, 2010). Research has suggested that working with varied groups can actually be advantageous, as uniform and cooperative workforces are not always conducive to creativity, industrious thinking, and pursuing quality improvement goals (Black & Morrison, 2010). This can also lead to teams more being more open and willing to apply quality improvement methods in their work environment.

One quality improvement method is the Plan Do Study Act (PDSA) cycle, a theoretical framework used to systematically influence change (Taylor, McNicholas, Nicolay, Darzi, & Bell, 2013). A systematic narrative review hypothesized that the PDSA cycle is a natural iterative cycle, in effect requiring multiple cycles and a multifaceted approach (Taylor et al, 2013). Data were collected and tabulated through identified, peer-reviewed studies. Findings suggested that healthcare leaders might incorrectly assume that conducting PDSA cycles would influence positive change, especially when key PDSA principles were not frequently followed. This was illustrated when less than 20% of reviewed articles reported conducting methodical, iterative cycles of change, and only 15% of those tests demonstrated increased confidence scales (Taylor et al, 2013). This presented an opportunity for nursing managers to capitalize on the PDSA methodology,

with both technical expertise and philosophical understanding of the principles helping create greater quality improvement.

Clinical managers should look to foster collective energy around a quality improvement change initiative (Martin, McCormack, Fitzsimons, & Spirig, 2014). Creating a shared need for teams to accomplish concerted goals requires both technical and interpersonal savvy (Sanford, 2014). A mixed-methods study was conducted that evaluated the causative relationship seen in high-quality healthcare environments that boast visionary leaders. It was hypothesized there are favorable benefits when clinical managers outline a sharp vision for department quality goals when the managers are supported by change-management skills, tools, and resources (Martin et al., 2014). Collectively, there were 420 total observer assessment questionnaires and 42 self-assessment questionnaires, with findings suggesting successful nursing leaders inspire a shared vision and challenge the routine process. When organizations do not have optimal education or resource systems in place, issues can arise (Martin et al., 2014). Different studies have concurred that investments in educational programs can help facilitate and nurture nursing leaders (Martin et al., 2014).

Literature Synthesis

Leadership development academies represent a resourceful and innovative approach to fostering talent development for healthcare systems. These academies have created highly attractive mechanisms to augment change-management competencies for clinical managers. This is important, considering the extensive responsibilities clinical managers are tasked with in leading complex system change. If they are equipped with tools, resources, and greater sophistication, the outcomes can be much more favorable.

Yielded results can be seen in all elements of organizational performance, highlighted by improved financial performance, engaged staff, satisfied consumers, and systematic methods to transform issues into solutions.

Enormous changes in the healthcare industry carry significant consequences for the way these systems operate, with a strong emphasis on patient safety, quality assurance practices and policies, designing interoperable systems and processes that create efficiencies, while simultaneously leveraging their workforce. Although these items are unique in their own nature, they must be tactically addressed for organizational viability, growth, and solvency (Kumar, Kumar, Deshmukh, & Adhish, 2015).

Unfortunately, many healthcare systems have not demonstrated the same discipline in developing leadership development academies, specifically to enhance change-management skills (Sanford, 2011). When clinical managers are not given opportunities to foster change management skills, there can be negative ramifications, witnessed by skill deficits, leaders who lack both soft and hard skills, and ineffective project management abilities (Hart & Donde, 2014). Furthermore, these findings can erode healthcare organizations' overall operations, illustrated by poor staff retention, obsolete processes that lack innovation, unsafe and high-risk care, and overall financial losses (Hess, 2013). To narrow these findings and remain competitive in challenging and competitive markets, healthcare organizations should look to capitalize on the potential of leadership development academies.

Chapter 3

Theoretical Model

Methodology

Dr. Albert Bandura originated the idea of self-efficacy, which has been widely instrumental for correlating how self-efficacy determines one's ability to overcome challenges (Platt, 2010). Self-efficacy has been defined as beliefs in one's capabilities, and in turn mobilizing resources, commitment, and collective energy around a defined task (Mesterova, Prochaska, & Vaculik, 2015). Bandura outlined the essence of self-efficacy through his Social Cognitive Theory (Platt, 2010). Social Cognitive Theory explains that human behavior is not simply externally influenced, but instead is a triadic exchange that occurs between environment, behaviors, and internal cognitions (Platt, 2010). Bandura suggested that individuals possess the remarkable ability to shape their thoughts and actions, which can help them navigate, influence, and overcome barriers in complex environments (Platt, 2010). Bandura stated, 'In order to succeed, people need a sense of self-efficacy, to struggle together with resilience to meet the inevitable consequences and inequities of life." His thoughts directly illustrate the undeniable challenges and rewards of being a leader in today's modern society.

Sources of Self-efficacy

The development and emergence of self-efficacy can be attributed to four main sources of influence. One of the most effective ways to increase one's self-efficacy is through challenging and complex experiences, which require a tremendous amount of grit, perseverance, and focus to accomplish a singular goal (Bandura, 1994). When the individual reaches an objective goal, self-efficacy is reinforced, as well as one's mastery

over the experience. Moreover, an individual's self-efficacy is significantly influenced through social models, particularly when individuals witness similar social group's aspired goals (Bandura, 1994). These vicarious or indirect observations can represent the vast, untapped potential we possess as individuals. However, there can be negative consequences when one indirectly witnesses failure from their social groups, consequentially creating negative feelings of inferiority, demotivation, and fear of pursuing individual goals (Bandura, 1994). In fact, negative connotations from social models impose more self-doubt and internal condemnation on individuals compared to positive, empowering factors. Unrealistic boosts of self-efficacy are quickly unsubstantiated when one faces disappointment, setback, and personal failure. The tremendous impact of relatedness to one's own self-efficacy cannot be underemphasized (Bandura, 1994). Relatedness occurs when individuals describe a deeper emotional connection with similar role models who accomplish a task, goal, or objective, all promoting persuasion. Individuals are also persuaded when they witness role models or heroic figures demonstrating proficiencies, managing environmental demands, and the acquisition of better means.

