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Career Coaching: A Study of Veterans Health Administration (VHA) Leaders'

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Career Coaching: A Study of Veterans Health Administration (VHA) Leaders' Perspectives

A Dissertation by

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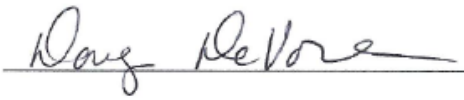

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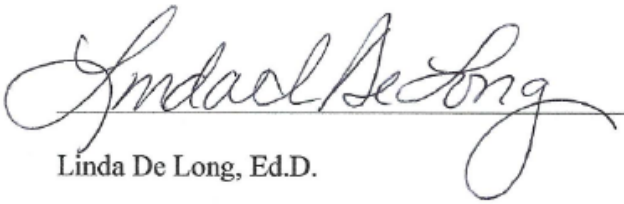

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ABSTRACT

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Purpose: The purpose of this qualitative multiple case study was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California.

Methodology: The researcher selected a qualitative multiple case study to explore and describe VHA leaders' perceived impact of coaching on their career performance growth and retention. Further, the researcher conducted semi-structured, interviews with 15 participants to gain a better understanding of the lived experiences of the participants at the institute they attended. The transcriptions from all interviews were analyzed using NVivo, a qualitative data analysis software used to organize and analyze interview responses to elicit themes from the participants' answers aligned to the 2 research questions in this study.

Findings: The data analysis resulted in 21 themes with 238 references across the 2 research questions. Six key findings emerged from the data relating to the VHA participants' lived experiences related to career growth and retention. The VHA participants identified personal growth as the crucial element relating to their career performance growth. The perception of leadership development was unanimously viewed as a significant influencer on employment retention within the VHA.

Conclusions: All participants (EL, LDI, and ECFD) perceived that individuals who are coached are equipped with personal development skills necessary to lead and coach others. All 15 VHA participants responded that recognition was an essential element for retention. Recognition proved to be a key ingredient in coaching for motivation, commitment, enthusiasm, and retention at the VHA. Leadership development was critical to career performance growth and retention of institute participants.

Recommendations: VHA should conduct studies that measure the benefits of incorporating aspects of coaching for entry-level employees to help navigate personal growth and development. Another recommendation is to replicate this study with a larger sample. The study would pay particular attention to gender differences in participants among the 3 different institutes. The study could be a longitudinal case study over a period of 5 years or more to provide expanded and meaningful long-range data on the topic of coaching within the VHA.

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CHAPTER I: INTRODUCTION

Career coaching is an invaluable tool in the workplace, but there is limited research available concerning coaching practices for leaders in healthcare organizations. Existing studies on coaching have primarily examined the effectiveness from the viewpoint of a coach or an employing corporation rather than that of the leader or coachee (Carter, Blackman, Hicks, Williams, & Hay, 2017). Previous studies on coaching have framed its purpose as a remedy for poor performance (Fournies, 1987). The more recent concept of coaching has moved beyond an emphasis on deficiency to a more developmental orientation in which coaching is considered to be a process for helping employees, especially leaders, expand their capabilities.

The subject of career coaching for leaders continues to be a growing field of research. Career coaching, as it relates to healthcare leaders, is more challenging than ever before (Numerof & Abrams, 2003). Furthermore, the tenure of a hospital CEO averages about three years (De Chant, 2016). The turnover rate for hospital CEOs is the highest of any field; according to Besheer and Ricci (2010), "The loss of a CEO can cost a healthcare organization $1.5 million in severance, recruitment expenses, and the new CEO's salary" (p. 44). Organizations today need to ensure that they are generating an effort to preserve their top talent and not disregarding them by assuming they are doing fine and do not require any feedback (Hagen, 2014). According to Hicks and McCracken (2009), McKinley (2004), and O'Toole, Cabral, Blumen, and Blake (2011), the need to expand coaching for healthcare leaders is vital. Coaching may be one useful strategy for healthcare organizations to reduce the high turnover rate of healthcare leaders and top

potential employees to include emerging leaders within an organization (Underhill, McAnally, & Koriath, 2007).

Healthcare leaders are required to promote, facilitate, and model changes in healthcare practices that improve quality and safety or save money. The urgent needs for coaching leaders in healthcare are to encourage the development of leadership skills aimed at addressing changes in healthcare (Stone et al., 2009). Healthcare organizations must continually develop the competencies of their leaders to improve efficiency and effectiveness. The effectiveness of healthcare organizations is increasingly reliant on leaders who are coached.

Coaching has proven beneficial in refining clinical practice and positively influencing quality healthcare delivery. Furthermore, the research suggests that transferred knowledge can intensify job satisfaction, performance, and effectiveness.

Background

Career-coaching terminology is widely used and varies across jobs. The different descriptions used extend coaching boundaries beyond the boardroom into individuals' personal lives (Liljenstrand & Nebeker, 2008). Career coaching is a form of training or teaching, frequently involving one-on-one support, aimed at improving the career performance of the person coached. Historically, career coaching carried a stigma associated with struggling employees requiring a trainer. With coaching's professional evolution and high profile, it is now relatively standard for successful employees to receive coaching to increase performance (Liljenstrand & Nebeker, 2008).

Bozer and Sarros (2012) published research based on long-term observations on the developmental use of career coaching, which has exposed some trends in the

workplace. One study revealed that more than $650 billion was spent in a year as a result of ineffective use of time in the workplace (Goldschein & Bhasin, 2011). Furthermore, with each passing year, the cost of ineffectiveness to organizations continues to grow. Another study indicated that the leading cause of unproductiveness in the workplace was the insufficient training of employees at all levels, including leaders (Ashe-Edmunds, 2017). Additionally, despite nursing shortages, rapid changes in healthcare systems, and the challenge of an aging workforce, the majority of healthcare organizations do not have leadership development programs in place (Whaley & Gillis, 2018). More importantly, studies on career coaching suggest a need to retain and prepare healthcare leadership. Career coaching for leaders has been adapted over the years to increase employees' effectiveness in carrying out their organizations' objectives. Bozer and Sarros (2012) observed that the trend has become widespread; in 2003, career coaching generated $1 billion worldwide, rising to $1.5 billion in 2007.

According to Witherspoon and White (1996), the word *coach* originated in the English language in the 1500s. The concept of coaching was first documented in the form of a personal instructor in 1848, and later in 1861, in an athletic context. Coaching is "the process of equipping people with the tools, knowledge, and opportunities they need to develop themselves and become more effective" (Peterson & Hicks, 1996, p. 14). Similarly stated, Witherspoon and White (1996) claimed that the basis used in the interpretation of the verb *to coach* is to take a valued person from where one was to where one desires to be. Although the initiation of the concept of coaching most likely came from the athletic sector, Kampa-Kokesch and Anderson (2001) admitted that it is not precisely clear when career coaching began.

Career-Based Improvement for Leaders

Salter (2013) studied the development of the leader's career, position, and the manner in which coaching helps with individual growth. According to Salter, "Leaders who participate in leadership coaching are often at a transitional point in their career, looking to develop in areas of new responsibility" (p. 75). Leadership coaching tends to open up doors and possibilities for promotions and advancement for leaders. Usually, leaders are focused on getting the right kind of connections and knowledge, which will help to boost their achievement of career goals. Therefore, coaching becomes a significant source of growth-based training. Views on career-based improvement suggest that the field of career coaching is vast and it tends to influence the growth and development of employees, especially leaders, in many different ways. The connection of shared knowledge and experiences results in expanded growth and development (Salter, 2013).

A pilot project conducted by Gurbutt and Gurbutt (2016) examined participants' reflections on coaching experiences. Conclusions from the project described coaching as a "real asset when used in an executive role as it ignites successful goal achievement, growth, learning, and development" (Gurbutt & Gurbutt, 2016, p. 89). The benefits of coaching were also seen in the healthcare field (Cummings et al., 2015). In many cases, Cummings et al. (2015) asserted that healthcare leadership needs to understand what is required of them—the goals and objectives and their obligation to achieve them in a specified amount of time. Cummings et al. studied the impact of coaching on healthcare workers and examined how coaching affected younger healthcare workers. According to the research, career coaching caused a significant change in the manner in which younger

healthcare workers conducted healthcare-based activities (Cummings et al., 2015). Moreover, younger healthcare workers were able to focus well on research-based interventions, a trend that significantly improved the outcomes of healthcare interventions (Cummings et al., 2015). Despite comparing different models of coaching, Cummings et al. did not examine the specific benefits of coaching among healthcare leaders.

Cummings et al. (2015) suggested that focusing on career coaching is especially useful for executives and may help to increase positive healthcare outcomes. Cummings et al. further worked to understand career coaching and its challenges and effects. Positive coaching impacts include effectiveness, better focus, and a workforce that is well motivated to execute the task that has been assigned to the coach. However, Cummings et al. suggested that there are drawbacks associated with a direct approach to coaching. In some cases, the straightforward approach may not be as openly received as most would expect, and, as a result, coaches could be viewed with negativity (Cummings et al., 2015). It takes an experienced coach to know what kind of approach is best for a given leader.

Coaching

Some experts in the field recognized that coaching focuses more on assisting emerging leaders and executives to become their best than on teaching new strategies and techniques (Witherspoon & White, 1996). Such coaching is arranged to aid high performers with a new challenge, encouraging them to discover opportunities and develop new behaviors. The practice of using coaches to enhance performance is now predominant in the business world (Gladis, 2007). Career coaching is a systematic

methodology that encourages a rigorous process of self-discovery and awareness. However, Gladis (2007) asserted that executive coaching promotes goal setting, accountability, action learning and execution, and evaluation to increase the quality of their leadership skills. Furthermore, based on the adult-learning theory framework, executive coaching fits well with the coaching process because the emphasis is on self-determination, self-actualization, and self-transformation of the learner (Gray, 2006).

Coaching Process

The career-coaching process is described as a systematic, goal-directed process to facilitate sustained change (Greene & Grant, 2003). The following five steps express the opinions of numerous researchers on coaching methods and goals.

1. Setting the foundation by defining the context, establishing the contract, and building a working alliance between the coach and the client (Liljenstrand & Nebeker, 2008; Natale & Diamante, 2005; Witherspoon & White, 1996).
2. Assessing the client, using conversations, data collection, and 360-degree assessment (Kiel, Rimmer, Williams, & Doyle, 1996; Lijenstrand & Nebeker, 2008; Witherspoon & White, 1996).
3. Strategizing the engagement and development plan to target areas for development (Liljenstrand & Nebeker, 2008; Natale & Diamante, 2005; Saporito, 1996).
4. Implementing the development plan to build competence, confidence, and commitment, while ensuring that actions achieve desired results (Liljenstrand & Nebeker, 2008; Natale & Diamante, 2005; Witherspoon & White, 1996).

5. Evaluating the intervention and reevaluating the preliminary target areas using feedback from the client's sponsor, human resources, and other internal resources (Liljenstrand & Nebeker, 2008; Witherspoon & White, 1996).

The research demonstrates that there is a clear-cut process for best practices in coaching. Following these steps results in multiple benefits of coaching. Many researchers asserted that career-coached employees, especially leaders, reported higher levels of purpose, respect, goal achievement, and confidence (Cascio & Boudreau, 2008; Hunt & Weintraub, 2007). Similarly, Greenawald (2017) contended that there was a distinct advantage that came from the use of a coach. Consequently, effective coaching—whether internal or external—was cited as one of the most critical functions leaders received because it communicated clear performance levels and expectations, outlined the importance of the tasks and responsibilities, and established a caring attitude from a critical friend (Greenawald, 2017).

Value of Coaching

Coaching is building the self-belief of others (Whitmore, 2009). Understanding employees' needs, wants, and ability to adapt to their surroundings, based on the information they get, is critical to the job function of leaders. Equally important is that a leader does not ignore the aspect of self. Leaders who are coached should know themselves and have some self-awareness on the kind of impact they have on their employees (Salter, 2013). Based on the ideas of the International Coach Federation (ICF, 2017), coaching improves leadership performance dramatically and enhances communication skills and public speaking by empowering leaders and emerging leaders with renewed confidence. Also, coaching helps employees and leaders navigate

organizational politics by fine-tuning listening skills and assisting employees to accept feedback from colleagues (ICF, 2017).

Types of Coaching

Multiple types of coaching can be found in the literature. For example, the field of life coaching had roots in psychology and was designed to offer guidance and advice to assist people in navigating personal growth and development (Kimsey-House, Kimsey-House, Sandahl, & Whitworth, 2011). Relevant to this study were career coaching and executive career coaching.

Career coaching. According to Jenson (2016), career coaching is a training process that has been used to equip emerging leaders with the right kind of knowledge for the workplace in such a manner that they will embrace any form of change. Whitmore (2009) stated that some concepts often associated with coaching are performance, skill enhancement, and unlocking potential. Delaney (2012) asserted that coaching incorporates goal setting and giving feedback. These two authors provided a broader understanding and approach to career coaching and its goals in general.

Executive career coaching. Executive coaching is a more nuanced field of career coaching. In these instances, the coaches are typically current or former executives themselves and work with newly promoted executives as they transition into the highest levels of leadership roles (Hayes & Kalmakis, 2007). In recent years, the subject of executive coaching has been discussed extensively in the literature (Garman, Whiston, & Zlatoper, 2000). Moreover, current trends have seen the use of training in work areas with the goal of trying to improve the effectiveness of employees as they strive to achieve

their aims. Jenson (2016) examined the idea of workplace coaching and the manner in which it has been used to have an impact on the growth of employees in the workplace.

Formats of Coaching: Internal and External

Fielden (2005) examined the differences between the internal and the external coaching experiences and the ways each affected the organization as a whole. According to Fielden, coaching is vast, and the varied approaches to coaching can be used only if the coach is impartial. There are instances where coaches need to come from outside the organization. Such coaches are expected to perform specific duties, including providing feedback to the team, particularly in case of a potential conflict of interest (Fielden, 2005). The functions of the external coach will differ from those of the internal coach. However, assignments from both the internal and the external coaches will aim at improving the effectiveness and the efficiency of the output of the employees.

Internal coaching. Internal coaches have been tasked with ensuring that they help employees understand the internal frameworks of the organization (Fielden, 2005). Internal coaches provide quick and cost-effective solutions. The internal coach will give employees an understanding of the organization's values and ensure that the organization can keep the cost of consultation low. Internal coaches ensure that consulting time is not seen as a commodity or trade. Some types of coaching undertaken by internal coaches include performance coaching, career development, leadership development, and transition (St. John-Brooks, 2014). Understanding the overall approaches used by organizations to embrace internal career-based coaching helps to clarify the different levels of competence that influence how employees tend to measure up to these competencies (Fielden, 2005).

External coaching. Fielden (2005) noted that "external coaches are most useful when there are highly sensitive or private issues that need interpretation within the relationship, or when an extensive or diverse experience is required" (p. 10). External coaches provide a broad set of knowledge. The use of external coaching has been found to be one of the fastest-growing interventions in the professional development of leaders (Gray & Goregaokar, 2007). The Executive Development Association (EDA) focused on executive development programs and coaching that help organizations develop skills needed to attain strategic goals. EDA found that empowering others, through coaching leaders, was the newest theme for executive development (Hagerman & Chartrand, 2009-2010).

Leadership

According to Northouse (2013), "Leadership is defined as a process whereby an individual influences a group of individuals to achieve a common goal" (p. 5). Similarly Burns (1978) defined leadership "as the reciprocal process of mobilizing, by persons with certain motives and values, and economic and political resources, in a context of competition to realize goals mutually held by both leaders and followers" (p. 425).

According to Hernon and Rossiter (2006), leadership includes the understanding of a number of traits and a capacity to employ different leadership styles. More so, leadership styles are important factors in the interactions between leaders; and leadership styles play a crucial function in facilitating positive organizational relations in team building (Darling & Heller, 2012).

Northouse (2013) addressed some of the most prominent leadership styles, which are servant, transactional, and transformational. Consequently, Hersey and Blanchard

(1969) asserted that there is no one best leadership style that addresses all situations; successful leaders are those who are able to modify their leader behavior to meet the requirements of their followers and a specific situation. First, Greenleaf (1970), who coined the term *servant leader*, described the servant leader as an individual who possesses the following characteristics: (a) good listening, (b) empathy, (c) awareness, (d) emotional healing, (e) conceptualization, (f) persuasion, (g) commitment to the growth of people, (h) building community, (i) stewardship, and (j) foresight (Northouse, 2013). According to Greenleaf (1970), the servant leader shares power, puts the needs of others first, and helps people develop and perform as highly as possible. Servant leadership rotates the leadership influence of the pyramid upside down; rather than the people working to serve the leader, the leader stands ready to serve the people (Greenleaf, 1977).

Secondly, Burns (1978), a pioneer in the field of leadership studies, advanced the transactional leadership theory. His book entitled *Leadership* laid out the elements of transactional leadership. Consequently, Burns asserted that, "transactional leadership style is characterized by rewards for compliance and punishment for not getting commitment" (p. 6). Ingram (2018) contended that transactional leadership styles are more engaged with maintaining the normal discharge of operations. Transactional leadership can be described as "keeping the ship afloat" (para. 2). Transactional leaders exercise disciplinary power and a range of incentives to motivate employees to perform at their best (Ingram, 2018).

Lastly, Burns (1978) stated that transformational leadership happens when one or more persons connect with others to such a degree that leaders and followers raise one

another to a greater level of motivation and morality. Transformational leaders' intention is to develop individual's potentials, abilities, and skills (Gilitinane, 2013). The "transformational leadership style depends on high levels of communication from management to meet goals" (R. Johnson, 2018, p.1).

Leadership in Veterans Hospitals

The U.S. Department of Veterans Affairs (VA) is the second largest federal agency, employing over 312,800. Its mission is to "fulfill our Nation's enduring commitment to Veterans" (Cournoyer, 2015, pp. 1-2) by providing benefits, healthcare, and other services. The Veterans Health Administration (VHA) is a complex healthcare group, providing care for severely ill or injured veterans. Adding to the complexity are the ever-changing needs of veterans serving in different conflicts. For example, high infection rates were a recognized need among Vietnam veterans; however, more recent needs of veterans from the wars in Iraq and Afghanistan are the treatment for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD; Cifu, Scholten, & Campbell, 2013).

As a large and complex organization, the VHA relies on two levels of leadership to meet the needs of veterans: the executive leaders and emerging leaders. The executive leaders serve as strategic planners and set the vision and goals for the hospital. Emerging leaders oversee the day-to-day operations and ensure the execution and delivery of services.