Additionally, role models provide structure, empowerment tactics, and pragmatic solutions to ensure that followers are successful and triumphant when faced with challenges (Bandura, 1994). The role model espouses a keen sense of self-awareness and commitment to individual, team, or organizational success, particularly by providing tools, resources, and techniques that improve followers' self-efficacy.

Individual's emotional and somatic states are an incredible, antecedent factor in obtaining improved self-efficacy. This can be postulated by the understanding that one's

emotional or somatic states represent sources of heightened stress, emotional proclivities as well as distortions with overall capabilities (Bandura, 1994). These feelings are determinate and have varying levels of intensity. However, perhaps even more pervasive and damaging, is one's own perception and interpretation of their self-efficacy. Positively, when one has higher self-efficacy, they describe a stronger internal "locus of control," equate themselves to energized facilitators, and feel empowered by their circumstances.

Setting

The study was conducted at the flagship campus of a healthcare organization in the Midwest, with the overall healthcare system that has multispecialty medical services, a teaching hospital, regional community clinics and affiliates, and other specialty clinical services. It was on the flagship campus where the study was conducted. This healthcare system is certified as a level II trauma center by the American College of Surgeons.

Procedures for data collection

The study design included a pre-test and a post-test with descriptive statistics, examining the relationship between the change-management academy and its impact on improving the Generalized Self-Efficacy (GSE) scores for participating clinical managers. Participants' demographic information was collected, with the pre-test accompanying their participation in the academy, and information stored and secured through Research Electronic Data Capture (REDCap). REDCap is a secure web application that allows students to manage online surveys and databases, through a completely secure and accessible online application (REDCap organization, 2017). Data were analyzed using descriptive statistics, including frequencies or percentages,

determined categorical data, as well as continuous data. Because the sample size was not large, pre-test to post-test comparison of self-efficacy scores used the Wilcoxon signed ranks test. Because of the pre-test / post-test design, it was necessary to maintain identifiers for study participants until data analysis was completed. Statistical findings from the pre-test / post-test design were evaluated using Statistical Package for Social Sciences Analysis (SPSS), investigating observations and comparison between groups through a paired sample *t* test. Moreover, both categorical and continuous measurements were assessed and compared through the pre-tests and post-tests. Additionally, data were analyzed and appraised by the primary investigator, co-researcher, and student researcher, with the data being destroyed within three years of study completion.

Study Population

To meet inclusion criteria, participants were designated as an inpatient or outpatient unit clinical manager when the study commences. Participation was considered voluntary, and the organization's Human Resources department confirmed participants' status and role in organization. Participants were licensed or certified appropriately in their area of specialty, showing proficiency in speaking, reading, and writing English.

Multiple recruitment sources were utilized, comprised of individual emails, staff meetings, organizational meetings, and formal explanatory meetings. Communication was disseminated only to individuals working in the study setting, and who met the inclusion criteria. The email outlined major components of the survey including: (a) name, contact information, and professional background of the primary investigator; (b) time commitments for participants if they chose to participate in project study; (c) list of activities involved, including the tool, pre-and post-test surveys, collection of

information, etc.; (d) informing the participants that no compensation is offered for taking part in the study; (e) logistics surrounding the project study, regarding the time commitment and location of the study; (f) the delivery of education and overarching framework was explained to generate clarity of project study.

All clinical managers who met the inclusion criteria were eligible to participate in the study on a voluntary basis. To ensure full transparency and clarity regarding the study, all participating participants were provided information about the following items: purpose and aim of study, associated risks with participation, measures to maintain anonymity/confidentiality, explaining voluntary participation, and their ability to withdraw from the study with no penalty. The participants were provided informed consents to engage in the study, with consents provided in an electronic format. All consent forms have been maintained and protected with security measures, including any data collected through the REDCap system.

While there were minimal risks, participants were given the option to withdraw at any moment, with the consent informing all participants of established protective measures. By using REDCap, this study mitigated any risks to participants, such as loss of confidentiality, loss of privacy, or any associated emotional harm from their participation. However, participants were informed they may experience slight discomfort when completing the GSE instrument. This may be due to the nature of the instrument requiring them to examine their own strengths, confidence in abilities, and personal identities. A participant may choose to not answer a question that makes them uncomfortable, yet remain as a participant in the study.

Furthermore, no conditions existed where an investigator would withdraw a participant who met the inclusion criteria. Any surveys where incomplete data was obtained were still considered valid, particularly when evaluating the overall study. All final analyses were shared with participants following the completion of the study, utilizing aggregated data, thus maintaining confidentiality of participants' personal results.

Scholarly project framework

Excellent healthcare executives know the importance of equipping their nursing mangers with change-management tools that have produced outcomes and validity industrywide. A cornerstone change-management framework that healthcare and non-healthcare industries have endorsed has been the Change Acceleration Process (CAP). The CAP tool is a seven-step method that provides a systematic approach for leaders when embarking on a new change (General Electric, GE, 2006). Integral CAP concepts include using tools that address the human side of change, mobilizing commitment, transferring change into operational targets, sustaining change, as well as identifying and eliminating waste (GE 2006). CAP has produced favorable findings across all industries, including healthcare, engineering, manufacturing, as well as a multitude of privatized companies across the globe (GE, 2006).

Though CAP has been a powerful and highly effective model for cultivating change-management competencies, it also represents a methodical and comprehensive strategy for successfully leading change. The CAP model has equipped GE's managers with tactical knowledge aimed at leading change, with initiating, operationalizing, and sustaining implemented projects for the duration (Fulmer, Gibbs, & Goldsmith, 2000).

This model revolutionized GE's approach not only to leading dynamic change, but also provided a strategy for leadership development. This occurs when elite organizations, such as GE, recognize the importance of tying leadership development practices to organizational functions, such as change-management functions (Fulmer et al., 2000). In turn, companies provide a formal pathway for leadership development that can elucidate succession planning strategies, especially for high performing individuals who show high talent and potential (Fulmer et al., 2000).