The VHA has expressed its commitment to organizational transformation and developing emerging leaders (U.S. Department of Veterans Affairs [VA], 2016). Emerging leaders have the potential for career growth and promotion. The VHA

increased its focus on the development of current and future leaders by providing different coaching and leadership training opportunities. Following are the three primary types of leadership development programs:

- *Emerging Leaders (EL)* is a comprehensive VHA program designed to identify employees who have an interest in career development and have demonstrated leadership potential. Applicants selected for this program are involved in orientation of leadership, performance improvement projects, coaching and broad spectrum of developmental experiences over 12 months.
- *Leadership Development Institute (LDI)* is a long-standing 1-year leadership development program, which is vital to the VHA system. The program is designed to identify and prepare future VHA leaders. Selected applicants participate and are engaged in leadership orientation, coaching, and development for a full year (Petzel, 2013). Applicants are expected to complete a project that will benefit VHA facilities and contribute to improving the care of veterans.
- *Executive Career Field Development (ECFD)* is a yearlong program designed for career development of executive leaders. ECFD involves a rigorous selection process aimed at accepting the highest caliber candidates. Trained individuals assume VHA's most challenging executive assignments.

EL, LDI, and ECFD target all levels of personnel within the VHA planning for critical staffing positions. The leadership skills obtained from one of these programs may assist with building a pool of skilled candidates able to fill future leadership positions. Providing various levels of leadership development within the VHA may afford more employees aspiring leadership opportunities. The need for securing future leaders is

critical due to the exodus of baby boomer leaders retiring from executive leadership (Besheer & Ricci, 2010).

The health sector workforce projections are, in fact, quite staggering: A 2009 survey conducted by Health Leaders Media Industry reported that nearly 75% of healthcare organization CEOs would be retiring in the next 10 years. In a similar report published by Runy (2008), more than 60% of nurse leaders will be making a job change, and 25% will be retiring completely. The immediacy of the situation implies that some healthcare organizations face the prospect of losing up to 50% of their leadership to retirement in the next 10 years. At the top of the executive hierarchy, the loss of a CEO can cost a healthcare organization $1.5 million in severance, recruitment expenses, and the new CEO's salary (Besheer & Ricci, 2010).

The necessity of preparing employees who will likely become the future leaders has never been greater. Moreover, keeping competent individuals in the organization has become an important task (Yamamoto, 2013). Within the VHA, only a select number of available leaders, however, are accepted to participate in leadership coaching in EL, LDI, and ECFD training programs. For example, there are 22,000 employees currently on staff at the Southern California VHA. On average 12 employees per year for the past 5 years have received leadership training. Statistically, this equates to merely 1.5% of staff who receive coaching and grooming for leadership; however, the needs for coaching are growing as a result of the anticipated retirement of the baby boomers (Besheer & Ricci, 2010).

The use of internal coaching at the VHA. The VHA's leadership development methods demonstrate a belief in a combination of both internal and external coaching.

Internal coaches are sought, due to being knowledgeable about the VHA's organization, culture, and policies. The internal coach may communicate organizational information to include budget-related changes and leadership changes.

The use of external coaching at the VHA. Internal coaches are likely to have to deal with more ethical dilemmas than external coaches. External coaches are more objective and unbiased (St. John-Brooks, 2014). The external coach is primarily providing consultation. On the other hand, there is a necessity for peer coaching, a need best met by internal coaches.

Connecting internal and external coaching for a positive change. Research demonstrates that internal and external coaches affect positive change in the effectiveness and efficiency of employee activity; their strengths and weaknesses, however, differ significantly (Fielden, 2005). Both internal and external coaching services are used for developing future VHA leaders, selected from EL, LDI, and ECFD coaching programs. Fielden (2005) asserted that directing attention or enhancing performance and the development of skills is essential to an effective coaching relationship.

Problem Statement

Healthcare leaders in the VHA need to have a positive impact on the workplace. The VHA needs to continuously improve employee performance and leadership's commitment to the organization. One strategy to bring about positive change in leaders' development is coaching.

Experts agreed that leadership coaching could influence employee satisfaction (Ellinger, Ellinger, & Keller, 2003; Elloy, 2011; Lok & Crawford, 2004). Other studies indicated that efficient organization and leadership behavior could intensify employee

satisfaction with a supervisor (Bass & Bass, 2009; Ellinger & Bostrom, 1999; House, 1996; Noelker, Ejaz, Menne, & Bagaka's, 2009; Northouse, 2013). Organizations have seen an increased enthusiasm for coaching as employees seek to develop and enhance their personal experience in primary areas of interest (Greenawald, 2017). In a changing world, coaching has become a remarkable phenomenon. Coaching is a valuable strategy for the change and development processes of organizations (Bennett & Bush, 2009). The problem of career coaching for healthcare leaders unfortunately is that coaching has not been viewed as a priority among many senior executives in healthcare organizations (Hays, 2008; Starcevich, 2001).

The VHA has experienced this same trend. A limited number of VHA leaders are admitted for coaching and leadership development in the VHA's highly competitive EL, LDI, or ECFD programs (Petzel, 2013). Coaching may be a valuable method to improve and expand leaders' skills and in directing leaders' development (Ellinger & Bostrom, 1999). Coaching may also aid in increasing the performance and retention of leaders (Wallis & Kennedy, 2013).

Purpose Statement

The purpose of this qualitative multiple case study was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California.

Research Questions

The central research question guiding this study was, What is the perceived impact of career coaching on the job performance growth and retention of emerging

healthcare leaders who have attended leadership professional development institutes at VHA hospitals in Southern California? The following were the subquestions of the study:

1. What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?
2. What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at a VHA hospital in Southern California for a minimum of 1 year?

Significance of the Study

Career coaching for leadership has been shown to have a myriad of benefits for organizations such as the VHA (McDermott, Levenson, & Newton, 2007). Changes noted as a result of career coaching include transformations in productivity, quality, organizational strength, retention, customer service, and profitability (McNally & Lukens, 2006). Moreover, coaching supports creativity, breakthrough performance, and resilience, giving organizations an efficient way to flow and operate within an environment of continuous change (Cacioppe, 2012). Coached employees are more committed to and invested in the outcomes of their work and achievement of organizational goals (Cacioppe, 2012).

Leaders have been shown to be a driving force, promoting and sustaining change within organizations (D. Anderson & Ackerman-Anderson, 2010). Coaching is an essential strategy for the modification and development processes of organizations

(Bennett & Bush, 2009). As the VHA and other healthcare organizations throughout the nation strive to develop exemplary leaders, findings suggest an almost 6:1 return on investment from individuals receiving executive coaching (McGovern et al., 2001).

To successfully operate increasingly complex healthcare organizations such as the VHA, leaders in the healthcare industry need to acquire and demonstrate new competencies. Research shows the effectiveness of career coaching in teaching such skills (Henochowicz & Hetherington, 2006). Retention is critical as it offsets employee replacement costs and reduces the indirect costs related to decreased productivity. As a result, career coaching aims to support employees, especially emerging leaders, leadership professional development, and satisfaction, which may be a factor in retaining valued employees. Therefore, an urgent need exists for leaders to use plans and tools aimed at increasing the levels of employee productivity to improve organizational success (D. Anderson & Ackerman-Anderson, 2010).

Furthermore, research shows that leaders must understand the issues that underlie the current trends in healthcare to include career coaching as a critical leadership and organizational competency (Numerof & Abrams, 2003). As the baby boomer generation of leaders retires, there will be a greater need to develop the next generation of leaders. The results of this research have the potential to provide current and future VHA healthcare leaders much-needed information to better understand the impact career coaching has on developing future leaders. Since the VHA only currently assigns 1.5% of its emerging leaders to professional development coaching institutes, this study may influence these healthcare organizations to begin to require a higher percentage of emerging leaders to participate. Local, state, and national healthcare policymakers may

find this study useful in establishing support for career coaching of 21st-century healthcare leaders.

Definitions

The following terms are relevant to this study. Definitions are based on blending information from numerous research studies, books, and articles about leadership coaching in the field of healthcare.

Adult learning theory (ALT). Principles that are applied to adult learning involve adults in the planning and evaluation of their instructions.

Career coaching. Mujtaba (2007) asserted that career coaching is a continuous process of conversational collaborations and connections designed to support others to unlock and realize their full potential at a pace appropriate for the individual being coached.

Coach. It is a widely used term with various meanings, depending on the situation. The term *coach* typically refers to methods of helping others to improve, develop, learn new skills, find personal success, and achieve aims, and to manage life changes and particular challenges.

Coachee. Someone, who receives training or support from a coach.

Emerging leader. Emerging leader is an identified employee who has an interest in career development and has exhibited leadership potential. According to Corso (2015), emerging leaders are flexible high-potential frontrunners possessing complete confidence in their abilities—these individuals know what career path to pursue and are confident they will reach their goal and continue to advance in their career.

Executive coaching. Executive coaching is an individualized, structured, confidential process of providing purposeful support to another individual in an executive leadership role to help him/her clarify or to achieve goals. It is not training, therapy, or mentoring (Ennis, Otto, Goodman, & Stern, 2012; Hargrove, 2008).

Executive leader. Executive leader is the ability of those who lead employees in the organization to influence and guide these individuals, fulfilling organizational goals, strategic planning development, and overall decision making.

Healthcare organization. Universally refers to a sizeable hospital or system that provides a broad range of acute care and supplementary services (Olden, 2015).

Job effectiveness. Perceived job effectiveness is influenced directly by knowledge sharing, cooperative attitude, and the ability to be able to achieve one's intended objectives (Kondalkar, 2013).

Job performance. The work-related activities expected of an employee and how well those actions are executed.

Leader. The leader is the person who leads or commands a group, organization, or country.

Servant leader. Focused largely on the development and interest of people and the communities to which they belong. It is a viewpoint and set of practices that enrich the lives of individuals and organizations and, ultimately, produces a more just and caring world (Greenleaf, 1977).

Situational leader. Situational leadership is an adaptive leadership style. This strategy motivates leaders to take stock of their team members, weigh the many variables

in their workplace and choose the leadership style that best fits their goals and circumstances (Hersey & Blanchard, 1977).

Supervisor. A person in the first line of the organization; a supervisor could also be an emerging leader. Supervisors monitor and regulate employees in their performance of assigned or delegated tasks and are usually authorized to recommend and affect hiring, disciplining, promoting, punishing, rewarding, and other associated activities regarding the employees in their departments.

Transactional leadership. A transactional leader is determined by achieving short-term goals and performing tasks correctly and to requirements. This type of leader does not drive change but, rather, follows established protocols and procedures. Transactional leaders are still generally found in the military and large corporations where rules and regulations dominate (Bass, 1985).

Transformational leadership. Transformational leadership is characterized by the engagement of a leader with his or her followers, focused on changing goals, values, and performance of all parties (Northouse, 2013).

Delimitations

This study was delimited to purposefully selected healthcare emerging and executive leaders at VHA hospitals in Southern California. The leaders represented graduated from EL, LDI, or ECFD institutes within the past 5 years. These leaders received coaching for a minimum of 1 year through internal coaches or external consultant coaches.

Organization of the Study

This study is structured into five chapters, including the introduction, literature review, methodology, data analysis, and conclusion chapters. An elaboration of historical information and current research that provides a foundation and theoretical framework for this study follows in Chapter II. Chapter III describes the process the researcher used to collect data for this study. Chapter IV provides an analysis of the data collected and a narrative of the findings. Chapter V summarizes the entire research, offers conclusions, implications, and makes recommendations for future research. References and appendices are included as documentation of the research processes.

CHAPTER II: REVIEW OF THE LITERATURE

The job of a healthcare leader has evolved into a complicated, highly political position requiring a myriad of skills and competencies (American Hospital Association, 2015). Currently, healthcare organizations are struggling to appoint and retain these healthcare leaders due to high turnover rates and a shortage of qualified and experienced candidates. Once on the job, many healthcare leaders are accountable for every aspect of the medical facility, which includes establishing an overall vision, management of organizational operations, supervising staff, maintaining facilities, monitoring safety issues, developing and executing a comprehensive budget, and developing and evaluating programs.

At the same time, healthcare leaders engage in challenging human resources and personnel issues, including negotiating with unions. Further, healthcare leaders are spending significant time with agencies outside of the organization to coordinate resources. Additionally, healthcare leaders are tasked with meeting state and federal guidelines. These healthcare leaders communicate with all stakeholders, understanding the political atmosphere, and, most importantly, assuring patient access and quality care (Buchbinder & Shanks, 2012).

It is also important to realize, in this era of continual healthcare reform, that healthcare leaders are charged with leading and implementing transformational change. At the same time, healthcare leaders must respond to the unique operational and budgetary needs of their local organizations. Often, these two obligations are not compatible (Kaufman et al. 2017).

Historically, advancement to leadership positions in healthcare was based on the candidate's academic or clinical accomplishments, with no expectation of knowledge about finances, team building, communication skills, and emotional intelligence (Sonnino, 2016). Moreover, healthcare leaders were uniquely employed without the protections of the union or the expectation of a long tenure. Additionally, healthcare leaders reported a lack of training or too few career coaching opportunities. Consequently, most leaders stepped down from their positions prematurely because of work overload, pushing them to the brink of exhaustion and decreasing job satisfaction (Fields, 2011).

One strategy to specifically support the needs of and preparing for future healthcare leaders would be to provide leadership coaching. Effective leadership is about establishing direction and helping individuals to achieve. The development of healthcare leaders can be exercised to include leaders and emerging leaders. Boyatzis, Smith, and Blaize (2006) asserted that to sustain effectiveness requires leaders to emphasize coaching as a crucial part of their role and behavior.

Healthcare leaders need support and coaching. Surprisingly, very few healthcare leaders conveyed receiving coaching as a form of career and leadership professional development. Recently Le Comte and McClelland (2017) conducted a mixed-methods study on senior leaders, using semi-structured interviews to assess the value and impact of leadership development and coaching programs. The findings suggested paucity in the literature on the impact value of coaching programs for healthcare leadership development.

This chapter provides an overview of the relevant literature for this study and includes a thorough examination of the history of the U.S. Department of Veterans Affairs, Veterans Health Administration (VHA), its evolution, and definitions of leadership and coaching. In this chapter, an overview of the context of the VHA is provided. This is followed by a thorough review of leadership development theory including sections specific to leadership in healthcare, which includes the VHA. Next, the topic of coaching is discussed, which includes the roles and different types of coaching. The chapter concludes with a summary of coaching emerging leaders within the VHA organization and explores the benefits and value of coaching.

History of the VHA

The foundation of the VHA can be traced back to the pilgrims of Plymouth Rock in 1636 (U.S. Department of Veteran Affairs [VA], 2018). As the result of the war with the Pequot Indians, the pilgrims passed a law to ensure that the colonies would care for disabled soldiers. By World War I, veterans benefits were being led by three federal departments: the Bureau of Pensions and Internal Administration, the Veterans Bureau, and the National Hospital for Disabled Soldiers.

During the 20th century, the federal government recognized that the delivery of veterans benefits needed restructuring. As a result, by 1930, the outcome was a consolidation of all programs that provided service to war veterans (U.S. Department of Veteran Affairs [VA], 2013). The VHA replaced the Veterans Bureau in March 1989. The VHA is recognized as the most comprehensive system of assistance for veterans of any nation in the world (VA, 2013).

It is crucial to understand VHA leadership and coaching of emerging leaders; considering that half of all U.S. doctors have acquired a portion of their medical training at the VHA. However, it is also important to understand that many of these doctors went on to lead their organizations, although there was limited training and coaching offered on leadership development at the VHA (VA, 2013). Unfortunately, limited literature exists regarding a VHA leadership development model. Most of the literature that exists focuses on quality control and nursing; each of those two areas is important, but little attention has been given to the subject of VHA leadership in general.

In the 2010 article "Executive Coaching: Leadership Development in the Federal Government," Richard Koonce observed that while executive coaching is commonplace and is considered a leadership development instrument in the corporate world, that is not the case in the government sector. Koonce (2010) pointed out that training programs within the federal government are inconsistent among federal government agencies for staff. Also, those already serving in leadership roles in the federal government rarely, if ever, receive executive coaching when compared to their counterparts in the corporate world (Koonce, 2010). The scope of leadership responsibilities in the VHA organization necessitates a firm understanding of its leadership training needs. It is time for scholars to begin filling the gap in the literature. This study only partially fills the gap in the observational record surrounding the impact coaching may have on the development of its emerging leaders in the VHA.

History of Leadership Development

This section introduces the history of leadership through the studies that influenced the field of leadership over time. The concepts defining effective leadership

changed dramatically throughout the years depending on the period of history and the field.

History of Leadership Styles and Theories

Hersey and Blanchard (1969) asserted that there "was no one best style of leadership; most successful leaders are the ones who can match their style to a given situation" (pp. 26-34). Situational leadership consists of four general styles, which include coaching, directing, delegating, and a supporting style. For this study, the type of situational leadership style examined was coaching.

McCleskey (2014) contended that the study of leadership spanned more than 100 years. Around the first 3 decades of the 20th century, the definition of leadership appeared to emphasize control and centralization of power and intermutual themes. Leadership was defined as "the ability to instill the will of the leader on those led" (Moore, 1927, p. 124). Yukl and Van Fleet (1992) summarized that there were a variety of leadership theories offered over the past several decades: great man theory (1840s), trait theory and group theory (1930s-1940s), contingency theory (1960s), transformational theory (1970s), and emotional intelligence theory (1990s).

Great Man Theory

The great man theory was the earliest leadership theory to be studied. Thomas Carlyle popularized the great man theory, in the 1840s. The great man theory of leadership saw great leaders as those destined at birth to become a leader. The great man theory of leadership asserts that some individuals are born with the indispensable qualities that place them apart from others assuming positions of power and authority.

The theory suggests that those in power deserve to be there because of their special qualifications (Northouse, 2013).

Trait Theory

By the 1930s and 1940s, there were two types of leadership theories in practice: group and trait. The trait theory in the 1930s assumed that great people are born with certain traits that make them great leaders (Northouse, 2013). Leadership traits associated with the trait theory were intelligence, self-confidence, determination, integrity, and sociability (Northouse, 2013). One's traits became the focus of defining leadership. Later in the 1940s, leadership was defined as the behavior of an individual involved in directing group activities (Hemphill, 1950). Then, leadership by persuasion was distinguished from leadership by coercion (Copeland, 1942).

Three themes influenced leadership's definition during the 1950s. First, leadership continuance of group theory outlined leadership as what leaders do in groups. The next themes that influenced the leadership definition during the 1950s included leadership as a relationship to incorporate shared goals. Another essential theme during the 1950s was the leader's ability to influence group effectiveness (Northouse, 2013).

Next, leadership in the 1960s was expanded and defined as a relationship with employees focused on developing shared goals. The prevailing definition of leadership as behavior that influences people's performance toward shared goals was highlighted by Seeman (1960) who described leadership as "an act by persons who influence other persons in a shared direction" (p. 53).