In this leadership development academy, participants will be taught principles through GE's CAP framework. The organizational setting implemented CAP in 2009 to meet the needs of our employees when leading change.

Intervention design

Through noted healthcare industry changes, this healthcare organization saw an opportunity to enhance delivery of CAP, specifically by coupling CAP principles through this change-management leadership academy. The change-management leadership academy was conducted over the course of eight weeks, with one-hour sessions each week. The advanced CAP content and principles were tailored to clinical managers, such as understanding business concepts and principles essential for long term project success, adding value for the healthcare consumers, and sophisticating their own change-management skillset. Varying subject matter experts (SME) throughout the organization were chosen to deliver diverse content through the scheduled eight week sessions (see Appendix B). SMEs possessed expertise leading organizational change, spanning clinical operations, executing quality and efficiency initiatives, as well as developing program growth.

Sources of Data/Instrumentation

Evaluating leaders' own self-efficacy required deploying an instrument that is reliable, valid, and structurally supportive to a change-management academy. This study utilized an instrument assessing individuals' ability to solve problem and reach goals, the Generalized Self-Efficacy (GSE) scale (Stoet, 2016). The GSE is a 10-item scale questionnaire that evaluates one's belief to bring about requisite performance during challenging tasks (Chen et al., 2001). The GSE demonstrated high reliability with Cronbach's alphas, ranging from 0.76 to 0.90, with the majority of scores in the high 0.80's (Schwarzer, 2014). Additionally, criterion-related validity was documented in numerous correlational studies, producing favorable findings for fostering positive change in leaders (Kusurkar, 2013).

Gaps in the literature exist regarding the influence of self-efficacy on nursing leaders' effectiveness when changing systems and structures (Kusurkar, 2013).While Bandura stated that general self-efficacy may not result in specific outcomes and behaviors, other authors have found general self-efficacy to be a valid construct and to be reliable when gauging individual responsiveness (Kusurkar, 2013). Furthermore, the GSE is considered to be a credible assessment in educational interventions, especially when individuals demonstrate lower self-efficacy or remediating behaviors that hinder individual progress (Kusurkar, 2013).

Valuable demographic information was obtained through the pre- and post-test surveys, such as the age of the clinical manager, their background, their highest level of education obtained, and number of years served as a clinical manager. Moreover, participants also completed the GSE instrument through the pre-test and post-test surveys

(see Appendix G). Additional post-survey questions were incorporated to identify any

positive correlation with individuals' attendance and overall satisfaction, particularly with

content applicability, improved self-efficacy when leading change, and presenters' style.

Data Collection Process and Tools

REDCap is a secure, web-based application designed to support data capture for

research studies, providing (a) an intuitive interface for validated data entry, (b) audit

trails for tracking data manipulation and export procedures, (c) automated export

procedures for seamless data downloads to common statistical packages, and (d)

procedures for importing data from external sources. Study data were collected and

managed using REDCap electronic data-capture tools hosted at the University of New

Mexico.

Data Protection Plan

No one at the healthcare system was authorized access to study data except for the

student investigator. Only the primary investigator, the co-researcher and the student co-

investigator were authorized access to view the original survey data, with information

protected by a password on an encrypted laptop computer. Both the primary investigator

and co-researcher are located in New Mexico, and the student co-researcher is located in

the upper Midwest. Data will be stored and maintained only in REDCap, utilizing

aggregated data to maintain confidentiality of participants' personal results.

Timeline

The study was conducted during a three-month period in quarter four of 2016; it

included initial communication about the purpose of the study, voluntary participation,

querying participants through a pre-test, implementation of academy, and querying of

participants through a post-test. Specific timelines included the following: participants were sent preliminary communication informing them of the study (September 19th); eligible participants who expressed interested were offered informed consent documents regarding study (October 3rd); eligible participants were provided a pre-survey GSE scale to complete (October 16th); the study was conducted (October 28th – December 23rd), eligible participants were provided a GSE post-scale to complete (December 30th); presentation of preliminary findings to organizational executive team (March 1st, 2017); date of completion and presentation of the study (May 12th, 2017);

Budget

This study had minimal budgetary costs to the organization, with the only financial impacts being incurred by the student researcher (Appendix H).

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Chapter 4

RESULTS AND DISCUSSION

Results

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This study evaluated participants' GSE-scale responses, along with specific descriptive statistics integral to the study, prior to and after their involvement in the study (see table 1).

Table 1

Demographics of Study Sample

Category	N	M	SD	Min	Max
Age	22	42.77	8.76	31.00	58.00
Years in Current Role	22	5.49	6.00	1.00	26.00
Years at Organization	22	15.68	9.96	2.00	37.00

Years Working in Healthcare Outside of This Organization	22	6.93	7.93	0.00	29.00

Note. Table describes participants' different ages, length of time in current role, employment outside of this organization, and years working within organization.

A paired sample *t* test was conducted comparing two different means from the individuals participating in the study. The purpose of the test was to determine statistical evidence from the mean difference, specifically comparing the paired-participant group (see table 2).

Table 2

Descriptive Statistics and t-test Results for Study Test

	Pretest			Post-test				95% CI for Mean Difference			
Outcome	M	SD	Std. Error Mean	M	SD	Std. Error Mean	n		t	df	Sig.(2-tailed)
	31.91	2.84	0.61	34.64	3.06	0.65	22	-4.32, -1.13	-3.55*	21	.002

There was a significant difference in the scores for the total sum pre-test scores (M=31.91, SD= 2.844) and total sum post-test scores (M = 34.64, SD = 3.064); t (21) = -3.552, p = .002. There was an improvement in the scores for the total sum pre-test scores (M = 31.91, SD = 2.844) compared to their total sum post-test scores (M = 34.64, SD = 3.064), with p = 0.05. Based on these significant results, the findings rejected the null hypothesis.

Discussion

Through observation, discussions, and an evaluation of participants, it was evident this academy represented a vehicle for clinical managers to acquire change-management knowledge. This project provided insight into the future possibilities for

leadership development academies, especially when concentrated around a specific area of competency such as change management. Content was designed to address both essential technical skills and interpersonal skills commensurate with successful change, with subject experts delivering diversified academy content. Content that was more analytical based included PDSA process improvement methodologies via the CAP model, focusing on eliminating waste, over-processing, and improving overall performance.

Coupling this knowledge was a rigorous analysis of process improvements, looking at benchmarking fundamentals, measurement systems analysis, design of experiments, and control plans. Conversely, the academy also accounted for essential soft skills that help clinical managers when leading change. These learning opportunities were elucidated as well, particularly around the content of soft skills via the CAP model. Content discussed creating a shared need, shaping a vision, mobilizing commitment, making change last, and monitoring progress.

Structuring academy content with both hard skills and soft skills produced fortuitous findings, as clinical managers demonstrated positive improvements comparing pre-test and post-test analyses. While this academy provided measurable, quantifiable improvements through statistical analyses, there were also interpersonal benefits due to the academy configuration, size of groups, and intimate setting. Participants were encouraged to ask questions, network with organizational experts who led change, and cultivate collegial relationships with their contemporaries. Providing a safe and constructive environment for participants spurred on dialogue for complex topics corresponding to leading change, such as requisite project management expertise and

identifying project metrics. Moreover, participants were challenged to learn about traditional financial principles that are analogous to leading change, such as return- on-investment applications, profit margin, and understanding market shares. Concepts and curriculum were proportionate to the current healthcare environment when leading change.

Implications for Evidence Based Nursing

The results indicated that leadership development academies can provide great value to healthcare organizations, with clinical managers expected to be more talented, skilled, and capable to surmount previously cited industry challenges. In analyzing the results, it could be inferred that attendees found their participation valuable and enriching. The practicality and usefulness of academy tools, resources, and content helped ensure leadership application with key change-management projects. Building on this momentum was anticipated, and there were assumptions that healthcare organizations would find advantages and benefits with this leadership development process.

It is anticipated results will be disseminated via varying channels, including sharing codified results with the organization's executive team, administration and operational leaders, as well as all-inclusive participants in the study. Additionally, there will be opportunities to present this project and statistical findings at the organizations' internal quality improvement recognition event held each week.

Limitations and Strengths

One of the initial limitations to this DNP scholarly project was ensuring that goals, objectives, and aims were in alignment with organizational readiness, strategic

plan, and vision. Additionally, it was important that this learning platform complemented and coincided with the organization's new strategic plan, predicated on quality, personalized care, and providing equitability to our consumers. Consequently, the student researcher met with organizational executive leaders to reaffirm project goals, emphasizing the development of project management acumen, as well as developing both analytical and interpersonal awareness. Doing this allowed the project to be preserved, as well as sanctioned support and investment during the implementation phase.

Further, organizing an eight-week academy session for individuals with demanding schedules and pressing commitments initially posed limitations, yet being adaptable to more flexible timeframes proved to be helpful. Reconfiguring and proposing a new eight-week block of successive courses helped ensure consistent attendance by all participants. Futuristically, there is also an opportunity to utilize more technology that would further academy connectivity, such as web-based portal learning methods and dual campus interfacing. This would help accommodate individuals who were required to travel between campuses.

Moreover, it was important to account for the availability and session expectations for the subject experts who facilitated the different academy dates. This too required methodical preparation, helping facilitate and anticipate the content, forecasting problems, and meeting session objectives. The time, energy, and coordination for executing a successful session were initially underestimated, especially when accounting for these numerous logistical elements.

The nature of this project provided clinical manager participants with a unique leadership development experience. While this experience proved to be substantive and

rendered key learnings, it also challenged traditional approaches to skill development at the organization level. While there were copious planning and coordination prior to the sessions, the real crux of the success of the project was the marked quality delivered by all academy presenters. Elucidating real-life, industry-tested change-management projects legitimized the academy, and ensured participant relatedness. Consequently, the dynamic and charismatic nature of the presenters kept participants consistently engaged and disarmed any sense of irrelevancy.

Additionally, there were organic, unplanned occurrences where participants would share best-practice tips, areas of perpetual struggle, and aspirations for growth. These conversations stemmed from successes and failures that clinical managers have encountered when shepherding change. The storytelling that emerged was appropriate, adding credibility to the sessions, and instilling a sense of community, trust, and honesty for all participants.

Suggestions for Future Research

The results indicated that leadership development academies can provide great value to healthcare organizations, with clinical managers expected to be more talented, skilled, and capable to surmount previously cited industry challenges. Understanding this skill or talent gap is an implicative factor for healthcare organizations interested in establishing leadership academies, primarily as problems are complex and multifactorial.

However, it could be suggested that leadership academies instill a focused approach when educating on relevant foci, in turn understanding the distinct dynamics of each respective topic. There are opportunities to design change-management academies with corresponding subset topics, such as patient flow, service excellence initiatives,

improving team culture, and capital project management. Having content with depth and relevancy creates a substantive experience for the attendees, meshes the philosophy with pragmatic application and helps systematize learning.

Dedicated leadership academies can also be authoritative programs for healthcare organizations that look to augment their recruiting and retention processes for their clinical managers. These academies can be assets that not only develop their own internal talent, but also the competitive edge necessary to remain competitive and marketable to external clinical managers. Healthcare organizations can market and publicize such leadership academies through career affairs, promotion materials at leadership conferences, and internal leadership development programs. Reputable high-value leadership academies can be recognized as an investment and acknowledgement for the criticality of the clinical manager role. Beyond essential skill and competency development, such academies can enhance the satisfaction of clinical managers, succession planning, and promotion of innovations.

Additionally, healthcare organizations may look to other leadership roles beyond the chosen clinical manager role, particularly in service lines that are integral for overall performance. Areas such as human resources, decision support and analytics, finance, and business services represent service lines that can benefit from immersion in a leadership academy. Designing and structuring multi-team leadership academies can augment different learning platforms, as well as systematically reinforce organizational vision and strategy.