Contingency Theory

During the 1960s, contingency theories also put forth the idea that the success of a leader hinged on the specific situation at hand. Those factors included the task and personality of the leader and the composition of the group to be guided. Its underlying assumption was that leadership—success or failure—is situational. Some different sub-theories fall under the general contingency topic. They include Fiedler's contingency theory, the situational leadership theory, the path-goal theory and the decision-making theory (Fiedler, 1964).

During the 1970s and 1980s, the most important concept of leadership emerged when Burns (1978) asserted that "leadership [is] the reciprocal process of mobilizing a person to realize goals" (p. 425). Throughout this decade, scholarly and general work on leadership exploded. Leadership themes during the 1970s and 1980s included influences, traits orientation, and transformation.

Emotional Intelligence Theory

During the 1990s, the emotional intelligence (EI) leadership theories included the idea that EI is an ability to monitor one's own and other's feelings and emotions and to use this information to guide one's thinking and action (Salovey & Mayer 1990). Similarly, Goleman (2000) asserted that effective leaders are alike in that they all have a high degree of EI. With regard to EI, research promoted the concept that EI can be developed and learned, so organizations have the opportunity to use this concept to train future leaders.

Transformational Theory

By the 21st century, leadership approaches included authentic leadership, spiritual leadership, servant leadership, adaptive leadership, and transformational leadership (Northouse, 2013). During this era, leadership scholars agreed that no universal definition for leadership was dominant; however, leaders might take an idea from several researchers depending on the context of their organizational culture.

Over time, however, a significant portion of leadership literature and research focused on transformational leadership. A transformational leader's emphasis directed toward the organization and his or her behavior builds follower commitment toward organizational objectives (Bass & Bass, 2009). Institutions in which transformational leadership can be most effective include business, military, industrial, hospital, and education. Table 1 is an illustration of the historical leadership theories developed from the early 1900s through today.

Table 1

Historical Conceptualization of Leadership

Year	Conceptualization of leadership
1900-1929	Control and centralization of power (Moore, 1927).
1930s	Trait theory and interaction with personalities in a group.
1940s	The behavior of an individual involved in directing group activities (Hemphill, 1950).
1950s	Three themes dominated leadership definition during this decade: Group theory, leadership as a relationship that develops shared goals and effectiveness.
1960s	Influencing behavior (Seeman, 1960).
1970s	Initiating and maintaining groups or organizations to accomplish group and organizational goals.
1980s	Influence and transformation (Burns, 1978).
21st century	Multitude of leadership definitions (Rost, 1991) and transformational leaders.

Note. Adapted from *Leadership for the Twenty-First Century*, by J. C. Rost, 1991, pp. 2-4. New York, NY: Praeger.

Leadership Development Programs Today

Currently, leadership development programs incorporate self-development activities framed for leaders, emerging leaders, and executive-level employees aimed at developing leadership expertise and behaviors required to deal with a variety of circumstances. Boyce, Zaccaro, and Wisecarver (2010) asserted that leadership development programs extend beyond formal curriculums to include developmental job assignments, 360-degree feedback, executive coaching, self-directed studies, training, and career experience. Several researchers agreed that although these methods may occur independently, they are more efficient in combination (Boyce et al., 2010; Day, 2000). Additionally, Sonnino (2016) asserted that a combination of early, mid, and late career development represented the optimal training periods in a leader's career as an effective leader.

Based on the findings of Kouzes and Posner (2007), views on leadership development illustrated leadership development as 10 commitments within a model that is structured in what these researchers termed as five practices. These researchers concluded that the five practices and 10 commitments depicted in Table 2 could assist individuals to become more effective leaders by practicing real leadership skills (Kouzes & Posner, 2007).

Kouzes and Posner's (2013) work on commitments and practices is used in many organizations. The VHA incorporates many of the values of Kouzes and Posner's work on commitments and practices as a part of the leadership development training in Emerging Leaders (EL), Leadership Development Institute (LDI), and Executive Career Field Development (ECFD). Kouzes and Posner asserted that "exemplary leaders search

for opportunities by seizing the initiative and looking outward for innovative ways to improve, constantly generating small wins and learning from mistakes" (p. 27).

Table 2

Practices and Commitments Model

Five practices	Ten commitments
Model the way	1. Find your voice by clarifying your values. 2. Set the standard by aligning actions with shared values.
Inspire a shared vision	3. Envision the future by imagining exciting and ennobling activities. 4. Enlist others in an accepted vision by appealing to shared aspirations.
Challenge the process	5. Search for opportunities by seeking state-of-the-art ways to change, grow and advance. 6. Research and take risks by constantly generating small wins and learning from mistakes.
Enable others to act	7. Cultivate collaboration by promoting cooperative goals and building trust. 8. Strengthen others by sharing power and discretion.
Encourage the heart	9. Acknowledge contributions by showing appreciation for individual excellence. 10. Celebrate the values and victories by creating a spirit of community.

Note. Adapted from *The Leadership Challenge*, by J. M. Kouzes and B. Z. Posner, 2007. San Francisco, CA: Jossey Bass.

Kouzes and Posner's (2007) practices and commitment model are used in VHA leadership training or can be observed in selected programs the VHA uses for leadership development. The five exemplary practices and commitments of Kouzes and Posner's leadership model provide development of leaders through coaching processes focused on the development of leadership skills.

Furthermore, leadership development, broadly defined, concentrates on the development of multiple individuals (Day, Fleenor, Atwater, Sturm, & McKee, 2014). A leadership development skill, as explained through Kouzes and Posner's (2007) practices and commitments model, allows people to build solutions to problems. Ideally, leadership development would include an intrinsic curriculum of general, comprehensive

concepts presented with diverse methodologies, including didactic teaching, coaching, and experiential leadership opportunities.

Sonnino (2016) recommended that leadership development programs focus in addition on the following competencies: Finances and economics, strategic planning, personal and professional development, adaptive leadership, conflict management, time management, ethical considerations, work-life balance.

While Kouzes and Posner's (2007) concepts can be found in VHA leadership development programs, these leadership concepts explored by Sonnino (2016) are very relevant to the work of the leadership profession in the healthcare industry. As a result, leadership development is a multifaceted and complicated topic (Day et al., 2014). Leadership development is not a natural process and outcomes are built incrementally over time (Day et al., 2014). Growing future leaders is a long-term quest that requires both planning and action. It is essential to ensure the development of skills and competencies needed for success. The development of healthy workplaces that are responsive to the ever-changing healthcare environment is vital (Kouzes & Posner, 2007).

Leadership Development in Healthcare and the VHA

Today three styles of leadership are widely recognized in healthcare, each with its definition: transactional, transformational, and servant. Leadership development in healthcare was started primarily as internal institutional curricula, with a limited opportunity, for the development of faculty or practitioners (Sonnino, 2016). Philosophies on healthcare leaders have progressed over the decades. Before the 21st century, doctors were at the forefront and led healthcare organizations. During this same

time, an insignificant number of collateral administrators supported physicians. By the 1990s, with the rise of regulation and administration, the composition of healthcare administrators changed; of the 6,500 hospitals in the United States, only 235 were led by physicians (Gunderman & Kanter, 2009).

Leadership Styles in Healthcare Industry

During the early 1960s, leadership in hospital environments transformed based on a strong influence, due to the emergence of practices within the Canadian health organizations, which bolstered leadership. The post-World War II construction boom influenced leadership during this timeframe. Leadership was impacted by the developing professional unions in the clinical profession and the resultant and conflicted labor relations of the 1960s and 1970s. The environment of leadership was in those days predominantly a transactional style. Each of these types of leadership has its place in healthcare; however, a transformational and servant leader is more likely to help the institution advance and transactional leaders are most likely to maintain the existing state of affairs (Sonnino, 2016).

The significant streamlining of an ever-more-expensive healthcare organization has set the framework for massive improvement and reorganization of the leaders in the system to integrate new technologies, personalized treatment, devolving scopes of practice, and entrepreneurial opportunities related to incentive support. Training on leadership styles and situational leadership components for emerging healthcare leaders curriculum, allows opportunities to interact with individuals with different personal paths and leadership styles (Sonnino, 2016).

Roles of Healthcare Leaders

Healthcare leaders apply business administration principles within the context of the health sector, fulfilling interpersonal, informational, and decisional roles. According to Mintzberg (1989), as outlined in Table 3, all leaders fulfill these three central roles

Table 3

Mintzberg's Leaders Roles

Interpersonal roles	Informational roles	Decisional roles
Figurehead	Monitor	Entrepreneur
Leader	Disseminator	Disturbance handler
Liaison	Spokesperson	Resource allocator
		Negotiator

Note. Adapted from *Mintzberg on Management: Inside Our Strange World of Organizations*, by Henry Mintzberg, 1989, p. 16. New York, NY: Simon and Schuster.

Understanding the changing role of the healthcare leader provided this researcher with insight into the expectations and challenges healthcare leaders encounter in their positions and the need for leadership development and coaching. In 1933, the American College of Healthcare Executives (ACHE) was founded as the American College of Hospital Administrators. At this time there was no roadmap for leaders in hospital administration. There were individuals responsible for supervising the operations of hospitals and performing hospital administrator duties, but the name *hospital administrator*—and healthcare executive—had not yet been used (Olden, 2015).

The alliance of leaders, who formed ACHE, and primarily the healthcare leadership profession, were true leaders ahead of their time. The role of healthcare executives evolved with the changing role of hospitals in the United States. The sudden growth in the number of hospitals accentuated this evolution. In 1873, there were 178 hospitals in the United States; by 1914, that number had expanded to more than 5,000.

By 1927, analysis of all 7,610 U.S. hospitals found that a significant shift in leadership had occurred with senior leaders in the hospital. The change in leadership showed that only 37% of hospitals were directed by a physician, 20% by nurses, 11% by laywomen, 10% by laymen, 9% by medical directors, 8% by nuns, and 5% of leadership was of an unspecified profession (Squazzo, 2010).

Before World War II, larger hospitals were directed by physicians; middle size hospitals were led by Protestant ministers or Catholic nuns; and nurses directed smaller hospitals (Gunderman & Kanter, 2009). Historical perspectives on hospitals included the fact that a primary problem of hospital administrators was maintaining the hospital in high quality and collecting debts (Squazzo, 2010).

The type of work a hospital administrator performed changed according to external factors and growing healthcare needs of the population. Hospital administrators' common concerns in the 1920s included construction, convalescent wards, and employee housing and pension systems. In the 1930s, shared concerns included training nurses and low hospital occupancy; yet from 1940 to 1941, there was an increased interest in hospital administration. As late as the 1940s, many hospitals, even those as large as 200 to 299 beds, had no acting administrator (Squazzo, 2010).

During the war, physicians often managed military hospitals, but as the war progressed and the need for more military hospitals grew, an increasing number were supervised by non-physician leaders. The end of the war saw a rise in hospital administration as a profession as the complexity of hospitals and the external healthcare environment developed. Similarly, Ledlow and Coppola (2011) suggested that healthcare

groups need leaders who consistently focused on the direction of the organization with emphasis placed on both descriptive and prescriptive notions of leadership.

The years 1945 to 1965 were labeled the era of "a focus on hospital management" (Ledlow & Coppola 2011). During this time, hospitals became larger and more complex. Hospital administrators no longer worked with day-to-day details; instead, technically skilled workers accomplished the work of the hospital while hospital administrators focused on the big picture. This era also welcomed a direction of growth by including graduate curriculums in hospital administration.

The 1960s and 1970s brought a shift in the hospital administrator's roles and responsibilities. During this time, most institutions had several assistant executives and vice presidents in leadership. The 1960s also experienced rising healthcare costs, increasing government regulation, and the introduction of Medicare and Medicaid. In 1966, Medicare and Medicaid were created as social insurance programs that allowed the financial burden of illness to be shared among healthy and sick, affluent and low-income families (Centers for Medicare & Medicaid Services, 2018). As a result, hospital administrators now had an additional complex program in Medicare and Medicaid government-funded services for which they were and are today responsible.

Throughout the 1980s, hospitals continued to grow even larger and also included women in the hospital administration field. These numbers increased again in the 1990s through 2007. The current era of the healthcare executive's role is much different than in previous periods. The profession is now more diverse, and a more significant number of executives are earning higher degrees. The modern era also has seen a higher demand for business skills and financial management as healthcare executives face issues such as the

rise of technology, staffing shortages, and reduced reimbursement from the government and third-party payers. Healthcare executives today focus more on issues including patient safety and physician-hospital relations. Top concerns, however, confronting today's healthcare leaders are financial challenges, care for the uninsured, personnel shortages, quality, patient safety, government mandates, patient satisfaction, technology, and capacity (Friedman & Kovner, 2017).

Today, healthcare leaders are role models for each respective organization; their performance and conduct are observed at all times by employees (Ledlow & Coppola, 2011). Many researchers provided suggestions on appropriate behaviors for healthcare leaders (Dye, 2010; Ledlow & Coppola, 2011, p. 348). These included (a) professionalism; (b) reciprocal trust and respect; (c) confidence, optimist, and passion; (d) visibility; (e) open communicator; (f) risk taker/entrepreneur; (g) admitting fault; (h) balance; (i) motivator, and (j) analyzer.

If all these behaviors and skills are important and so diverse for healthcare leaders, it would seem to be critical at this time in healthcare organizations like the VHA and others to develop all entering and current leaders through leadership development programs.

Personal Characteristics of Healthcare Leaders

Organizations searching for healthcare leaders are looking for someone to drive change rather than maintain the status quo. Hiring committees need to review the qualities potential executives possess and determine how their business philosophies and leadership style will work within the organization. According to Chamberlain (2012), characteristics that help leaders successfully guide an organization include the ability to

(a) develop and communicate the vision, (b) hold people accountable, (c) create a culture of continuous improvement, and (d) foster learning and coaching across the organization.

Leaders must have excitement for continuous improvement and create a culture of constant improvement. Given the ever-changing healthcare landscape, organizations must improve each day, or they will not be in business (Chamberlain, 2012). The leader must be data driven, share data, and, further, demonstrate that change is working. Historically, healthcare did an excellent job measuring a leader's performance on specific metrics. However, high-performing organizations also measure what leaders are not doing well. They analyze every type of error and are relentless in finding the cause of problems and improving quality (Chamberlain, 2012). Leaders provide ample opportunities for others to learn. Individuals learn from mistakes; what they do when errors occur makes them great (A. R. Anderson, 2013).

Challenges of the Healthcare Leader's Position

This current timeframe is a challenging time for healthcare executives. Healthcare leaders are sometimes portrayed by the media as heartless bureaucrats whose only job is to get in the way of heroic physicians and nurses doing everything possible to care for the sick or dying patient (Friedman & Kovner, 2017). Leaders are no longer tasked with the homogeneous workforce of the past. Currently, leaders have the responsibility for a more diverse workforce. One challenge of healthcare leaders is leading a staff with various backgrounds. Leaders need to embrace individual uniqueness and create wholeness out of the diversity. Kouzes and Posner (2007) asserted that other challenges leaders may face are lack of loyalty and commitment from their employees.

Leaders interviewed in a study by Kouzes and Posner (2007) suggested that the content of leadership has not changed, but the context has changed. Additionally, healthcare leaders face ongoing challenges, due to increasing price competition, narrowing of insurance networks, and a more significant proportion of patients with noncommercial insurance, Medicare, or Medicaid (Centers for Medicare & Medicaid Services, 2018). The Affordable Care Act (ACA) resulted in declining reimbursements, creating budgetary challenges for leaders. Beyond the ACA, healthcare leaders confront challenges including moving away from volume to value, protection of vulnerable patient data stored on electronic medical systems, and decreases in reimbursement costs (Friedman & Kovner, 2017).

Healthcare organizations struggle to appoint and retain leaders due to a lack of willing, qualified, and experienced candidates (Numerof & Abrams, 2003). The need for reliable healthcare leaders and an engaged workforce is higher than ever. Talent boards at many hospitals are in crisis. The healthcare industries are experiencing a shortage of leadership, with a soaring resignation of staff and a wave of retirements among executives (Besheer & Ricci, 2010).

Much of the literature asserts that healthcare organizations can lessen the effects of lost leaders with forecasting for future needs. Moreover, current planning and development programs foster the training and requirements of the next generation of leaders within an organization (Rothwell, Jackson, Ressler, & Jones, 2015). It is important to note that these next generation employees will most likely need training and support through leadership development programs and coaching structures.

Within the VHA, a significant challenge is that the leadership pipelines are not robust enough to meet current and future needs, a function of poor course forecasting and unfocused leadership development efforts (VHA Office of Workforce Services, 2015). As of March 2015, 23 VHA medical centers (16%) did not have a permanent director. VHAs experience difficulties in filling leadership opportunities based on the upcoming retirements of key leaders. Leadership positions are increasingly unattractive to the next generation of VHA leaders or remain unfulfilled due to lack of qualified candidates (VHA Office of Workforce Services, 2015).

A Theorectical Framework for Leadership Training in the VHA

The VHA recognized that it is facing a significant talent and leadership gap as the baby boomers reach the age of retirement. As stated in the report from the VHA Office of Workforce Services (2015), previous VHA career development programs would likely be insufficient to create the leadership skills required for senior career opportunities. However, early career programs may establish the foundation for continued development. Additional training programs and coaching are needed to make comprehensive leadership teaching more widely available (VHA Office of Workforce Services, 2015).

Currently, the VHA has focused on eight leadership development and coaching elements as outlined in the Veterans Access, Choice, and Accountability Act of 2014. These components include culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management. Of the eight leadership elements, most frequently identified are culture, leadership development, and accountability as elements that, if improved, would have the enormous opportunity to help advance the organization and leaders

(Veterans Access, Choice, and Accountability of Act of 2014, 2014). Based on a review of the literature on how well VHAs are developing the capabilities of current and future leaders, the following results were found:

- A lack of a comprehensive approach to leadership development, which resulted in leaders being unable to adequately prepare for future roles.
- The formal programs are not linked to career paths.
- Multiple competency models in use at VHAs result in inconsistent and incomplete leadership development programs. Common competencies used at VHAs are communication, professionalism, leadership, knowledge of the VHA healthcare system, and business skills. More specific VHA competencies models are reflected in Table 4.

Table 4

Competency Models in Use

VHA high performance development model	VHA leadership competencies	VHA all employee competencies	OPM ECQs
• Personal mastery • Technical skills • Interpersonal effectiveness • Customer service • Flexibility/adaptability • Creative thinking • Systems thinking • Organizational stewardship	• Leading people • Partnering • Leading change • Results driven • Global perspective • Business acumen	• Communication • Interpersonal effectiveness • Critical thinking • Organizational stewardship • Veteran and customer focus • Personal mastery	• Leading change • Leading people • Results driven • Business acumen • Building coalition

Skills and Competencies of VHA Leaders

Within the VHA, one leadership improvement was the practice of the Leadership, Effectiveness Accountability, and Development (LEAD) framework. LEAD is a national initiative established for the provision of leadership development in the VHA (VA,

2012). LEAD involves general oversight, committee governance, and specific criteria. LEAD, is a common leadership language within VHA organizations contributing to the health system transformation. LEAD serves as a guide for healthcare delivery of the future. Moreover, LEAD's coaches provide internal customized leadership development programs, services, and coaching to deliver a range of informative and practical leadership development opportunities.