Conclusions

Healthcare organizations are facing increased pressure to improve patient and safety scores, deliver efficient and accessible care, as well as ensure that their cost of care is reasonable and socially responsible. A critical factor of these outcomes is influenced at the micro level, with ambulatory or inpatient settings representing these care environments. Knowing these future challenges and opportunities, it is incumbent on healthcare organizations to invest in the clinical manager role.

The results of this study supported the conclusion that leadership development academies are effective, practical, and can influence organizational performance. Furthermore, the clinical manager represents a tremendous asset to healthcare organizations, and it could be posited that their quality of performance corresponds to their learning milieus.

While initially daunting, leadership development academies allow healthcare organizations an opportunity to give their clinical managers an intellectual edge when embarking on change efforts. Using leadership academy modalities is an innovative and intriguing way to escalate this knowledge, as transferrable knowledge positively influences employees, teams, and overall organizational performance.

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GENERALIZED SELF-EFFICACY SCALE

GL assessment
the measure of potential

Name: ....

Date: .... Record Number: ....

		Not at all true	Barely true	Moderately true	Exactly true
1.	I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
2.	If someone opposes me, I can find means and ways to get what I want.	1	2	3	4
3.	It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
4.	I am confident that I could deal efficiently with unexpected events.	1	2	3	4
5.	Thanks to my resourcefulness, I know how to handle unforeseen situations.	1	2	3	4
6.	I can solve most problems if I invest the necessary effort.	1	2	3	4
7.	I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
8.	When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
9.	If I am in a bind, I can usually think of something to do.	1	2	3	4
10.	No matter what comes my way, I'm usually able to handle it.	1	2	3	4

Framework: The framework of the academy will be the Change Acceleration Process (CAP) model, originating and endorsed through General Electric.

Concepts:

- General overview on leading change
- Reflective inventory on participants' leadership styles
- Using tools that address the human side of change / technical execution to implement successful change
- Creating a shared need and having clarity about purpose / project plan
- Mobilizing commitment
- Transitioning change to operational goals
- Making change last
- Monitoring progress through defined metrics / strategic objectives
- Plan Do Study Act (PDSA) cycles
- Leading teams through change with engagement strategies
- Identifying and eliminating waste / creating value
- Sustaining new systems and structures following implemented change

(General Electric CAP model, 2006)

Overview of CAP steps:
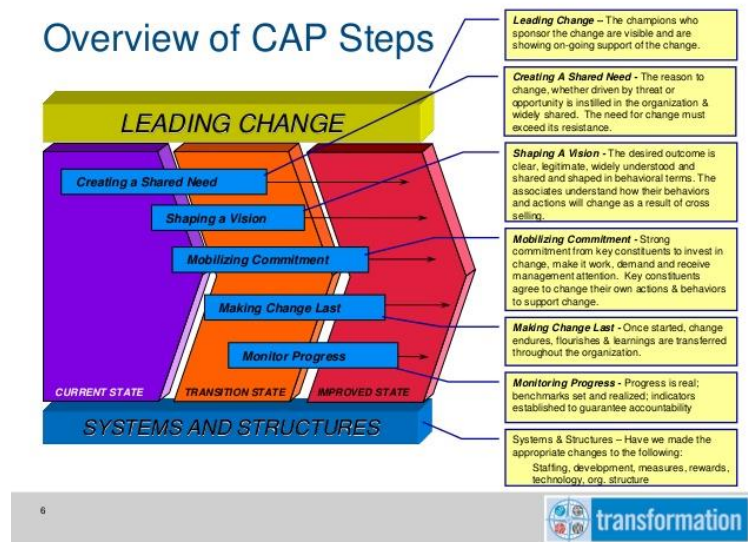
(General Electric, 2006)

Appendix C
Outline of CAP curriculum

Item	Concept 1 Week 1 Creating a share need: Session 1	Concept 2 Week 2 Shaping a vision: Session II	Concept 3 Week 3 / 4 Mobilizing commitment Session III (2 weeks)	Concept 4 Week 5 Innovative Operations: Session IV	Concept 5 Week 6/7 Making and monitoring change: Session V (2 weeks)	Concept 6 Week 8 Changing systems and structures: Session VI
Content	Threat vs. opportunity matrix Developing basic knowledge of CAP process, such importance, background and origination at GE, demonstrated (+) findings, technical and interpersonal focus, etc. Identify one 90 day project objective that will require change management practices (*will be pre-determined) Create both short and long term goals that address the change, specifically targeting operational and clinical outcomes	Articulating a vision for the overall project Creating a vision that is energizing and motivating Meeting team and organizational strategies simultaneously Interpersonal and technical tools to create team and org. alignment with change. Validating fears and opportunities with change. Correlating previous successful GHS initiatives that exemplified change management practices. What did we learn?	Identify key stakeholders / implementing tactical leadership skills to produce group synergy Analyzing sources of resistance and how to overcome barriers 'along the pathway of change' Conflict resolution skills: crucial conversations, leading with courage through change, maintaining momentum and endurance with change efforts Developing teams that problem solve / assuring commitment and mitigating risk when leading through change	Learn how innovative companies navigate through varying types of organizational challenges. Understand how external influencers, such as reimbursement methodologies, healthcare industry competitiveness, and consumer transparency, are necessitating consistent innovation. Understanding the healthcare innovation catalog: how consumers buy healthcare, why technology drives new products, and creating vertical integration in an organizational framework (Herzinger, 2006).	Understanding the magnitude of the total change effort Understanding the time commitment required to implement / maintain change Understand the level of clarity and alignment regarding the implementation process How change affects business and clinical goals throughout all different phases (i.e. downstream and upstream) Aligning resources and partnering disciplines to sustain change efforts	Changing systems and structures involves using or modifying the following variables: staffing, development, measures, rewards, communication, organization design, IS, and resource allocation. Understand all of these variables prior to embarking on change is important for successful efforts. Tools utilized will be changing systems and structures worksheet, control and influence assessment worksheet, and ensuring no other teams are addressing this change (i.e. minimize duplicative work)
Importance	High functioning teams know how to frame the need for change as both short and	Change management efforts that lack energy, focus, or	Change management efforts that naïvely dismiss short term and	Nursing leaders should incorporate innovative based thinking	After an implemented change sustainment becomes the	A main component of leading groups through change is conveying what is within / outside of your

	long term needs.	enthusiasm are vulnerable to becoming ineffective and uninspiring to frontline clinical staff.

Additionally, not aligning with organizational needs creates silo based work that antagonizes integrative efforts. | long term resistance is at greater risk. Developing leaders who have resilience, foresight, and unwavering commitment when leading change is critical. | into their skillset considering the current healthcare markets / environment (Herzinger, 2006). Innovation affects at us all levels of nursing leadership (Herzinger, 2006) | primary focus. Determining common barriers after change, whether it be human or systems, is key to assure change maintains effectiveness for business / clinical goals. | control.

Should validate integral aspects of change, such as rewards, communication, and resource allocation. |
| Objectives | Review 360 degree feedback analysis

Managers will articulate goals of determined project with colleagues.

Manage will complete their threat versus opportunity matrix | Construct an elevator speech regarding the implemented change (i.e. developing clear and strategic messaging) for areas of responsibilities (AOR).

Practice speech and receive feedback. | Use a resistance analysis chart to identify what's important to stakeholder group regarding targeted project

Determine level of resistance (high, medium, low) that group may leader may experience with change. Depending on the resistance, devise strategies to overcome these barriers.

Review and complete the attitude / influence matrix | Participants will demonstrate greater awareness about healthcare economics, specifically how organizations' are being reimbursed for value vs. volume

Explain how different healthcare institutions incorporated innovative tactics into workflow

Explain outcomes that can be attributed to innovative leadership, particularly with finances / human capital | Participants will demonstrate knowledge and comfort completing a Force Field Analysis (appendix) – will identify factors

Completion of the 'monitoring progress checklist' (appendix). Identify measures, assign individual / or team accountability for tracking objective, and determine how results will be communicated and to whom (communication plan worksheet) | Participants will identify key systems and structures that should be considered for further evaluation, review and observation

Identify long term strategies to maintain 'buy in' from key stakeholders.

Determine effective reward mechanisms to recognize positive behaviors / validating appreciation. |

(General Electric, 2006)

Instruments:

- The Generalized Self-Efficacy Scale (GSE) tool: GSE tool will be used to assess clinical nursing managers' self-efficacy. Instrument will be

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administered to participants at pre and post phases of the academy. The GSE (Appendix B) is a highly validated tool, provides strong reliability, can be administered to broad groups, and can be conducted as a pre and post survey (Redmond & McLoughlin, 2015).
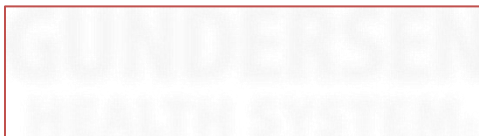
To whom it may concern,

                                    is a level II healthcare organization in the upper Midwest that is physician led, non-profit healthcare system headquartered Wisconsin. Our system includes multi-specialty group medical practices, a teaching hospital, regional community clinics, affiliate hospitals and clinics, behavioral health services, and other specialized clinical services.

We are incredibly proud of these broad services and pride ourselves on being innovative, geared toward continual improvement, and adaptable to new industry demands. However, being versatile to evolving expectations and market changes requires consistent development of our leaders, specifically our clinical manager team. We realize leading change can be highly complex and necessitates consistent action to ensure their skills can meet these challenges.

With that backdrop, we instituted the Change Acceleration Process (CAP) in 2009 to meet the needs of our employees when leading change. The CAP was created by General Electric and has a strong reputation equipping leaders with both the technical skills and human elements when leading change. Although CAP has produced favorable results with its concepts and content, we feel we can augment our clinical managers' knowledge of the CAP by promoting a 'change management academy.' This change management academy would be an organizational priority and would complement Chet Doering's DNP scholarly project.

CAP is an organizational philosophy that has been successful, however there are indications our clinical managers may greatly benefit from a defined leadership academy based off the CAP framework. This change management academy will be eight weeks long and tailored to just clinical managers. There will be diverse expert speakers who will teach core CAP concepts. By focusing on one discipline with a strong alignment of accessible resources we are confident our clinical managers' change management competencies can flourish.

This type of project will additionally allow us to encompass our current foundational CAP processes along with an innovative academy approach. We appreciate the idea of an academy as many elite healthcare institutions have benefited from leadership development programs, particularly Penn Health, Cleveland Clinic, and Kaiser

Permanente. Although we realize our academy would not be as robust as these healthcare systems, we are confident we can produce positive findings, albeit on a smaller scale.

Chet's scholarly project will also be focused on the essential elements that embody a successful leadership academy, particularly quality assurance, feasibility, and applicability for clinical managers to their own practice. There will also be an opportunity to assess the overall usefulness and effectiveness of our CAP curriculum, the program's speakers, and any identified key outcomes from participants' involvement. Chet's project also affords us an opportunity to enhance our traditional processes for leading change, while providing an innovative and personalized way to develop our leadership resources. If you have any questions please feel free to contact me anytime, thank you.

Best regards,

Bryan Erdman, MHA, Vice President Operating Team I

Beth Smith Houskamp, PhD, RN, Vice President Operating Team II, Chief Nursing Officer

Appendix E
Request for participant letter

Hello,

Leading change is challenging and requires specific, strategic skills to ensure you have successful outcomes. Through your clinical manager role you are expected to guide your teams through varying change on a daily basis. You may see this with targeting core clinical metrics, attempting to engage staff with a complex initiative, trying to make workflows more efficient, and endless other examples.