The LEAD program develops aspiring emerging leaders at the VHA, and its goals are to ensure that a cadre of high-potential leaders are available in the future to assume higher levels of responsibilities (VA, 2012). However, only a limited number of emerging leaders are taken into the program. For the past 5 years, on average, 12 employees per year have received leadership training. Statistically, this equates to only 1.5% of staff who receive coaching and leadership development.

The healthcare profession and systems emphasize the need to attain competencies related to a leader's workplace effectiveness. Healthcare leaders must have abilities sophisticated enough to match the increased complexity of the healthcare environment. Additionally, healthcare leaders are expected to demonstrate measurable outcomes and efficacy and to practice evidence-based management. The transformation of evidence-based organizations has led to numerous efforts to define the competencies most appropriate for healthcare (Stober, Wildflower, & Drake, 2006).

The Healthcare Leadership Alliance (HLA) consists of six major professional membership organizations. These organizations are the American College of Healthcare Executives (ACHE), American College of Physician Executives (ACPE), Healthcare Financial Management Association (HFMA), American Organization of Nurse

Executives (AONE), Healthcare Information and Management Systems Society (HIMSS), and Medical Group Management Association (MGMA). The research and experience from these organizations suggested that five competencies would support leadership effectiveness in the healthcare industry, and these competencies are shared among practicing healthcare leaders: (a) communication and relationship management, (b) professionalism, (c) leadership, (d) knowledge of the healthcare system, and (e) business skills and expertise (Stefl, 2008).

The Baldrige framework, which was extended to include the healthcare sector in 2000, has since been used by many healthcare organizations including the VHA as the structure for self-assessment and performance improvement (Baldrige Performance Excellence Program, 2015). The award criteria required these agencies to show evidence of systems thinking, benchmarking, and comparative results. Healthcare leaders look for performance excellence guided by the Baldrige National Quality Program to include the continual development of future leaders, enhancing personal leadership skills focused on actions achieves the organization's mission (Baldridge Performance Excellence Program, 2017). The Baldrige framework presented in Figure 1 is a comprehensive evaluation of the organization's system, competencies and performance enhancements, and the promise to improve health outcomes (Baldridge Performance Excellence Program, 2017).

Baldrige's framework is utilized by the VHA to provide guidance in establishing an integrated performance database system or for self-assessment and progress. The four competencies models in Figure 1 prepare and evaluate VHA leaders. Baldrige's framework helps to guide the VHA regarding innovation and improvement. The details of the model adapted from Baldridge are in Table 4 and include the four models used by

the VHA for leadership development and competencies. These are the high-performance development model (HPDM), VHA leadership competencies, VHA all employee competencies, and Office of Personnel Management (OPM) executive core qualifications (ECQ).

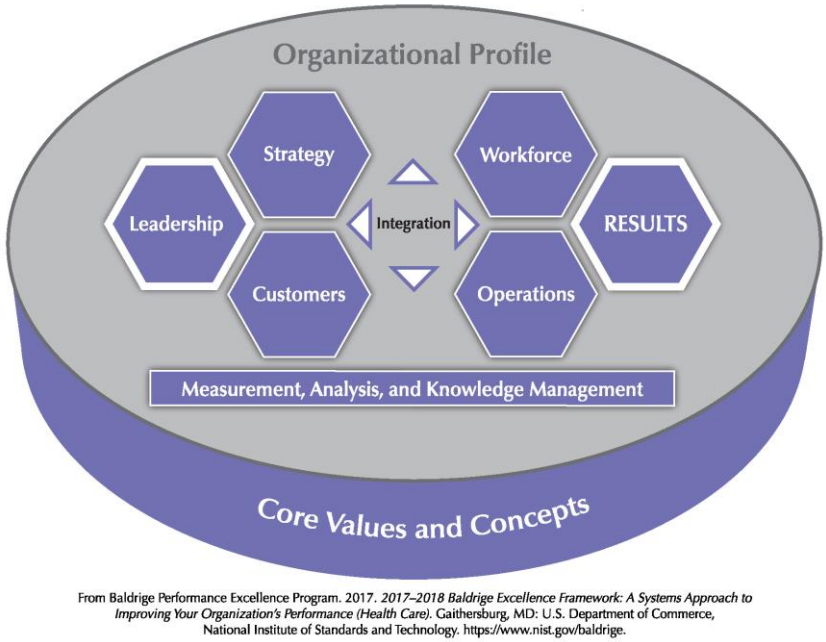

Figure 1. Baldridge excellence framework From 2017-2018 Baldridge Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care), Baldridge Performance Excellence Program, 2017. Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (https://www.nist.gov/baldridge).

HPDM is a healthcare-centered competency model favored within the VHA and used for training leaders and emerging leaders. This table exhibits the theoretical framework the VHA has accepted into its leadership development program. It includes theories from Kouzes and Posner (2007) and Sonnino's (2016) work. The curriculum and coaching programs like LEAD incorporate these training skills into their curriculum and coaching outcomes for leaders. VHA leadership competencies are the knowledge and skills critical for being a successful leader at the VHA. The VHA serves as a guide

for planning individual career growth by building knowledge and skills necessary to progress.

The OPM ECQs are required for entry-level executives and senior executives. ECQs are used by many departments and organizations in the selection, performance management, and leadership development for leaders and executive positions. The OPM ECQs were designed to assess executive experience and potentials. Career coaching is one component of OPM senior executive leadership development programs such as LEAD used in the VHA.

Coaching Roles and Types of Coaching

Coaching can be traced back to the studies of education, psychology, sports coaching, and organizational development (Du Toit & Sim, 2010). Many coaching themes are based on the humanistic approaches, which suggests that effective leaders developed in their careers due to coaches who helped them along the way (Goleman, Boyatzis, & McKee, 2002; Kram, 1985; McCall, Lombardo, & Morrison, 1998). Explicit training in coaching and development of leaders began decades ago as a necessary human resource practice in a variety of organizations, mostly on the business sector.

Dalton and Thompson's (1986) theory of career development called upon people in the first stage of career development to be an apprentice. During medieval times, the assumption was that a person would be an apprentice to someone more experienced and then be trained. During the later stages of their career, they would be required to become a coach and help with the development of others (Dalton & Thompson, 1986).

Coaching Defined

The definition of coaching and the understanding of its implementation in organizations has evolved through the years. Coaching first appeared in management literature in the 1950s and was viewed as part of a supervisor's responsibility to develop subordinates through a sort of master-apprentice relationship (Evered & Selman, 1989). During the same time, Evered and Selman (1989) also introduced the context of a committed partnership as the new paradigm of coaching, which suggested a movement from a "control, order and *prescription paradigm*" (p. 16) *to* a standard, which acknowledged, created, and empowered others.

In earlier times, coaching was understood as a more directive approach. The early directive conception gave way to a cleared nondirective understanding of coaching, which took a hands-off approach because performance is enhanced when control and responsibility are transferred from the coach to the leaders (Ives, 2008).

Definitions of coaching processes vary considerably in the degree of clarity and also the extent of an emphasis on direct instruction as opposed to facilitating self-directed learning (Grant & Stober, 2009). Hamlin, Ellinger, and Beattie (2009) conducted an extensive literature review on the definition of coaching. In their research on the meaning of coaching, the conceptual commonalities and differences suggested that all variance of "coaching is explicit and implicit intention of helping individuals to improve their performance in various domains, and to enhance their effectiveness, development, and personal growth" (p. 18).

Scholars and researchers have suggested numerous definitions of coaching. But a summary of these researchers' definitions indicates that coaching is ultimately an

ongoing, changing process of influence by which the coach and coachee collaborate to achieve increased job knowledge, improve skills, ensure job responsibility, and create a stronger more positive working relationship and opportunities for personal and professional growth (Yoder, 1995).

Similarly stated, Peterson and Hicks (1996) asserted that coaching is a continuous process of equipping people with tools, knowledge, and opportunities to develop themselves and become more efficient. Later, King and Eaton (1999) asserted that coaching is an open-ended process that analyzes the present situation; describes the performance goal; merges personal, organizational, and external resources; and then implements a plan for achieving that goal. Moreover, Redshaw (2000) stated that coaching is systematically increasing the capability and work performance of an individual by exposing him or her to work-based tasks that will provide a relevant learning opportunity, giving guidance and feedback to help the individual learn. After completing one of the three institutes, VHA leaders provide training to employees in support of developing others.

Coaching Relational Process

Coaching is unlocking the potential to maximize a person's performance—it is helping individuals to learn rather than teaching them (Whitmore, 2009). Coaching is a way to engage with people that leads to more competence so that they can contribute to their organization and find meaning in what they are doing (Flaherty, 2005).

By 2007, coaching was viewed as relationship based. Coaching is considered to be an efficient means for developing a more capable workforce at all levels and creating a very competent organizational culture, one that can successfully compete for human

capital and achieve business results (Hunt & Weintraub, 2007). Coaching is interactive, direct, and a confidential process by which a leader and employee attempt to find the most efficient way for achieving objectives or making significant changes in the company (Vidal-Salazar, Ferron-Vilchez, & Cordon-Pozo, 2012).

More recently, Whitmore (2009) shared a new frontier for coaching and leadership development referred to as the performance curve model (PCM). The PCM maps the culture of an organization and relates the conditions for low, medium, or high performance. The PCM enhances understanding of how coaching creates a high-performance culture and thereby revolutionizes the traditional approach to organizational learning. The PCM, which Whitmore (2017) referred to, consists of the following four stages: (a) Stage 1 Impulsive "Whatever happens happens"; (b) Stage 2 Dependent "I follow the rules and do what I am told"; (c) Stage 3 Independent "I am a high performer"; and (d) Stage 4 Interdependent" We are truly successful together" (pp. 40-42). Each of these four stages has the specific characteristic that promotes a high-performance culture. The focus of coaching at each stage illustrates how an individual's mindset can change and evolve as they are coached through the stages (Whitmore, 2009). Coaching can provide a unique, differentiated kind of help. The International Coach Federation (ICF, 2017) suggested that the value of coaching is the support to organizations to develop a pliable, practical approach to accomplish essential business goals, sustainable workflow, and maintain high levels of customer satisfaction.

Today, under the title of coaching many of these types of relationships are incorporated. There are career coaches, executive coaches, life coaches, parent coaches, and, of course, athletic coaches. According to London (2002), there were approximately

10,000 professional coaches worldwide and an estimated 59% of organizations offered coaching or developmental support to their leaders. With regard to preparing and training leaders, Tichy (2002) also mentioned that the 21st century would be all about a coaching organization, further suggesting that all levels of leaders take responsibility for ensuring that they and their people are smarter based on preparedness for training the next generation of leaders.

Whitworth et al. (1998) placed a stronger focus on the relational aspects of coaching and noted that coaching is "a form of communication with unspoken ground rules of certain qualities that must be present: respect, openness, compassion, and rigor, our commitment to speaking the truth" (p. xvi). An operational definition of coaching described by Whitmore (1992) suggests that "coaching is unlocking people's potential to maximize their performance. It is helping individuals to learn rather than teaching them" (p. 10).

The Need for Coaching

Based on the ideas of Hargrove (2008), coaching is a compelling strategy for releasing the inner self into action, setting ambitious goals and endeavors to create new openings for the circumstances that were previously unknown. Stone et al. (1999) related that coaching provides a means for achieving professional goals through skill development and knowledge acquisition. Wheeler (2011) defined coaching as "interactions involving a leader's use of a facilitative and empowering approach, as opposed to the directive and prescriptive, techniques to help team members improve their performance, through personal learning and development" (p. 1).

Additionally, Peltier (2001) offered his definition of coaching as an individual from outside an organization utilizing intellectual skills to help a person develop into a more effective leader. Coaching has been defined as a strong bond, designed to move forward and enhance the lifelong process of human learning, effectiveness, and fulfillment, a means for increasing health and human potential (Hadikin, 2004), and a means for achieving professional goals through skill development and knowledge acquisition. Coaching is considered a partnership designed to help clients produce fulfilling results in their personal and professional life. Coaches render support to enhance the skills, resources, and creativity that the client already has (ICF, 2017).

According to Edelson (2006), the need for coaching existed for decades and continued to be a growing field of research, which is evident in the 1840s from education when coaching was referred to as tutoring and later in the 1880s as organizational coaching evolved from sports. For more than 30 years, historical roots and demonstrative examples of coaching were directed by the sports professions, focusing on goals and performance. More recently in healthcare, coaching has been reported as productive in motivating people toward personal and professional goal attainment (Edelson, 2006).

Since Evered and Selman (1989) established coaching as a core organizational activity, it has gained popularity. Coaching is used by many professions, and more often in business, coaching is used because it works (Coutu & Kauffman, 2009). Coaching helps the leaders and organization in meeting their goals. The coaching process relieves the stress and loneliness of challenging positions and provides a safe place for the coachee to vent and express frustration that otherwise would have no outlet. Coaching

feels valuable to the coachee and increases job satisfaction and job retention (Verquer, Beehr, & Wagner, 2003).

Coaches must train in the use of coaching strategies. The ICF (2017), which is one of the largest global coaching organizations, serves all coaches (life, career, executive, etc.) and has developed a code of ethics and competencies for coaches it certifies in training programs. These programs are available through the ICF, professional associations, and other consulting agencies. The hiring organization needs to ensure that the coach understands the vision, mission, and goals of the organization and any specific areas of focus for the coachee.

Coaching programs work best when participation is voluntary. Care in matching a coach and coachee is very important. The length of time the pair will work together, and the level of vulnerability needed, requires a good match (ICF, 2017). A well-thought-out orientation for the coachee to begin the program is a must. Starting with a face-to-face meeting to build rapport and review norms is essential. It is critical to document goals, processes, assessment tools, and responsibilities of each person. The coach needs to be accessible not only during scheduled meetings but at other times as required. Though coaching is a confidential process, feedback to the organization along the way, and at the end of the coaching program is necessary.

Coaching Develops Future Healthcare Leaders

In the review of the literature, coaching programs cited efficient ways to support and develop executives and emerging healthcare leaders. As explained, by Wolf, Bradle, and Greenhouse (2006), the essential criteria to leadership success in today's healthcare

environment includes (a) transformational leadership, (b) planning and decision making, (c) developing people, (d) innovation and change, and (e) healthcare economics.

The researcher discovered that there is a body of research related to executive coaching in the world of business, but very few studies were found associated with executive or leadership coaching for healthcare leaders. Coaching builds capacity in healthcare leaders through providing self-assessment and reflection opportunities, defining organizational goals, creating action plans, and allowing the coachee to be the problem solver (Wolf et al., 2006). Despite the recognized need in healthcare organizations, the number of comprehensive leadership development opportunities that include career coaching is still limited. Coaching is a useful tool for supporting executives. The cost of coaching programs is less than the cost of replacing a healthcare leader (Besheer & Ricci, 2010).

Coaching in the workplace is driven by changes in the leader's role from that of an individual who supervises subordinates' work to that also of a coach who engages and empowers employees to improve performance (Gilley, Boughton, & Maycunich, 1999). So not only do the leaders need coaching, but they also need to coach the people they supervise. Coaching leads to improved communication, leader-employee relationships, creativity, and employee performance, all of which contribute to organizational effectiveness, efficiency, and performance (Gilley & Gilley, 2007).

Different Methods of Coaching

Currently, what is known about the state of coaching practices is that there are nearly as many methods as there are coaches. Many researchers suggested that there is a wide array of professional backgrounds and orientations of coaches, which includes a

diverse clientele of coaching interventions. Standardized qualifications or licensure are not required for coaching responsibilities; however, there are several organizations and books on the market that provide certification and training for those who aspire to be a coach by fostering selected coaching approaches or strategies. Some of these noted coaching organizations include the International Coach Federation (ICF), the Institute of Coaching (IOC), Positive Psychology and Coaching, and the Institute of Coaching Professional Association (ICPA).

According to Witherspoon and White (1996), the ongoing nature of coaching enhances its success. Though the specific practices of coaches vary widely, some core principles have emerged that differentiate coaching from other interventions with leaders (Nieminen, Biermeir-Hanson, & Denison, 2013). Coaching was defined as the set of behavioral techniques used to improve a leader's performance and individual achievement, and consequently, the effectiveness of the organization (Kilburg, 2001).

Coaching involves a great deal of hands-on involvement in an employee's work process. Coaching becomes effective when an employee indicates a desire to improve. Coaching extends support for challenging personal issues such as communication style and stress management (Ennis et al., 2012; Hargrove, 2008). Contemporary organizations recognize the need to develop leader competencies through coaching that enhance leaders' capacity to understand and distinguish their feelings, manage their behavior, and manage relationships (Blattner & Bacigalupo, 2007; Grant, 2007).

There are compelling results from related fields, which suggest that healthcare leaders and emerging leaders would benefit from coaching programs to resolve challenges in performance and retention. Healthcare systems, educational institutions,

and professionals would be well prepared to identify ways to offer leadership development programs and make them available as part of the routine career transformation for emerging healthcare leaders (Sonnino, 2016).

Coaching in Healthcare

Even though there is limited research about the benefits of coaching in healthcare organizations, and specifically the VHA, some programs are available to selected leaders. The use of coaching in healthcare settings differs considerably from its use in the commercial sector. Coaching in healthcare settings is typically used with patients to help improve their health outcomes (Palmer, Tubbs, & Whybrow, 2003). Indeed, "health coaching" is now a well-established field of professional practice. Health coaching includes enhancing well-being in cancer survivors (Galantino, et al., 2009), diabetes (Thom et al., 2013) and other chronic diseases (Kivelä et al., 2014), as well as with patients in primary care (Man et al., 2016).

However, the healthcare service system worldwide has been somewhat slower to embrace coaching as a central leadership development tool for its staff (Risley & Cooper, 2011). The penetration of leadership coaching in healthcare lags behind that observed in other industries. This lag is partly due to a lack of research supporting healthcare leadership training and practices. The coaching industry's demand for rigorous studies in the healthcare sector is historically low. Coaching is not viewed as a priority due to the healthcare industry's ever-increasing demand and the constant change of operational requirements.

Nonetheless, the skillsets of executive coaches with this specialized knowledge are needed to support healthcare leaders in a tumultuous time. Unfortunately, healthcare

innovation is not encouraged within the healthcare culture; while other organizations have become adept at conveying ideas from outside their boundaries, healthcare has lagged behind (Wagner, 2013).

Coaching as a strategy for supporting healthcare leaders is not frequently cited. Recent statistics reveal a glaring and essential breakdown in how healthcare leaders place their focus on prioritizing and caring for the well-being and health of others at the expense of their self-care (Schneider, Kingsolver, & Rosdahl, 2014). Healthcare leaders face significant burdens and stress that affect their well-being and ultimately their ability to provide quality care. Coaching is a relevant strategy to promote healthcare leaders in areas of active reflection, building self-awareness, and focusing on individual strengths. The value of coaching leaders is an approach to supporting professional development and performance. Coaching attempts to help leaders "explore their cares, . . . increase self-awareness, . . . take small steps, . . . learn to manage capacity (Schneider et al., 2014, pp. 372-378).

Additional benefits of coaching leaders most often described include improvement in productivity, quality, organizational strength, customer service, reducing complaints, retaining executives who have been coached, cost reductions, and bottom-line profitability. Despite repeated calls for the healthcare systems to use coaching as a way of improving engagement, communication, and performance (Hays, 2008; Henochowicz & Hetherington, 2006), there is limited empirical literature on coaching healthcare leaders exists (Throgmorton, Mitchell, Morley, & Snyder, 2016). The healthcare sector is ready for comprehensive programs for all healthcare leaders as a part of their optimal training.

The benefits of coaching leaders in healthcare are to enable resilience and innovation. Stoller (2013) stated that leadership competencies are identified in industrial-organizational fields with minimal work done in the arena of healthcare. Some researchers asserted that leadership abilities in healthcare would ideally include coaching skills that foster optimal performance and well-being of the workforce. The healthcare leadership programs researched in this study contained several components, including coaching training, self-assessment instruments, and evaluations. Prime examples of assessment tools frequently used in healthcare for leadership coaching training include the Myers-Brigg Type Indicator, Center for Creative Leadership's 360 Degree Evaluation, and Kouzes and Posner's Leadership Practices Inventory.

The healthcare sector needs leadership coaching to aid resilience and innovation (Bierly, Kessler, & Christensen, 2000). Equally important, Bierly et al. (2000) noted the importance of providing critical development experiences to those that can move into promotion and more advanced roles. Brent and Dent (2014) also added that there are numerous skills that an effective coach should be able to demonstrate to assist leaders. Figure 2 provides Brent and Dent's (2014) recommended skills required of an effective coach.

Types of Coaching in VHAs

In the VHA, there are limited opportunities for leadership development. However, the few programs that provide training and coaching that are available through the VHA are selective. Only 1.5% of leaders have the opportunity to participate (VHA, 2014). The need is much greater. These programs available include EL, LDI, and ECFD. Both, internal and external coaching is provided within the institutes and there

are demonstrated benefits for leaders to achieve an increased sense of motivation and ability to successfully handle challenging situations (McNally & Lukens, 2006).

Figure 2. Skills for effective coaching. From *The Leader's Guide to Managing People: How to Use Soft Skills to Get Hard Results*, by M. Brent and F. E. Dent, 2014, p. 40. Harlow, England: Financial Times.

Internal Coaching

Increasingly, organizations including the VHA are recognizing the importance of strengthening internal communication among leaders and their staff through coaching.

Internal coaching is essential for building a culture of transparency between leaders and employees. A significant advantage of an internal coach is that the coach knows the organization's culture and policies and has immediate credibility. Additionally, internal coaches can communicate organizational updates such as Joint Commission on Accreditation of Hospital Organization (JCAHO) surveys, budget-related activities, and leadership changes (H. Johnson, 2004). The VHA on a limited basis uses internal coaches.

External Coaching

External coaches are perceived to be more objective and unbiased. The external coach may be a source of a broader experience and resources because of exposure to a variety of clients, and coaching is often his or her only job, allowing him or her to focus solely on coaching. The purpose of external coaching in the VHA is to provide support when highly sensitive issues need interpretation.

Both internal and external coaching can demonstrate personal benefits to include an increased sense of motivation and interest and also an ability to deal with frustrations encountered. Of the external coaching pool, and the significant investment that went into creating it, results showed that coaches were getting inconsistent levels of support from their organizations, and specifically in the VHA, to continue spending time in providing coaching (Stewart-Lord, Baillie, & Woods, 2017). External coaching was reduced with an increased emphasis on internal coaching. Participants who spend significant periods of time training together often develop a unique camaraderie, which encourages ongoing collaboration and synergy among colleagues and institutions (Sonnino, 2016).

As it relates to healthcare, Ammentorp, Jensen, and Uhrenfeldt (2013) suggested that the use of coaching in hospitals was less than in private and public organizations where coaching is often utilized as a professional development strategy in continuing professional development. The parties perceived that coaching improved their work attitude and was effective in enhancing core performance (Ammentorp et al., 2013).

Coaching ELs. The VHA EL is a 12-month program for the development of selected staff at pay grades 9 and 11. Ideally, the EL program includes self-assessment, presentation of a workplace project, group discussions, reading assignments, journal reflections, and experiential activities. Robust training from an experienced leader helps an emerging leader with self-development plans. Emerging leaders do not receive structured coaching; however, the training is provided through a mentor-protégé program. Rather than formal coaching, the mentor transfers knowledge to the emerging leader providing continuous access to the mentor for support and guidance during the 12-month development program. Emerging leaders are provided leadership growth by shadowing a VHA staff member in a leadership position in which the emerging leader aspires to attain a future position as a result of job performance and career growth.

Coaching Leadership Development Institute (LDI). The VHA LDI is a 12-month program for the development of selected staffs at pay grades 12 and 13. The LDI program seeks to identify and develop high-performing midlevel employees for senior-level leadership positions. The LDI provides a framework to develop future leaders with a focus on placement in a leadership position. Each participant is assigned an internal coach and creates an individual development plan. The program structure includes two resident sessions, a shadowing experience, leadership coaching, and a specific

assignment. The focus is placed on elements of the organization's mission, resources, budget, leveraging technology, and developing subordinate employees. Networking is also important. An announcement is made each year for candidates. A small percentage—perhaps about 1.5% per year is selected from each VHA hospital. The selection and training of leaders usually matches one of the philosophies of EL, LDI or ECFD curriculum for leadership development. Eligible candidates are selected based on experience, the quality of their application, and the interview.

Coaching Executive Career Field Development (ECFD). The ECFD program identifies VHA's high potential emerging leaders to prepare candidates for their role as an executive. Favorable interviewees enter a 2-year career development program while keeping their current position. The first year includes being matched with a certified external coach who guides and creates a personal development plan. The ECFD requires attendance at VHA's Health Care Leadership Institute and participation in a series of audio conferences with chief officers in the central office. In the second year, candidates attend the assessment center and choose a specialized targeted training experience as associate director, chief of staff, nurse executive, or Veteran Health Administration Central Office (VHACO) healthcare program executive. ECFD is the most competitive leadership development program in the VA. The number of candidates allowed into the program nationwide annually does not exceed 25 (VHA Office of Workforce Services, 2015).

Summary

The complex role of the healthcare leaders has evolved over the years (American Hospital Association, 2015). The healthcare leaders need to be visionaries and facility

managers, tasked with organizational operations, patient care, and executing a comprehensive budget.

The review of the literature confirms that the position of healthcare leaders has become more complex and political. This literature review covered all available resources regarding leadership, roles, and challenges of leaders; leadership development; coaching leaders; and the VA EL development programs. The historical overview of the VHA provided an in-depth summary of how the VA came to be. It included background on the mission of the VHA and its role as a broader healthcare organization. The literature review discussed perspectives on leadership, leadership development, and the impact of coaching healthcare leaders.

The literature review cited coaching programs as an effective way to support and develop executives and other leaders like healthcare leaders. A gap however exists in the research because there are studies about executive coaching in the world of business, but very few studies were found associated with executive or leadership coaching for healthcare leaders. In addition, there is limited research about how leadership skill development can lead to career growth, promotional opportunities, and how it influences employee retention. Many professions use coaching because it works (Coutu & Kauffman, 2009). Coaching helps leaders meet organizational goals. Coaching is cited as being valuable to the coachee. Coaching in the workplace provides job satisfaction and often leads to promotions and increased job retention (Joo, 2005).

CHAPTER III: METHODOLOGY

Overview

This study was designed to determine if coaching impacted the careers of Veterans Health Administration (VHA) healthcare leaders in terms of career performance growth and retention in the VHA hospital. This chapter describes the research methodology used for this study. A purpose statement is provided and establishes the reason for the study along with the central research question and subquestions that relate to the overarching issue researched. Next, the research design, population and sample, data collection procedures, and data analysis processes are addressed. Finally, the limitations of the study and a summary conclude the chapter.

Purpose Statement

The purpose of this qualitative multiple case study was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California.

Research Questions

The central research question guiding this study was, What is the perceived impact of career coaching on the job performance growth and retention of emerging healthcare leaders who have attended leadership professional development institutes at VHA hospitals in Southern California? The following were the subquestions of the study:

1. What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected

leadership professional development institutes at VHA hospitals in Southern California?

2. What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at a VHA hospital in Southern California for a minimum of 1 year?

Research Design

A qualitative multiple case study approach was used for this research because this design emphasizes collecting input on naturally occurring phenomena, and the format of the data was in words rather than numbers (McMillan & Schumacher, 2010; Roberts 2010). A qualitative case study was chosen because it provided rich data and offered a deep understanding of the participants' perceptions identified in the study.

Case study is the best methodology utilized for areas of study in which the researcher examines a program, an event, or set of individuals bounded in place (Creswell, 2008). According to Patton (2015), qualitative research is different from quantitative research since data in qualitative research are collected using fieldwork, in-depth interviews, field observations, and document analysis. The qualitative research analyzes the character or nature of something, not the quantity (Stake, 2010). A qualitative methods design was used to understand circumstances from a coaching participant's perspective.

Describing perceptions cannot be interpreted through statistical methods, but instead through rich data described by individual responses (Patten, 2014). A qualitative design was typically used to understand circumstances from a participant's view as the intent of this study was to describe perceptions from a single entity.

Case Study

There are several types of case studies. Yin (2003) defined case studies in terms of single and multiple designs explained by their units of analysis with a rationale for when to use each type:

- Type 1, single-case (holistic) designs,
- Type 2, single-case (embedded) designs,
- Type 3, multiple-case (holistic) designs, and
- Type 4, multiple-case (embedded designs) (pp. 46-47)

According to McMillan and Schumacher (2010), a case study focuses on an individual, group, activity, or event. Case studies typically examine single entities and are characterized as either intrinsic or instrumental. An intrinsic case focuses on groups, events, or individuals. An instrumental case focuses on an interpretation of the specific issue or theme under study (McMillan & Schumacher, 2010).

In this multiple case study, the single entity was leaders employed at one of two VHAs located in Los Angeles County who attended, for a minimum of 1 year, selected VHA institutes that included coaching for leaders. This multiple case study focused on the perceived impact of individual career coaching on healthcare leaders' career performance growth and retention in the VHA after their involvement in selected VHA leadership development institutes lasting a minimum of 1 year.

A multiple case study enables the researcher to explore variations within and between cases. The goal is to replicate outcomes throughout cases. Because comparisons will be depicted, it is important that the cases are selected carefully so that

the researcher can surmise similar results across cases or determines contrasting results based on a theory (Yin, 2003).

Using qualitative multiple case study for this research allowed for analyzing and describing the framework of an occurrence through collective records using various sources of data in an attempt to understand the meaning ascribed with explicit neutrality by groups or individuals to human or social difficulties (Creswell, 2014; Patton, 2015). This study examined the perceived impact coaching had on healthcare leaders who participated in Emerging Leaders (EL), Leadership Development Institute (LDI), or Executive Career Field Development (ECFD). Furthermore, this qualitative multiple case study approach allowed the researcher to identify the most important elements of coaching healthcare leaders, which were their career performance growth and retention in the VHA.

Patton (2015) asserted that in case study research, "Each narrative adds to the others, creating a collage of information on the whole situation from which similarities and differences are identifiable" (p.129). Creswell (2014) stated that case studies are a design of inquiry found in different fields in which the researcher formulates an in-depth analysis of the case, usually a program, event, activity, process, or one or more individuals. Accordingly, "cases are bounded by time and activity, and researchers collect detailed information using a variety of data collection procedures over a sustained period" (Creswell, 2014, p. 14). Similarly stated, Denzin and Lincoln (2011) asserted that the main strength of case studies involves the depth of detail provided along with the completeness and richness of information.

Population

A population is defined as a group of individuals who meet specific criteria, and therefore, the results can be generalized to them (McMillan & Schumacher, 2010). Similarly, Roberts (2010) stated that a population is the group of interest to the researcher, the group to which he or she would like the results of the study to be observable. The population for this study consisted of veterans healthcare administrators or leaders who attended one or more of three leadership development institutes in which they received coaching: EL, LDI, and ECFD institutes. These EL, LDI, and ECFD trainings are offered in all 170 VHAs throughout the United States and its territories. Approximately 2,040 leaders nationally attend these institutes per year.

Additionally, leaders in the VHA are defined and identified by six leadership competencies categories that apply to any person in a leadership role (VHA Learning University, 2011). The categories are leading people, partnering and developing networks, leading change, results driven, global perspectives, and business acumen. In the VHA, these leaders hold official titles such as directors, supervisors, and managers.

Target Population

The target population was identified as individuals in a geographic area (McMillian & Schumacher, 2010). Likewise, Creswell and Plano Clark (2011) defined a target population as a collection of individuals with similar defined characteristics, which the researcher may identify in the study. More so, McMillian and Schumacher (2010) asserted that the target population should be positively described in advance of the inquiry and that it is intended to define the population that the results of the inquiry are meant to be generalized.

In Los Angeles County, trained EL, LDI, and ECFD leaders who have attended VHA leadership institutes over the past 10 years comprise approximately 1.5% of the total VHA workforce. There are two VHAs in Los Angeles County, geographically located in Los Angeles and Long Beach, California. More than 2,200 employees are employed at each of the VHAs in this study. An average of 1.5% of emerging leaders are considered for selection in EL, LDI, and ECFD institutes from each facility.

The defined characteristics of the target population for this study included VHA employees in Los Angeles County who attended one or more of the previously listed leadership institutes and received at least 1 year of coaching. In addition, the target population for the study was focused on only VHA employees in Long Beach and Los Angeles, California, in order for the researcher to conduct face-to-face interviews whenever possible. In addition, participants in this study had 5 or more years of VHA employment, were currently employed by the VHA, and completed either one or more of the EL, LDI, and ECFD institutes. Other items such as demographics identification are provided in Appendix A.

Sample

Roberts (2010) suggested, "When the researcher does not have an opportunity to study a total group, select a sample as representative as possible of the total group, in which you are interested" (p. 149). A sample consists of a subgroup of the population, a group of subjects from whom the data were collected (McMillan & Schumacher, 2010). (2010) argued that before the researcher decides how many to select for the sample, the researcher must know the size of the population so that one can accurately draw out the appropriate sample size. The sample for this study was selected from Southern California

VHA leaders who were employed at a VHA located in Southern California, and specifically in Los Angeles County. Purposive sampling was used to identify VHA leaders as having the study's defined characteristics.

Purposive sampling involved strategically selecting study participants who met the criteria for completion of the EL, LDI, and EFCD leadership institute training and who could provide rich, narrative information (Patton, 2015). The VHA leaders were purposefully identified based on the following criteria:

- participation in one or more of the leadership development institutes in either EL, LDI, and EFCD training;
- participation in a year of coaching through the institute;
- current employee at the VHA in one of the two Los Angeles County's VHA hospitals in either Long Beach or Los Angeles; and
- tenure of 5 or more years of employment in the VHA.

In addition to purposive sampling, the study was conducted using convenience sampling as well as snowball sampling research strategies. According to Patton (2015), convenience sampling is when participants are selected because they are readily available for face-to-face interviews. The researcher interviewed VHA leaders in Los Angeles County employed in VHA hospitals to conduct face-to-face interviews whenever possible.

This study also utilized snowball sampling. Snowball sampling consisted of participants providing referrals for future participants (McMillan & Schumacher, 2010; Patton, 2015). Snowball sampling was obtained by participant referrals from the two Los Angeles VHA human resource departments in Southern California. Once these emerging

leaders who were VHA employees were identified, the researcher asked them for additional referrals, and many offered names of emerging leaders who met the study criteria. The researcher was able to identify 15 leaders who initially met the criteria through the snowball sampling process.

According to McMillan and Schumacher (2010), "The researcher develops a profile of the attributes, or particular trait sought and asks each participant to suggest others who fit the profile or have the attribute" (p. 327). Snowball sampling was used in addition to purposeful sampling in this study in order to obtain the required number of sample participants.

The researcher crosschecked the participant criteria and demographic information (Appendix A) to confirm the number of participants who met the study criteria and who were willing to be interviewed. This process yielded 15 total individuals who participated in the interviews. Creswell (2014) contended that there are many qualitative research sample sizes, such as phenomenology, which range from 3 to 10; grounded theory, 20 to 30; and case studies to include about four to five cases. Patton (2015) asserted that there are "no rules to sample size in qualitative inquiry" (p. 311); the sample depends on what the researcher wants to find out. Further Yin (2003) described that the sample size for several case studies suggests the quantities of case replications a researcher considers relevant for the study. Since participation was voluntary, the researcher interviewed 15 leaders who volunteered to be interviewed and met the criteria for the study.

Site and Participant Selection Process

Participation in the research study was confidential, anonymous, and voluntary. The researcher intended to interview 15 participants with equal numbers of participants from each of the three institutes: ELI, LDI, and ECFD. However, while 15 participants of the 25 solicited met the criteria, five met the criteria for ELI interviews, only three met the criteria for ECFD, and the remaining seven were interviewed from LDI. The researcher sent an invitational e-mail to the 15 identified participants in the sample, asking them to take part in the study. An example of the e-mail is provided in (Appendix B).

Prior to sending out the e-mail to identified participants and before conducting interviews, the researcher requested permission from the research and development committee at the selected VHA site, the director of the VHA site, and Brandman University Institutional Review Board (BUIRB) to interview the identified participants in this study.

Interview Procedures

Participants received information on the confidential procedures that would be used in this study and were assured that their participation was voluntary. The researcher sent an e-mail to all study participants 2 weeks before their scheduled interview date to confirm the date, time, and their willingness to participate. Additionally, each participant was sent a copy of the informed consent (Appendix C), the interview questions (Appendix D), the audio release form (Appendix E), and Brandman University's Participant's Bill of Rights (Appendix F). Once the letters were sent out requesting

participation in the study, a response deadline of 1 week before the scheduled interview was communicated with participants.

All study participants agreed to an in-person, face-to-face, 1-hour interview. The researcher adhered to the interview protocol with each study participant. The purpose of the case study was restated, and signed consent forms were obtained. Time was allotted for participants to ask questions before the start of the interview. The researcher addressed the topic of confidentiality and shared with the participant that the responses from the interview would be kept confidential. The researcher asked the participant's permission to record the interview and informed him or her that he or she could stop the interview process at any time. Subsequently, the interview process was initiated with the researcher asking the interview questions and taking notes for potential follow-up questions. At the completion of each interview, the researcher stopped the recording and thanked the participant. Later, all the interviews were transcribed to facilitate the data coding and analysis process of responses.