On a larger scale, there have been significant shifts in our healthcare industry, illustrated by reimbursement changes, greater focus on value instead of volume, and being more efficient. All require our clinical managers in our organization to be adaptable to managing and leading change. Additionally feeling confident with the hard and soft skills that accompany change is paramount and can be a core determinant to you having success or not.

Based upon that background, I invite you to participate in a leadership academy that is tailored your own professional development with leading change. The goal of this academy is to improve your change management skills, in turn improving your own self-confidence no matter the scale of change. Throughout this eight-week session you will receive individualized class training that connects theory and applicable practice. In addition, the academy will have a new and highly knowledgeable content expert each week that has real life industry experience leading change. We will be equipping you with specialized knowledge that was created and endorsed through the renowned General Electric (GE) Company.

GE created the Change Acceleration Process framework (CAP) and has empowered their own leaders with this knowledge to be transformative 'change agents.' The CAP will be our framework throughout this academy that will guide us through the different phases of learning. Although highly educational this academy is also geared toward being practical and result orientated. We realize your time is incredibly precious and we want to make sure you graduate from this academy with tangible skills and enhanced confidence leading change.

We will be surveying your participation with a highly validated survey that assesses your own self-confidence prior and post-test. This information will be generalized and shared with all participants following the academy so you can apply findings to your own growth. I request your consideration to participate in this study. If you have any questions please feel free to reach out me anytime.

Regards,
Chet Doering, DNP student
Email: chdoerin@gundersenhealth.org
Phone: 608-775-6037

The University of New Mexico Health Sciences Center
Consent to Participate in Research

Enhancing Clinical Manager Self-Efficacy through a Change Management Academy

June 3rd, 2016

Purpose and General Information

You are being asked to participate in a research study that is being done by Dr. Christine Delucas (Principal Investigator) and Dr. Kim McKinley (Co-Researcher), along with Chet Doering (Student Researcher). This research is being done to evaluate the effect a change management leadership academy has on the self-efficacy of clinical managers participating in the academy. The aim of this study is to improve clinical managers' confidence and skills in leading change efforts through the utilization of a formal leadership academy. You are being asked to participate because you are a clinical manager within this healthcare system and are responsible to lead change each day through your role. Approximately 35 people will take part in this study at

This form will explain the study to you, including the possible risks as well as the possible benefits of participating. This is so you can make an informed choice about whether or not to participate in this study. Please read this Consent Form carefully. Ask the investigators or study staff to explain any words or information that you do not clearly understand.

What will happen if I participate?

If you agree to be in this study, you will be asked to read and sign this Consent Form. After you sign the Consent Form, the following things will happen:

- You will be responsible to complete a pre-academy participation survey, specifically obtaining demographical information and assessing your own self-efficacy through the Generalized Self-Efficacy scale (pre-academy).
- Full participation and commitment to attending change management academy, 1 hour over 8 weeks long
- You will be responsible to complete a post-questionnaire survey, specifically obtaining demographical information and assessing your own self-efficacy through the Generalized Self-Efficacy scale (post academy).

- Opportunity to participate in an academy that equips participants with dynamical technical and interpersonal skills leading change.
- Opportunity to develop leadership skills specific to leading complex change, either at the department or system level

Participation in this study will take a total of 8 hours over a period of 8 weeks for the full academy.

What are the possible risks or discomforts of being in this study?
Every effort will be made to protect the information you give us. However, there is a small risk of loss of privacy and/or confidentiality.

How will my information be kept confidential?
Your name and other identifying information will be maintained in locked files, available only to authorized members of the research team, for the duration of the study. Additionally, all collected information will be stored via REDCap, an online surveying tool that ensures full security of data. Any personal identifying information and any record linking that information will be managed through the REDCap systm. Information resulting from this study will be used for research purposes and may be published; however, you will not be identified by name in any publications.

Information from your participation in this study may be reviewed by the primary investigator, co-researcher, student researcher, and by the UNM Human Research Review Committee (HRRC) which provides regulatory and ethical oversight of human research. There may be times when we are required by law to share your information. However, your name will not be used in any published reports about this study.

What are the benefits to being in this study?
There may or may not be direct benefit to you from being in this study. However, your participation may contribute to your own growth and leadership development leading change.

What other choices do I have if I don't participate?
Taking part in this study is voluntary so you can choose not to participate.

What will happen if I am injured or become sick because I took part in this study?
If you are injured or become sick as a result of this study, UNMHSC will provide you with emergency treatment, at your cost.

No commitment is made by the University of New Mexico Health Sciences Center (UNMHSC) to provide free medical care or money for injuries to participants in this study.

In the event that you have an injury or illness that is caused by your participation in this study, reimbursement for all related costs of care will be sought from your insurer, managed care plan, or other benefits program. If you do not have insurance, you may be responsible for these costs. You will also be responsible for any associated co-payments or deductibles required by your insurance.

It is important for you to tell the investigator immediately if you have been injured or become sick because of taking part in this study. If you have any questions about these issues, or believe that you have been treated carelessly in the study, please contact the Human Research Review Committee (HRRC) at the (505) 272-1129 for more information.

How will I know if you learn something new that may change my mind about participating?
You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

Can I stop being in the study once I begin?
Yes. You can withdraw from this study at any time without affecting your employment and current organizational status.

The investigators have the right to end your participation in this study if they determine that you no longer qualify to take part, if you do not follow study procedures, or if it is in your best interest or the study's best interest to stop your participation.

HIPAA Authorization for Use and Disclosure of Your Protected Health Information (HIPAA)
As part of this study, we will be collecting health information about you and sharing it with others. This information is "protected" because it is identifiable or "linked" to you.

Protected Health Information (PHI)
By signing this Consent Document, you are allowing the investigators and other authorized personnel to use your protected health information for the purposes of this study. This information may include: all information obtained through participation in the academy, including your pre-questionnaire and post-questionnaire submitted information.