Once the transcription was completed, the researcher reviewed the documents several times to ensure accuracy. All study participants were sent their transcription and asked to review their transcription for accuracy and to provide additional details as needed. The researcher corrected all participants' comments, as noted by participants, to ensure everything was correctly documented.

The VHA hospitals in Southern California were selected as the study sites. All interviews and observations were conducted in the work environment of the participants at the VHA facilities in Los Angeles County for convenience for the participants in the study.

Instrumentation

For a case study, the researcher served as the instrument when conducting interviews (Creswell, 2013). Patton (2015) explained, "Qualitative inquires study how people and groups construct meaning" (p. 5). Additionally, Patton (2015) asserted that the researcher is the primary instrument leading qualitative inquiry because the researcher conducted interviews with each of the identified participants in the study. Furthermore, Patton stated that the "quality of qualitative data depends to a great extent on the methodological training skill, sensitivity, and integrity of the researcher" (p. 15). Consequently, all potential bias needed to be removed to allow data to be reliable (Creswell, 2013).

A specific protocol was used to avoid researcher bias for each participant in this study. All participants were asked the same interview questions and allowed the same 45 to 60 minutes to complete the interview process. Electronic recordings were made during the interview process and transcribed to identify errors and misinformation in the data.

Interviews

Semi-structured interviews were utilized for this study. According to Creswell (2013) and Patton (2015), semi-structured interviews consisted of developing a predetermined interview script whereby each participant was asked the questions in basically the same order. The strengths of the semi-structured instrument format were that it allowed participants to address the same questions for comparison and simplified organization and analysis of data (McMillan & Schumacher, 2010). Subsequently, the researcher developed an interview script of 10 items to address the research questions and aligned them with the purpose of the study (see Appendix I). Probing questions were

also integrated to enhance the interview process and capture additional details. Additionally, participants were told that the interview would be recorded and that they would have an opportunity to review the transcript for accuracy. Participants were also informed that they could request that the interview end at any time they felt the need to do so.

Baldridge's healthcare criteria consists of seven principles (see Appendix G), which serve as a guide for healthcare organizations to evaluate its quality, performance, and productivity. The Baldridge excellence healthcare criteria framework components guided the researcher's development of the interview instrument for this study as it related to a leader's career growth and retention. The interview questions were adapted from the Baldridge framework, which is used in the VHA institutes for training and coaching leaders. Moreover, Appendix H provides the Baldridge Framework for Healthcare Process Improvement as it pertains to leadership. The highlighted areas in Appendices G and H align with the research and interview questions in Appendix D.

Interview Protocol

An interview protocol (Appendix I) was developed. This protocol helped maintain the consistency of the interview for multiple participants over time, while at the same time providing the researcher flexibility to clarify questions and to ask probing questions.

Demographic questions were included at the beginning of the interview, which was designed to build trust, put the participant at ease, and access the number of years of employment by the VHA. The demographic categories of age, race, ethnicity, gender, position, and years of experience in the participant's current position were elicited before

the interview started. The researcher also confirmed completion for all participants in one or more of the three leadership institutes through VHA Human Resources and made certain that they met the research criteria.

Human Subjects Consideration

No data were collected until permission to conduct the study was obtained from the VHA Institutional Review and the BUIRB. All the data collected during the study were protected to ensure the privacy of participants. The researcher was the only person with knowledge of the identity of each participant. Before the start of each interview, the researcher restated the confidentiality measures undertaken. Any data mentioned during the interview recordings that could identify a study participant was replaced with pseudonyms for confidentiality. All recorded audio files were password protected and could only be accessed by the researcher. All audio files were destroyed once each interview was transcribed.

Pilot Test

Before conducting the study, three healthcare consultants were asked to participate in a pilot test (Appendix J) of the interview process. More importantly, Merriam and Tisdell (2016) explained that a pilot, or field test, requires more than practicing data collection. The three individuals matched the criteria of the sample population but were not included in the study and the data analysis. According to McMillan and Schumacher (2010), "Pilot tests are conducted to test for the existence of bias" (p. 206). Creswell (2014) and McMillan and Schumacher (2010) both asserted that pilot testing also provided the researcher with a means to evaluate the questions for clarity of words and projected length of the interview. Each person who agreed to be

involved in the pilot test was interviewed separately. After the pilot test, the researcher conferred with each person identified to review the interview protocol the researcher used and provide feedback on possible observed researcher bias as well as input on the interview questions. Based on this information, revisions were made in the protocol and interview questions. Before conducting interviews, any suggested adjustments to the interview process were made. The researcher asked the field-tested participants to discuss any questions, concerns, or feedback the participant had as parts of the interview field-test experience.

Reliability and Validity

Reliability

Roberts (2010) stated, "Reliability is the magnitude to which an instrument consistently measures something from one time to another" (p. 137). Similarly stated by other researchers, reliability is described as consistency of results, which could be attained by standardization of data collection (McMillan & Schumacher, 2010; Patten, 2014). Reliability depended on the skills of the researcher in developing and maintaining trust, building relationships with participants, and addressing the research process from a position of impartiality (McMillan & Schumacher, 2010).

The researcher strengthened internal reliability by conducting all interviews in person using a standard interview script and by audiotaping all responses. Furthermore, the definitions of study terms were provided to all participants before the interview to ensure mutual awareness and avoid confusion that could lead to varying interpretations of the interview questions. The interview participants reviewed their interview transcripts for accuracy to ensure reliability. The researcher reviewed transcripts for any

inaccuracies made during transcription. Creswell (2014) asserted that detailed documentation of interview protocol with all participants ensures consistency of execution and results. The researcher amended the responses if any feedback from interviewed participants included changing their responses.

Validity

McMillan and Schumacher (2010) "referred to validity as the degree of similarity between the explanations of the phenomena and the realities of the world" (p. 330). Validity in qualitative research included both the researcher and participants concurring on interpretations of data collected and its meanings (McMillan & Schumacher, 2010). Validity was established for this study by noting participant language, recording the interviews, and testing the interview script before its use. Participant language consisted of utilizing easy-to-understand terms, and participants in this study were given a list of term definitions before the interview to provide a mutual understanding of said definitions. All interviews were recorded and transcribed to provide proper documentation and accurate reports from study participants. Additionally, participants were provided an opportunity to review their interview transcript to strengthen the accuracy and validity of data collected, to identify any discrepancies, and to modify their transcripts.

The researcher also had an independent expert who had a doctorate and experience with interviews and format of interview questions review the questions beforehand. This feedback provided the researcher with information about the validity of the questions asked, and appropriate amendments were made before the participant interviews.

Triangulation

The researcher used triangulation to support validation for this study. McMillan and Schumacher (2010) stated, "Triangulation is used when the strength of one method is used to off-set the weakness of the other, together providing a more comprehensive set of data" (p. 26). Multiple data collection methods were employed to allow for triangulation of findings and thus increase the reliability of the study (McMillan & Schumacher, 2010). This study utilized in-depth interviews and two or more forms of artifacts, such as awards and letters of commendation, as its primary method of inquiry for triangulation.

The four basic types of triangulation are (a) data triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) methodology triangulation (Patton, 2015). Creswell (2014) reported that conducting interviews and also using existing documentation and audio materials to check for consistency in findings across the data collection methods could accomplish data triangulation. For this study, combining both interviews and a minimum of two different types of artifacts, such as awards and letters of commendation, allowed for data triangulation in this multiple case study. The researcher collected artifacts from each participant in this multiple case study at the end of each interview, as artifacts were available. Data triangulation was used to increase validity of the study findings (McMillan & Schumacher, 2010).

Data Collection

Qualitative data were collected primarily through face-to-face interviews based on the open-ended, semi-structured questions for the instrumentation protocol found in Appendix I. The researcher maintained field notes throughout the data collection process for this study. Data collection methods consisted of qualitative interviews with 15

identified VHA emerging leaders who participated in one or more EL, LDI, or ECFD institutes at a VHA hospital in Southern California. The researcher collected artifacts for this study to contribute to the triangulation process (McMillan & Schumacher, 2010; Patton, 2015).

All electronic data from audio recordings of each interview were stored on the researcher's password-protected computer. All field notes from each interview were stored in a locked file at the researcher's residence. The researcher also completed the National Institute of Health (NIH) certification training for the protection of human research participants used in this study (Appendix L). The collection of data began after the BUIRB approved the collection of data from participants.

Data Analysis

The researcher captured and stored information derived from interviewing participants. Roberts (2010) stated, "Data analysis is making sense of the data and interpreting them appropriately not to mislead readers" (p. 38). Data coding for this study was performed using NVivo; a qualitative, data analysis software. The NVivo software was used to organize and analyze interview responses to elicit themes from the participants' answers. As themes emerged, the researcher annotated passages of text with a code label to identify commonalities between study participant opinions, perspectives, and ideas (Patton, 2015). Further, Patton (2015) noted that the researcher sought to identify high-frequency themes through this process, which led to the findings of the study. In this study, data coding was completed for each interview.

The researcher also documented interviews and used NVivo software to organize, analyze, and find insights in qualitative data. The NVivo software was helpful to the

researcher in sorting and organizing emerging themes captured from the participants about coaching and its impact on career performance growth and retention. While the use of computer software in the inquiry process provided an effective method to accomplish data preparation, identification, and manipulation, the software did not replace the researcher as the primary *tool* of the investigation (Merriam & Tisdell, 2016).

Upon completion of each interview, the transcription data were uploaded to NVivo. The ultimate goal of qualitative research was to formulate overall assertions about the categories by discovering patterns in the data. The NVivo software helped the researcher to sort and organize emerging themes; however, the researcher was responsible for analyzing and identifying the themes. Once the possible patterns had been identified, the researcher sought to validate the patterns and legitimate findings.

Interrater Reliability

In addition to triangulation, the researcher assured uniformity in the coding analysis by putting into action an interrater reliability test to discover the extent of similarity of the data analysis between two researchers (McMillan & Schumacher, 2010). Interrater reliability is a method to make certain the analysis of the data is similar when more than one person examines the themes (Roberts, 2010). According to Trochim (2006), interrater reliability is a means to determine the extent to which different individuals give corresponding ratings of a related experience. An interrater reliability test made sure that the researcher stayed away from biases when analyzing the data and exploring patterns and themes. With the help of a colleague researcher, the process of the interrater reliability test established that the researcher averted biases when analyzing the data and scanning for patterns and themes.

To carry out this effort, the researcher presented a qualitative researcher colleague a hard copy of 10% of the transcribed interviews to look at themes the researcher and NVivo found. After careful review, the colleague and this researcher came to a consensus in 90% of the themes that were found. The indicated approach showed a high percentage of the interrater agreement at or greater than 90% demonstrating that the researcher accurately analyzed the data and participants' answers. Lombard, Synder-Duch, and Campanella Bracken (2004) established intercoder reliability as "coefficients of .90 or greater are nearly always acceptable, .80 or greater is acceptable in most situations, and .70 may be appropriate in some exploratory studies for some indices" (p. 3).

Limitations

The sample population under investigation was limited to the identified institutes that offered coaching as one of their leadership development strategies in training. The study was also limited to geography in that only employees who worked 5 years or more and were employed by Los Angeles County VHAs in the city of Los Angeles and Long Beach participated in the study. The study did not investigate leaders who worked in other VHA hospitals outside of Los Angeles County or who were coached through other institutes. Perhaps there may have been different outcomes as perceived by national VHA leaders as compared with Los Angeles County VHA leaders.

This study was also limited by participants' responses to interview questions based on their perceptions of their coaching experiences. Guaranteeing the honesty and sincerity of the participants' responses was impossible, so the study was limited by what the participants remembered and their willingness to share information.

Summary

The purpose of this qualitative multiple case study methodology was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California. The research case study methodology design provided a greater understanding of each participant's case based on the qualitative interview processes employed. The population for this study was VHA emerging leaders. Data collection along with limitations of the research findings were also described. An analysis of the results of data is provided in Chapter IV. Chapter V offers conclusions, implications, and recommendations derived from the findings presented in this chapter.

CHAPTER IV: RESEARCH, DATA COLLECTION, AND FINDINGS

Chapter IV provides an analysis of the data elicited from the responses of 15 healthcare leaders interviewed to describe the impact of career coaching on the career performance growth and retention as perceived by healthcare leaders who participated in selected coaching program institutes at Veterans Health Administration (VHA) hospitals in Southern California. This chapter begins with a review of the purpose of the study, the research questions, methodology, data collection procedures, population, and sample. The data from each interviewee are then presented under each research question, and subsequently, overall themes that were elicited as responses to each research question are presented. Finally, Chapter IV culminates with a summary of all major elements related to the study's research data collection, and findings from all participants' responses.

Purpose Statement

The purpose of this qualitative multiple case study was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California.

Research Questions

The central research question guiding this study was, What is the perceived impact of career coaching on the job performance growth and retention of emerging healthcare leaders who have attended leadership professional development institutes at VHA hospitals in Southern California? The following were the subquestions of the study:

1. What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?
2. What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at a VHA hospital in Southern California for a minimum of 1 year?

Research Methods and Data Collection Procedures

This qualitative multiple case study used semi-structured interview questions to explore and describe how Emerging Leaders (EL), Leadership Development Institute (LDI), or Executive Career Field Development (ECFD) participants at VHA hospitals in Southern California perceived the influence of coaching on their ability to achieve career performance growth and also influenced their retention after being coached a minimum of 1 year. Qualitative methodology was the best approach to this study to examine human lives and experiences (Patton, 2015). Case study methodology was representative of what the researcher wanted to find out about each individual who was interviewed. Creswell (1998) defined case study as "an exploration of a bounded system or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context" (p. 61).

While the topic of career coaching leaders has received considerable attention in recent times, there is not enough information about career coaching for healthcare leaders explicitly concerning support of their individual career growth and retention. Thus, there is a need for a study on career coaching of healthcare leaders. According to McMillan

and Schumacher (2010), qualitative case studies have fewer but carefully chosen participants. The researcher used nonprobability, purposeful snowball, and convenience sampling to identify and select participants. The purposeful sampling method allowed the researcher to recruit participants who met identified characteristics intentionally. The participants' characteristics included current employment in the VHA Los Angeles County, those who completed either one or more of EL, LDI, and ECFD and had 5 or more years of VHA employment. These participants provided useful information for the study. The snowball strategy provided the researcher an opportunity to identify participants by asking the Human Resources Department (HRD) at the Southern California VHA sites to refer individuals and then these individuals referred others to participate in this study as potential candidates for the interviews. Finally, using convenience sampling, the researcher was able to interview 11 participants face-to-face and four interviews were conducted by telephone.

The researcher began by contacting HRD at VHA hospitals in Los Angeles County to invite leaders who had participated in the selected VHA coaching program institutes identified in the study to be interviewed. Of the 25 leaders referred by the HRD and the initial participants who referred others, the researcher was able to identify 15 individuals who met the criteria for the study. The criteria included leaders who completed one or more of the three leadership development institutes in which they received coaching for a minimum of 1 year.

The researcher engaged in semi-structured interviews with a total of 15 leaders to gain an understanding from their perspectives about the influence coaching had on their career growth and retention. The researcher developed an interview protocol that

included 12 questions and follow-up probing questions. Each participant was asked the same questions and follow-up probing questions as needed. The researcher collected demographic information from each participant. The first question in the interview set the stage for the participants to begin thinking about specific reasons that led them to participate in one or more of the leadership institutes used for coaching and training for leadership development in the VHA. The remaining questions encouraged the participants to think about how coaching through these institutes influenced their career growth and retention. The interview protocol including all 12 questions is provided in Appendix I.

Once participants agreed to engage in this study, the researcher's contact information was made available. Further, the researcher provided each participant with an official invitation letter via e-mail explaining in detail the nature of the study (Appendix B), a copy of the informed consent (Appendix C), audio release consent (Appendix E), and the Brandman University Participant Bill of Rights (Appendix F). The informed consent was provided via e-mail for reference. Individual face-to-face interviews were set up at a place and time that was convenient for participants. At the time of the interview, a hard copy of the informed consent was provided to all participants for their signature. Each participant agreed to be audio recorded during the interview. Additionally, each interview was recorded, using an iPhone recording application, and a computer audio recording was set up as a backup recording device.

All 15 interviews were intended to be conducted face-to-face. Due to availability and preference, 11 interviews were conducted face-to-face and four interviews were conducted by telephone. All interviews were recorded as indicated in the informed

consent form (Appendix C) and audio release consent (Appendix E). Any questions a consenting participant may have had concerning the study and interview protocol were answered before the recording. All participants interviewed by telephone were e-mailed a signed electronic informed consent form and verbally confirmed participation at the beginning of the recorded interview.

Upon completion of each interview, each audio-recording file was sent to a transcriber for professional transcription. Once the transcription was available, interviewed participants were sent the transcription and asked to verify the transcript content and make any corrections in the transcription within 3 days of the interview. There was only one person interviewed who sent back corrections, and this correction identified by an interview participant was due to a misspelled word.

The researcher uploaded each interview transcription into NVivo coding software. Each transcript was then coded to produce themes and patterns. An interrater, with qualitative data experience and an earned doctoral degree, coded one of the initial interview transcriptions. The researcher and the interrater compared their coding results to ensure interrater reliability. An accuracy of 90% between the interrater and the researcher's interpretation surpassed the no-less-than 80% requirement for interrater reliability.

Population and Sample

The population for this study consisted of VHA EL, LDI, and ECFD participants in Southern California. All 15 participants in this study were VHA leaders. Each participant in the study attended one or more of three leadership development institutes (EL, LDI, and ECFD) for a minimum of 1 year in which they received coaching. Five of

the 15 participants completed EL, while one of the five participants also completed LDI. Seven of the 15 participants completed LDI. Additionally, three participants completed ECFD. Table 5 summarizes the demographic description of the 15 participants from this study: the institutes that the participant attended, their gender, ethnicity, and the number of years of VHA employment.

Table 5

Emerging Leaders (EL), Leadership Development Institute (LDI), Executive Career Field Development (EFCD) Demographic Information

Participant case #	Gender	Ethnicity	Age range	Years of VHA employment	Education
			Emerging Leaders (EL)		
1	F	AA	35-44	12	MS
2[a]	F	H	45-54	30	BA
3	M	AA	45-54	5	MS
4	F	AA	55-64	38	BS
5	F	AA	55-64	34	BA
			Leadership Development Institute (LDI)		
6	M	AA	45-54	14	BA
7	M	AA	35-44	8	Some college
8	F	AS	45-54	21	Ed.D
9	M	H	45-54	20	DNP
10	M	H	45-54	15	BA
11	F	AA	55-64	30	MS
12	F	C	45-54	20	PhD
			Executive Career Field Development (EFCD)		
13	F	AA	55-64	30	MA
14	F	AS	55-64	23	PhD
15	F	C	45-54	31	MS

Note. AA = African American; AS = Asian; C = Caucasian; H = Hispanic
[a]Participant 2 also attended LDI.

Of the five EL participants in this study, four were females and one was male, four were African American, one Hispanic, three were employed by the VHA for over 30 years, one for 5 years, and one over 10 years. The participants ranged in ages from 35 to 64 years of age. These participants' educational backgrounds included three with a

bachelor's degree and two with a master's degree. Of the seven LDI participants, three were females and four were male, three were African American, two Hispanic, one Asian, and one Caucasian; and Participant 2 attended EL as well. One was employed by the VHA for 30 years, three for 20-plus years, one for 15 years, one 14 years, and one for 8 years. These participants also had varied educational backgrounds including one who had some college, two with a bachelor's degree, one with a master's degree, and three with doctorates. Additionally, all three EFCD participants were females; one was African American, one Asian, and one Caucasian. Two were employed by the VHA for 30-plus years and one for 23 years. Also, these participants' educational backgrounds included two with a master's degree and one with a doctorate.

Presentation and Analysis of the Data

The research questions (repeated here for ease of reference) for this study sought to discover the lived experiences of each of the cases that were conducted with the individual participants from VHA ELs, LDIs, and EFCDs. The data were analyzed to develop common themes and patterns and categorized to address the two research questions of the study. Individuals from each institute were assigned a case number to safeguard their identity and ensure anonymity for participation in the study. Tables were developed to graphically display the data analysis results of the VHA leaders interviewed and aligned to the research questions, institutes attended, themes, and frequency of responses to those themes.

Research Question 1 (RQ1). What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of one

year through selected leadership professional development institutes at VHA hospitals in Southern California?

Research Question 2 (RQ2). What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?

Emerging Leaders (EL)

VHA Participant 1. VHA Participant 1 was a female with 12 years of VHA employment who participated in EL for one year. Educated at a master's level with experience in mental health, this participant had prior experience in being coached. She received a promotion within 3 months of completing the EL with additional coaching as a part of this institute.

RQ1. VHA Participant 1 made reference to the theme of "personal growth" four times during the interview. VHA Participant 1 offered one idea on personal growth, "I wanted to learn more about the organization where coaching provided training techniques. . . . In addition to learning, coaching can prepare one for a potential promotion as it has done for me." VHA Participant 1 indicated, "Participation in Emerging Leaders gave me a better understanding of the VHA. . . . The training enhanced my skills to be a better leader."

Two times during the interview VHA Participant 1 made reference to the theme of motivation: "I think coaching helped me to get a deeper understanding of what's going on in the organization. . . . My motivation derives from giving and receiving support in the workplace, and I enjoy being a cheerleader for the team; coaching is a vital part of the job."

VHA Participant 1 credited being coached with providing opportunities for networking with others. Coaching was also credited by this participant for her ability to demonstrate her talents to others. VHA Participant 1's responses identified with five of the seven themes and patterns that related to RQ1. From her perspective, VHA Participant 1 identified personal growth and motivation as the first and second most important elements related to her career performance growth after being coached.

RQ2. VHA Participant 1 made reference to "motivation " two times during the interview regarding the perceived impact on her employment retention: "Coaching motivated and provided a deeper understanding of the organizational process. . . . Coaching motivated me to remain with VHA and had an impact on my employee retention."

VHA Participant 1 identified the theme of employment development as it related to her employment retention after being coached through selected leadership professional development institutes. A summary of VHA Participant 1's responses to RQ1 and RQ2 is provided in Table 6.

Table 6

EL Participant 1 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by response
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Personal growth	4
	Motivation	2
	Recognition	1
	Empowerment	1
	Enhanced skills	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Motivation	2
	Employee development	2

VHA Participant 2. VHA Participant 2 was a female leader with 30 years of VHA employment. Educated at the bachelor's level with experience in education, this participant completed the EL institute and also completed LDI 3 years prior to the commencement of this study. From her perspective, VHA Participant 2 shared that participation in VHA leadership training has provided an opportunity for her to be recognized for promotion.

RQ1. In response to the research questions, this participant identified with six of the seven themes and patterns that related to RQ1. From her point of view, VHA Participant 2 identified with the first and second themes—leadership development and empowerment—as the most important elements identified as it related to her career performance growth after being coached. VHA Participant 2's responses are tallied for RQ1 and RQ2 and these data are provided in Table 7.

VHA Participant 2 made reference to the theme of "leadership development." Participant 2 stated, "Emerging Leaders Institute included having a coach, which was extremely beneficial because it put me in a position where I had to develop an individual development plan." Further VHA participant 2 shared "I gained a better understanding as to what was my short-term goals and direction on reaching my long-term goals . . . Leadership development provided me with a continuous effort to strengthen my knowledge skills and abilities".

VHA Participant 2 also referred to empowerment four times during the interview. VHA Participant 2 stated, "ELI training empowered me to serve as a mentor for others. . . . Since ELI, I empowered others to mentor their staff through continuous training to provide additional staff with more experience and empowerment." Recognition was

referenced three times by VHA Participant 2 during her interview. VHA Participant 2 stated, "Receiving an abundance of awards and recognition after completing coaching and leadership training. . . . I was recognized by the local VHA and also from the network covering all of Southern California VHAs." Further, VHA Participant 2 stated, "I received the highest recognition that I am proud of as being awarded top ten women for the state of California for making a difference."

VHA Participant 2 also referenced motivation, enhanced skills, and personal growth one time each during her interview. From Participant 2's perspectives, EL training provided her with the "opportunity to be coached and kept her motivated and inspired to continue despite any obstacles that she was facing." VHA Participant 2 indicated, "Emerging Leaders teachings gave me introductory enhanced skills needed for my leadership and career growth." Finally, VHA Participant 2 expressed that EL provided her with personal growth. . . . We must continue to provide education and coaching for other individuals who want individual growth within their organization."

RQ2. VHA Participant 2 referred to motivation and employee development two times each during the interview regarding her perceived impact on her employment retention in the VHA. Participant 2 shared, "I work with staff to motivate and help them develop goals and improve individual skills . . . to strengthen the department or individual." VHA Participant 2 identified with the elements, motivation, and employment development as it related to "her satisfaction and employment retention after being coached through selected leadership professional development institutes."

Table 7

EL Participant 2 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by response
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Leadership development	4
	Empowerment	4
	Recognition	3
	Motivation	1
	Enhanced skills	1
	Personal growth	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Motivation	2
	Employee development	2

VHA Participant 3. VHA Participant 3 was a male leader with 5 years of VHA employment. Educated at a master's level with experience in business and healthcare administration; this participant had the least VHA years of employment of all participants in the study.

RQ1. VHA Participant 3's responses identified with four of the seven themes and patterns that related to RQ1. From his perspective, VHA Participant 3 identified with personal growth as the most crucial element as it related to his career performance growth after being coached. VHA Participant 3 shared that "EL provided inspiration and additional resources. . . . The numerous leadership courses provided a platform for moving forward in my development."

VHA Participant 3 referred to the theme of personal growth three times. VHA Participant 3 stated that he acquired personal growth through coaching and by connecting and establishing relationships through ELI. VHA Participant 3 stated,

> I am a believer in communication. . . . Communication is key in everything that we do, and everything begins with communication and having the ability to determine which type of communication to use during specific scenarios has been vital to my career path.

Other comments provided were the following:

> My goal has always been for me to grow personally and professionally . . . Personal growth has always been my mantra. . . . Coaching received through participation in Emerging Leaders was inspirational and provided me with numerous leadership courses that I can take with me going forward in my career development.

Also, VHA Participant 3 referred to recognition and enhanced skills one time each during the interview. VHA Participant 3 voiced recognition as "part of being recognized is being asked to share your talents with others. . . . I had the opportunity to teach a portion of the new employee orientation on servant leadership." Furthermore, VHA Participant 3 shared his feeling that the "opportunities to enhance one's skills as a result of him teaching new staff at the employee orientation" was beneficial.

RQ2. VHA Participant 3 referred to employee development and passion one time each during the interview on his perceived impact regarding his employment retention at VHA. VHA Participant 3 stated that, when it comes to employment development and passion,

> There are resources; it's just up to us as an employee to utilize them. . . . There are numerous committees and projects to allow us to learn and grow new skills.

. . . Coaching supported by emerging leaders provided me with an advantage to explore what I am passionate about.

Moreover, VHA Participant 3 stated, "The importance of developing one's skills and doing what one loves are important elements for one's retention." A summary of VHA Participant 3's responses to RQ1 and RQ 2 is provided in Table 8.

Table 8

EL Participant 3 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by response
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Personal growth	3
	Recognition	1
	Enhanced skills	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Employee development	1
	Passion	1

VHA Participant 4. VHA Participant 4 was a female leader with 38 years of VHA employment. VHA Participant 4's education is at a bachelor's level. VHA Participant 4 worked in many areas of the hospital before advancing into leadership. Most of her career was primarily in an administrative support role. VHA Participant 4's responses identified with five of the seven themes and patterns that related to RQ1.

RQ1. VHA Participant 4 identified the first element and most crucial element of EL as coaching. Participant 4 indicated that coaching was excellent and referenced coaching four times, "It was the foundation for my leadership growth. . . . Coaching was the program for me because I had someone that was able to guide me through the

process." Additionally, VHA Participant 4 stated, "Coaching helped me with the important parts of learning, having someone guide me. . . . Coaching helped me to interact with people on a more professional level. . . . All VHA employees could benefit from a coach."

The theme of personal growth was also referenced three times. VHA Participant 4 shared, "I have been with the VHA for a long time, and while I am here I want to do the best that I can. . . . Emerging Leaders Institute helped to guide my government career." Further, VHA Participant 4 offered an idea for an opportunity for personal growth, "When new employees come to this facility, especially young people, position them with a coach right away."

Recognition and leadership development were themes referenced one time each by VHA Participant 4. More importantly, Participant 4, shared,

> I have been recognized throughout my career for my work. . . . I thought it was time for me to step up and advance my career. . . . I applied for emerging leaders . . . which guided me on how to teach and relate information to others.

RQ2. VHA Participant 4 felt that the sense of confidence and influence received from her coach had a major impact on her career and VHA retention. One occurrence that VHA Participant 4 shared,

> I was nervous about speaking in front of VHA executive leadership. . . . My coach expressed confidence in me, asked if I knew the material, upon confirmation. . . . The coach suggested I go out there and tell executive leadership what I know.

A summary of VHA Participant 4 responses to RQ1 and RQ2 is provided in Table 9.

Table 9

EL Participant 4 Responses by Research Questions: Themes and Frequency

Research question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Coaching	4
	Personal growth	3
	Recognition	1
	Leadership development	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Influence	2
	Sense of confidence	1

VHA Participant 5. VHA Participant 5 was a female leader with 34 years of VHA employment. She was educated at a bachelor's level with experience in management. VHA Participant 5's responses identified with five of the seven themes and patterns that related to RQ1.

RQ1. From her perspective, VHA Participant 5 identified the first and second most important elements of EL as "coaching followed by leadership development." Participant 5 verbalized, "Leadership development provided coaching skills, which improved how she mentors and leads others. Blending coaching and leadership development opened doors for individuals completing the EL program to apply for advanced leadership training." Also, VHA Participant 5 found that "coaching helped her with public speaking and how to implement a performance development plan which was instrumental in guiding her career growth."

RQ2. VHA Participant 5 identified several themes—motivation, passion and recognition—as they related to her employment retention after being coached through selected leadership professional development institutes. VHA Participant 5 found that

"she overcame employment "hurdles" after attending ELI and being coached. Further, Participant 5 shared,

> I don't think I could have obtained my current job. . . . It would not have been possible without completing the Emerging Leader Institute. . . . Recognition as a leader occurred once I completed the Emerging Leaders' program. I was promoted to a supervisor. The promotion and recognition had a major impact on my employment retention.

A summary of VHA Participant 5's responses to RQ1 and RQ2 is provided in Table 10.

Table 10

EL Participant 5 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Coaching	4
	Leadership Development	3
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Motivation	1
	Passion	1
	Recognition	1

Artifacts of VHA EL participants. Four of the five leaders who attended EL institute provided the researcher with artifacts. VHA Participant 1 shared being recognized when she "received a promotion within three months of completing the Emerging Leaders Institute." Further, VHA Participant 1 stated, "Receiving the promotion also impacted my employment retention."

VHA Participant 2 referenced her recognition and shared an abundance of plaques, certificates, and awards with the researcher. Moreover, VHA Participant 2 was recognized by the local VHAs. "I have an abundance of awards and recognitions . . . I am proud of the recognition from the network and the California Senate."

VHA Participant 4 responded to the interview questions that recognition occurred when she completed the EL institute. She shared a certificate of appreciation that she received from her supervisor. VHA Participant 5 shared an EL institute certificate of completion. Additionally, VHA Participant 5 reported receiving a promotion certificate.

The five leaders who attended the EL Institute provided the researcher with EL certificates of completion, and other artifacts received that directly supported their career growth, and retention are noted in Table 11.

Table 11

Artifacts From EL Participants

	Certificates of completion	Plaques	Promotion certificates
VHA Participant 1	X		X
VHA Participant 2	X	X	X
VHA Participant 3	X		
VHA Participant 4	X	X	
VHA Participant 5	X		X

Leadership Development Institute (LDI)

VHA Participant 6. VHA Participant 6 was a male leader with 14 years of VHA employment, educated at a bachelor's level with experience in nutrition and retail management. VHA Participant 6's responses identified with three of the seven themes and patterns that related to RQ1.

RQ1. From VHA Participant 6's perspective, the most critical elements of LDI were recognition, coaching, and networking. VHA Participant 6 indicated, "I think networking opportunities with local facilities as well as VHA facilities abroad opened doors to elevate leaders like myself to higher levels . . . coaching helped with my career growth to become proactive in work assignments, meetings and associating with other colleagues."

RQ2. VHA Participant 6 reported, "I received a plaque for my leadership skills and was named the Canteen Manager of the Year." More importantly, a major impact on retention reported by VHA Participant 6 was "after completing LDI, I was promoted to a supervisor." In response to RQ2, VHA Participant 6 identified several themes—influence, networking, and recognition—as they related to his employment retention after being coached through selected leadership professional development institutes. "These variables helped me to stay with the VHA because I felt valued and supported by my superiors."

A summary of VHA Participant 6's responses to RQ1 and RQ2 is provided in Table 12.

Table 12

LDI Participant 6 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Networking	2
	Recognition	1
	Coaching	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Influence	2
	Networking	2
	Recognition	1

VHA Participant 7. VHA Participant 7 was a male leader with 8 years of VHA employment. He completed some college. His experience included management and supervision of volunteer services.

RQ1. VHA Participant 7's responses identified with four of the seven themes and patterns that related to RQ1. From Participant 7's perspective, the essential elements of LDI are personal development, recognition, networking, and leadership development. Participant 7 stated, "At my current position, I didn't appear to have any leeway or room for upward mobility, so I signed up for LDI which helped enhance my career." Moreover, Participant 7 shared, "Coaching helped me to realize I was going to need to do more networking for career advancement. . . . I think networking was one of the most common components in the LDI training."

RQ2. VHA Participant 7 identified several themes—networking, personal development, training opportunities, and recognition—as they related to his employment retention after being coached through selected leadership professional development institutes. VHA Participant 7 shared,

> Coaching helped me to realize I was going to need to do more networking for career advancement. . . . I think networking was one of the most common components in the LDI training . . . that helped me fit in and desire to remain with the VHA.

Also, VHA Participant 7 reported "receiving thank you or kudos from service organizations." A summary of VHA Participant 7 responses to RQ1 and RQ2 is provided in Table 13.

Table 13

LDI Participant 7 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Personal development	4
	Networking	2
	Leadership development	1
	Recognition	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Networking	2
	Personal development	4
	Training opportunities	1
	Recognition	1

VHA Participant 8. VHA Participant 8 was a female employee with 21 years of VHA employment. She had a doctorate in education. Participant 8's experience with coaching was related to her current career as a vocational and rehabilitation advisor for veterans.

RQ1. VHA Participant 8's responses identified with three of the seven themes and patterns that related to RQ1. From Participant 8's point of view, the most critical elements of LDI are networking followed by recognition and leadership development.

Moreover, VHA Participant 8 shared, "I had a chance to network with senior executive leadership at my facility and other VHA's in southern California. . . . Networking was like having multiple coaches helping develop your career personally and professionally." Participant 8 further stated, "I believe coaching gave me an opportunity to learn leadership skills and move forward in my career advancement and growth."

RQ2. VHA Participant 8 reported that being recognized had an impact on her employment retention. As a matter of fact, VHA Participant 8 shared that after

completing LDI, "I was named the employee of the quarter and received a bonus almost every year since then based on work performance."

A summary of VHA Participant 8's responses to RQ1 and RQ2 is provided in Table 14.

Table 14

LDI Participant 8 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Networking	5
	Recognition	4
	Leadership development	2
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Networking	5
	Recognition	4
	Empowerment	2
	Commitment	1

VHA Participant 9. VHA Participant 9 was a male employee with 20 years VHA employment in healthcare. He has a doctorate in nursing.

RQ1. In response to the interview questions, this participant identified with five of the seven themes that related to RQ1. VHA Participant 9 shared, "coaching, influence, challenges, recognition, and leadership development" were the most important elements of LDI. Five times during the interview VHA Participant 9 made reference to the theme of coaching. Notably, VHA Participant 9 stated,

> A lot of people have coaches professionally that they bounce ideas off. The LDI program was great and opened my eyes to the ideas of even coaches need a coach. . . . Personally, I have not gotten to a position where I feel the need to have

continuous coaching; however, I would seek to receive coaching if I was at a higher level position or over the medical center.

RQ2. Participant 9 stated,

LDI is a career development program providing training opportunities at no cost to the employee. . . . I might as well make myself as educated as possible and use this VHA resource to further my professional career. . . . I'm going to be around the workforce and might as well get to become the best employee. . . . VHA employees are offered the best training benefits for career growth and retention.

A summary of VHA Participant 9's responses to RQ1 and RQ2 is provided in Table 15.

Table 15

LDI Participant 9 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Coaching	5
	Influence	2
	Challenges	2
	Recognition	1
	Leadership development	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Training opportunities	6
	Coaching	5
	Empowerment	3

VHA Participant 10. VHA Participant 10 was a male employee with 15 years of VHA employment. He has a bachelor's degree. This participant is responsible for public relations and communication with stakeholders.