In addition to researchers and staff at UNMHSC and other groups listed in this form, there is a chance that your health information may be shared (re-disclosed) outside of the research study and no longer be protected by federal privacy laws. Examples of this include disclosures for law enforcement, judicial proceeding, health oversight activities and public health measures.

Right to Withdraw Your Authorization

Your authorization for the use and disclosure of your health information for this study shall not expire unless you cancel this authorization. Your health information will be used or disclosed as long as it is needed for this study. However, you may withdraw your authorization at any time provided you notify the UNM investigators in writing. To do this, please send letter to them notifying them of your withdrawal to:

Dr. Christine Delucas, DNP, MHA, RN
MSC
1 University of New Mexico
Albuquerque New Mexico 87131

Please be aware that the research team will not be required to destroy or retrieve any of your health information that has already been used or shared before your withdrawal is received.

Refusal to Sign

If you choose not to sign this consent form and authorization for the use and disclosure of your PHI, you will not be allowed to take part in the research study.

What if I have questions or complaints about this study?

If you have any questions, concerns or complaints at any time about the research: Contact the PI through their contact information, degree of complaint, and someone will be glad to answer these questions. If you would like to speak with someone other than the research team, you may call the Human Research Review Committee (HRRC) at (505) 272-1129. The HRRC is a group of people from UNMHSC and the community who provide independent oversight of safety and ethical issues related to research involving human participants.

A description of this study clinical trial will be available on http://www.ClinicalTrials.gov as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of results. You can search this website at any time.

What are my rights as a research participant?

If you have questions regarding your rights as a research participant, you may call the Human Research Protections Office (HRPO) at (505) 272-1129 or visit the HRPO website at http://hsc.unm.edu/som/research/hrrc/.

Appendix G
GSE questionnaire

1. Are you a nurse clinical manager or non-nurse clinical manager?

- o Nurse
- o Non-Nurse

2. What is your age in years?

_____

3. What is the highest level of education you have obtained?

- o Doctorate
- o Master's
- o Bachelor's
- o Associate's
- o Diploma

4. How long have you been in your current role as a clinical manager at Gundersen Health System in years?

_____

5. How many years have you worked at Gundersen Health System?

_____

6. How many years have your worked in healthcare outside of Gundersen Health System?

_____

7. Have you ever participated in a formal leadership development academy?
- o Yes
- o No

*Additional questions for post test

1. Was the content you learned through this academy applicable to your development and growth as a leader?

- o Strongly Agree

o Agree
o Neutral
o Disagree
o Strongly Disagree

2. Overall were the presenters' style and delivery of education influential to your learning?

o Strongly Agree
o Agree
o Neutral
o Disagree
o Strongly Disagree
o

3. Do you feel you are more confident leading change at the intra-department level after completing the academy?
o Strongly Agree
o Agree
o Neutral
o Disagree
o Strongly Disagree

4. Do you feel you are more confident leading change at the inter-department level (e.g. system) after completing the academy?
o Strongly Agree
o Agree
o Neutral
o Disagree
o Strongly Disagree

5. Would you recommend a colleague of yours participate in this academy if offered again?
o Strongly Agree
o Agree
o Neutral
o Disagree
o Strongly Disagree

Appendix H

Budget	Resources	Cost
Initial planning meeting (1 hr.) **Meeting room** **Computer** **Supplies (e.g. paper, handouts)** **Lunch**	Break room Existing computer Supplies Project leader @ $50.00 / hr Clinical Manager @ $40.00 / hr. Office Assistant @ $18.00 / hr. Ordered lunch	No charge No charge $15.00 Salaried (exempt) Salaried (exempt) $18.00 $100.00
2nd meeting (1 hr.) **Meeting room** **Computer** **Supplies (e.g. paper, handouts)**	Break room Existing computer Supplies Project leader @ $50.00 / hr. Clinical Manager @ $40.00 hr. Expert consultant / speaker Office Assistant @ $18.00 / hr.	No charge No charge $15.00 Salaried (exempt) Salaried (exempt) Salaried (exempt) $18.00
3rd meeting (1 hr.) **Meeting room** **Computer** **Supplies (e.g. paper, handouts)**	Break room Existing computer Supplies Project leader @ $50.00 / hr. Clinical Manager @ $40.00 hr. Expert consultant / speaker Office Assistant @ $18.00 / hr.	No charge No charge $15.00 Salaried (exempt) Salaried (exempt) Salaried (exempt) $18.00
4th meeting (1 hr.) **Meeting room** **Computer** **Supplies (e.g. paper, handouts)**	Break room Existing computer Supplies Project leader @ $50.00 / hr. Clinical Manager @ $40.00 hr. Expert consultant / speaker Office Assistant @ $18.00 / hr.	No charge No charge $15.00 Salaried (exempt) Salaried (exempt) Salaried (exempt) $18.00
5th meeting (1 hr.) **Meeting room** **Computer** **Supplies (e.g. paper,**	Break room Existing computer Supplies Project leader @ $50.00 /hr.	No charge No charge $15.00 Salaried (exempt)

handouts)	Clinical Manager @ $40.00 hr.	Salaried (exempt)
	Expert consultant / speaker	Salaried (exempt)
	Office Assistant @ $18.00 hr.	$18.00
6th meeting (1 hr.) Meeting room Computer Supplies (e.g. paper, handouts)	Break room	No charge
	Existing computer	No charge
	Supplies	$15.00
	Project leader @ $50.00 /hr.	Salaried (exempt)
	Clinical Manager @ $40.00 hr.	Salaried (exempt)
	Expert consultant / speaker	Salaried (exempt)
	Office Assistant @ $18.00 hr.	$18.00
7th meeting (1 hr. wrap up) Meeting room Computer	Break room	No charge
	Existing computer	No charge
	Supplies	$15.00
	Project leader @ $50.00 /hr.	Salaried (exempt)
	Clinical Manager @ $40.00 hr.	Salaried (exempt)
	Office Assistant @ $18.00 hr.	$18.00
Total		$331 (* not finalized)