RQ1. In response to the interview questions, this participant identified with four of the seven themes that related to RQ1. From VHA Participant 10's observations, "challenges, recognition, influence, and networking" were the most important training elements of LDI. Five times during the interview, VHA Participant 10 referred to the theme of challenges. Specifically, Participant 10 stated,

> Coaching helped me learn how to address disappointments and challenges within the organization and not let challenges overwhelm me. . . . It's easy to be discouraged by bureaucracy. . . . Recognizing that being frustrated is a normal thing we all experience. . . . Even though the VHA organization may be challenging and frustrating, just remember that it's OK to be frustrated, it's OK to be disappointed . . . challenges helped to sharpen my leadership skills.

RQ2. As a result of being coached through LDI, VHA Participant 10 stated, "Relationships is the way I've got to this point in my career due to coaching. . . . Coaching helped me understand relationships matter and people count on the relationship more than they count on you solving problems." Also, Participant 10 indicated, "It was through coaching that I built relationships . . . true relationships that have impacted my retention at the VHA."

A summary of VHA Participant 10 responses to RQ1 and RQ2 is provided in Table 16.

Table 16

LDI Participant 10 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Challenges	5
	Recognition	3
	Influence	3
	Networking	2
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Relationship	3
	Recognition	3
	Influence'	3

VHA Participant 11. VHA Participant 11 was a female employee with 30 years of VHA employment. VHA Participant 11 has a master's in Health Services Administration. This participant has worked at two different VHA hospitals in southern California. VHA Participant 11's professional expertise has been in the medical specialty clinics.

RQ1. In response to the interview questions, this participant identified with five of the seven themes that related to RQ1. From VHA Participant 11's responses, "recognition, personal development, leadership development, coaching, and influence" were the most important elements of LDI. Three times during the interview, VHA Participant 11 referred to the theme of recognition.

VHA Participant 11 stated, "Coaching and training in LDI is beneficial for personal development and career performance growth . . . the training prepared me to step in unexpectedly for my supervisor which identifies leadership and management qualities to succeed." Additionally, VHA Participant 11 stated, "LDI has played a huge

impact on my leadership skills and has also enhanced my communication and leading of others."

RQ2. VHA Participant 11 declared, "The coaching I received in LDI is worth tremendous value and has impacted my employment retention . . . coaching has helped me to develop a new outlook on my role as a VHA leader."

A summary of VHA Participant 11's responses to RQ1 and RQ2 is provided in Table 17.

Table 17

LDI Participant 11 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Personal development	2
	Leadership development	2
	Coaching	1
	Influence	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Recognition	3
	Personal development	2
	Retention	1

VHA Participant 12. VHA Participant 12 was a female employee with 20 years of VHA employment. VHA Participant 12 has a doctorate. This participant had an extensive background in mental health and rehabilitation medicine. Notably, VHA Participant 12 published numerous articles in professional journals and has been a presenter at conferences and training programs.

RQ1. In response to the interview questions, this participant identified with five of the seven themes that related to RQ1. From VHA Participant 12's observation,

"Coaching, leadership development, challenges, personal development and recognition" were the most important elements of the LDI training he received. Five times during the interview, VHA Participant 12 referred to the theme of coaching. Participant 12 expressed the following:

> LDI coaching experiences helped me with being surrounded by a coach as well as other participants who are like-minded around change to move forward for career growth . . . watching, observing and getting feedback from a coach and being coached. . . . I think you have to be reminded of that at times . . . part of being coached and leadership development is being around other people who share that belief.

RQ2. Participant 12 viewed retention as "surrounding yourself with people who assist with personal career growth is favorable for upward mobility . . . retention at the VHA is a necessity for me because of accessibility, location, and social support."

A summary of VHA Participant 12 responses to RQ1and RQ2 is provided in Table 18.

Table 18

LDI Participant 12 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Coaching	5
	Leadership development	3
	Challenges	2
	Personal development	2
	Recognition	2
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Relationship	2
	Recognition	2
	Making a difference	2

Artifacts of VHA LDI participants. Seven of the seven leaders who attended LDI had something of importance to share with the researcher, which they had received that directly supported their career growth or retention are noted in Table 23. VHA Participant 6 stated, "I have a plaque for managing the Canteen of the year!" Moreover, VHA Participant 7 stated, "I have a noteworthy completion certificate from LDI thanking me for participating in the program and other certificates of appreciation from other service organizations." Likewise, VHA Participant 8 indicated, "I was given a certificate for completing LDI and later I was named the employee of the year from my specific VHA organization."

Additionally, VHA Participant 9 stated, "I have a portfolio where I keep all of my certificates of recognition and photos taken at award ceremonies." VHA Participate 10 stated, "I have numerous artifacts showing my rewards and recognition. . . . Those are meaningless because the truth is at the end of the day it is the veteran's opinion of my work that matters." Further, VHA Participant 11 shared, "I received an award for completing LDI . . . subsequently selected as president of my professional organization for the state of California." Also, VHA Participant 12 disclosed, "I have numerous awards on display in my office. . . . Some are recognition for publishing over 86 articles in professional journals."

The seven leaders who attended the LDI provided the researcher with LDI certificates of completion, and other artifacts received that they perceived directly supported their career growth, and "made a difference in their wanting to remain at the VHA." Seven of the seven said they believed they received these awards after being coached in LDI and participating in this institute. Summaries of LDI participants' artifacts are provided in Table 19.

Table 19

Artifacts From LDI Participants

	Certificates of completion	Plaques	Promotion certificates
VHA Participant 6	X	X	X
VHA Participant 7	X		X
VHA Participant 8	X		X
VHA Participant 9	X	X	X
VHA Participant 10	X	X	
VHA Participant 11	X		
VHA Participant 12	X	X	

Executive Career Field Development (ECFD) Institutes VHA Participant 13. VHA Participant 13 was a female leader with 30 years of VHA employment. VHA Participant 13 has a master's degree. This participant's experience includes finance and contract management.

RQ1. VHA Participant 13's responses identified with four of the five themes and patterns that related to RQ1. From VHA Participant 13's perspective, the most important elements of ECFD were "leadership development, personal development, emotional intelligence, and recognition." Interestingly, VHA Participant 13 shared, "Through coaching, I have realized how leadership development and overall expectations work. . . . I have changed my mindset around how I lead and guide others." As a result Participant 13 confirmed that ECFD helped her to be a better leader in her career performance and development.

RQ2. VHA Participant 13 identified several themes—"retention, commitment, emotional intelligence and recognition"—as they related to her employment retention after being coached through ECFD. VHA Participant 13 indicated, "What is key for job satisfaction and especially for retention are for employees to know and understand where

they fit in the organization." A summary of VHA Participant 13's responses to RQ1and RQ2 is provided in Table 20.

Table 20

ECFD Participant 13 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Leadership development	5
	Personal development	5
	Emotional intelligence	1
	Expectation	1
	Recognition	1
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Retention	2
	Commitment	1
	Emotional intelligence	1
	Recognition	1

VHA Participant 14. VHA Participant 14 was a female leader with 23 years of VHA employment. VHA Participant 14 completed a doctorate. VHA Participant 14's experiences included mental health, education, and research.

RQ1. VHA Participant 14's responses identified with six of the seven themes and patterns that related to RQ1. From Participant 14's perspective, the most critical elements of ECFD were "personal growth, recognition, and leadership development." Participant 14 stated, "ECFD leadership development provided training combined with highly selective enrollment . . . participation in leadership development and having a coach was essential."

RQ2. In response to RQ2, VHA Participant 14 identified several themes—"leadership development, retention, and recognition"—as they related to her employment retention after being coached.

Participant 14 shared, "After attending ECFD, I was influenced to retain my employment with VHA . . . ECFD impacted my retention 100 percent. . . . Before ECFD, I was ready to quit." Participant 14 expressed stagnation and feeling unchallenged as the reasons she wanted to quit. A summary of VHA Participant 14's responses to RQ1 and RQ2 is provided in Table 21.

Table 21

ECFD Participant 14 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Personal growth	4
	Recognition	2
	Leadership development	5
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Retention	4
	Recognition	2

VHA Participant 15. VHA Participant 15 was a female leader with 31 years of VHA employment. VHA Participant 15 has a master's degree. VHA Participant 15's career was in health systems management.

RQ1. VHA Participant 15's responses identified with seven of the seven themes and patterns that related to RQ1. From Participant15's perspective, the most critical elements of ECFD were "personal growth, leadership development, commitment, expectation and emotional intelligence." VHA Participant 15 stated,

> Part of coaching is not to be afraid to tell people what it is that you want to do. . . . Setting continuing goals and sharing this is what I want to do with others. . . . Let people who are around you help grow your career and support you.

Additionally, VHA Participant 15 asserted, “Ask others to keep an eye open for you and send things your way that might grow your career. . . . We need to be comfortable as leaders with having career growth conversations.”

RQ2. In response to RQ2, VHA Participant 15 identified with several themes—commitment, leadership development, personal growth, retention and recognition, emotional intelligence as it related to his employment retention—after being coached through selected leadership professional development institutes. Participant 15 shared that she was recognized when

> the Chief of Staff at another hospital who has worked for the central office contacted me about participating in the senior executive development program . . . when I finished the program, I was asked if I would present an orientation for the new fellows of my experience in the executive career field development program.

Participant 15 further stated “being recognized had a major impact on my retention, I felt like gold.”

A summary of VHA Participant 15’s responses to RQ1 and RQ2 is provided in Table 22.

Artifacts of VHA ECFD institute participants. Three ECFD (100%) VHA participants highlighted artifacts as they related to the perceived impact on their career promotions and employment retention after being coached. Collectively, the artifacts described by the ECFD participants were viewed as letters of appreciation, certificates of completion, and promotion certificates and plaques.

Table 22

ECFD Participant 15 Responses by Research Questions: Themes and Frequency

Research Question (RQ)	Theme/pattern	Frequency by responses
RQ1: What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?	Leadership development	15
	Personal growth	14
	Commitment	5
	Expectation	5
	Emotional intelligence	5
RQ2: What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year?	Commitment	5
	Emotional intelligence	5
	Recognition	5

VHA Participant 13 shared, "I have a certificate of completion of ECFD." Also, VHA Participant 14 reported, "Upon completing ECFD, I received a promotion." Similarly, VHA Participant 15 shared having "a certificate of completion from ECFD along with plaques." Mutually the three leaders who attended the EFCD shared "being recognized and promoted was instrumental in their VHA retention." The three leaders who attended the EFCD provided the researcher with EFCD certificates of completion, and other artifacts received that directly supported their career growth, and retention and are noted in Table 23.

Table 23

Artifacts From ECFD Participants

	Certificates of completion	Plaques	Promotion certificates
VHA Participant 13	X	X	X
VHA Participant 14	X	X	X
VHA Participant 15	X	X	X

Summary

Chapter IV presented the data that were collected and findings of this qualitative multiple case study. The study revealed the results of responses from semi-structured interviews of 15 VHA healthcare leaders interviewed to describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's leaders who participated in selected coaching program institutes. The population for this study consisted of VHA EL, LDI, and ECFD institute participants in Southern California. All participants were leaders at VHAs in Southern California. The VHA participants were 10 females and five males employed by VHA in southern California ranging from 35 to 64 years of age. Each VHA participant interviewed identified the most critical elements of EL, LDI, or ECFD discussed in this study and provided additional responses from their perspectives for each institute. An analysis of interview responses identified a total of 21 themes for EL, LDI, and ECFD regarding the perceived impact coaching had on career growth and employment retention.

The first research question was, What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California? Table 24 contains a summary of the themes of all three institutes in descending order.

Of the five participants who attended EL, the highest frequencies of themes for EL were leadership development (8) followed by coaching (8) and personal growth (7). The lowest frequency of themes identified were enhanced skills (3) and motivation (3). The theme common for all five EL institute participants was recognition. The uncommon

theme of EL institute participants was challenge. Collectively, the EL participants viewed the leadership development experience as a training component that strengthened their knowledge, skills, and abilities for career advancement.

Table 24

Research Question 1 Summary of the Themes for EL, LDI, and ECFD Institutes in Descending Order

Themes	No. of participants	Total frequency of responses	Frequency of responses		
			EL	LDI	ECFD
Leadership development	11	42	8	9	25
Coaching	6	20	8	12	0
Personal growth	7	17	7	0	10
Recognition	7	12	1	9	2
Networking	4	11	0	11	0
Challenges	3	9	0	9	0
Personal development	4	7	1	6	0
Emotional intelligence	2	6	0	0	6
Expectations	2	6	0	0	6
Influence	3	6	0	6	0
Commitment	1	5	0	0	5
Empowerment	2	5	5	0	0
Enhanced skills	3	3	3	0	0
Motivation	2	3	3	0	0

The highest frequency of an identified theme for LDI was coaching. Seven LDI participants responded nine times that leadership development was significant to achieving career performance growth after completing LDI and being coached. Unanimously, recognition experienced by LDI participants was viewed as being acknowledged for their individual career growth and accomplishments. The lowest frequency of themes for LDI was influence (6). Similar to the EL institute, the theme in common for all seven LDI participants was recognition.

The responses from the three ECFD participants identified a total of six themes related to Research Question 1. The highest frequency of themes for ECFD was leadership development (25). The lowest frequency of themes for ECFD was recognition (2). Although recognition had a low frequency in ECFD, it was the only theme mentioned by all 15 VHA participants (EL, LDI, and ECFD) in the study. Five of the six themes common for all three ECFD participants were leadership development, personal development, personal growth, recognition, and emotional intelligence. An analysis of the data shows that emotional intelligence and expectations were mentioned only by the ECFD participants in their interviews.

The second research question was, what do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year? Table 25 contains a summary of the themes of all three institutes in descending order.

The second research question was designed to identify the perceived impact of employment retention after the employee was coached through selected leadership professional development institutes at the VHA hospital in Southern California for a minimum of 1 year. An analysis of the interview responses identified seven themes regarding the impact that coaching had on retention, with recognition as the only one theme common for all VHA participants in the study. In all 15 VHA participants' answers to the interview questions, recognition received the most responses for both RQ1 and RQ2 for all three institutes.

Table 25

Research Question 2 Summary of the Themes for EL, LDI, and ECFD Institutes in Descending Order

Themes	No. of participants	Total frequency of responses	Frequency of responses		
			ELI	LDI	ECFD
Recognition	13	20	7	10	3
Personal growth	3	8	4	0	4
Commitment	5	7	0	4	3
Retention	4	7	0	2	5
Influence	5	6	3	3	0
Coaching	3	5	1	4	0
Making a difference	4	5	0	4	1
Networking	3	5	0	5	0
Leadership development	4	4	1	0	3
Empowerment	3	3	2	1	0
Motivation	3	3	1	1	1
Training opportunities	1	2	0	2	0
Relationship	2	2	0	2	0
Emotional intelligence	2	2	0	0	2
Personal development	1	2	0	2	0
Passion	2	2	2	0	0
Sense of confidence	2	2	2	0	0
Employment development	1	1	1	0	0

All the VHA participants attended three different institutes. Each participant entered these institutes possessing different career paths and education levels. Most of training and coaching that helped produce perceived outcomes for them in their careers, especially after being coached.

Chapter V in this study provides conclusions derived from the data analysis and these findings. Moreover, Chapter V offers implications, suggestions for actions, and recommendations for future research based on the findings and limitations of this study.

CHAPTER V: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter is a reflection of the findings, conclusions, and recommendations for this study titled *Career Coaching: A Study of Veterans Healthcare Administration (VHA) Leaders' Perspectives*. It begins with the purpose statement, research questions, methods, population, and sample. The researcher discusses the major findings of the study, unexpected findings, and conclusions drawn from the data analysis. Finally, Chapter V outlines the implications for future investigation of the findings as well as the researcher's recommendations for future research and concludes with observations and reflections from the researcher.

Purpose Statement

The purpose of this qualitative multiple case study was to explore and describe the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in selected coaching program institutes for a minimum of 1 year at VHA hospitals in Southern California.

Research Questions

The central research question guiding this study was, What is the perceived impact of career coaching on the job performance growth and retention of emerging healthcare leaders who have attended leadership professional development institutes at VHA hospitals in Southern California? The following were the subquestions of the study:

1. What do emerging healthcare leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected

leadership professional development institutes at VHA hospitals in Southern California?

2. What do emerging healthcare leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at a VHA hospital in Southern California for a minimum of 1 year?

Research Methods

The research methodology selected for this study was a qualitative multiple case study. A qualitative case study method contributed to obtaining more in-depth information about individual lived experiences of each participant (Stake, 2010). The researcher selected qualitative multiple case study methodology to explore and describe VHA leaders' perceived impact of coaching on their career performance growth and retention. The participating VHA leaders voluntarily answered 12 interview questions during either a face -to-face or telephone recorded conversation. Prior to addressing the interview questions, each VHA leader confirmed his or her consent to participate in the study and permission to record the interview. Each VHA leader provided an introductory statement about him or herself, demographic information, and how he or she became involved in a specific VHA leadership institute.

Each interview focused on 12 primary questions with additional probing questions designed for the VHA leaders to provide additional information about their lived experiences with the institute they attended. Interview Questions 1, 2, 3, 5, 6, 9, and 11 focused on VHA leaders' perception of their ability to achieve career performance growth after being coached. Interview Questions 4, 7, 8, and 10 were designed for the VHA leaders to assess the impact on their employment retention after being coached

through selected leadership professional development institutes (Appendix D). Additionally, the transcriptions from all interviews for this study were analyzed using NVivo, a qualitative data analysis software for coding. The NVivo software was used to organize and analyze interview responses to elicit themes from the participants' answers. All participants had a final review, which was in concurrence with the transcript.

Population and Sample

The population for this study consisted of VHA Emerging Leaders (EL), Leadership Development Institute (LDI), and Executive Career Field Development (ECFD) participants in Southern California. All 15 participants in this study were VHA leaders. Each participant in the study attended one or more of three leadership development institutes (EL, LDI, and ECFD) for a minimum of 1 year in which they received coaching. The participants were screened and referred to the researcher for selection through the VHA Human Resources (HR) based on their eligibility for this study and their willingness to participate.

Five of the 15 participants completed the EL institute, while one of the five participants also completed LDI. A total of seven of the 15 participants completed LDI. Additionally, three participants completed ECFD. For this study, the target population was VHA leaders in Southern California. During the interview, all participants provided the researcher with their demographic data.

Major Findings

The participants, leaders from Southern California VHAs, shared their lived experiences of leadership development and how they perceived coaching influenced their career growth and retention. Based on the 15 participant responses to interview questions

and shared personal stories, the researcher was able to elicit six major findings that were aligned with the two research questions. The study participants shared personal accounts and examples about their experiences relating to the impact of coaching on their career performance growth and retention of VHA EL, LDI, and ECFD leaders after being coached a minimum of 1 year. The major findings reflect the data analysis by common themes and patterns reviewed in Chapter IV and also align with the literature review in Chapter II. The following six major findings and descriptions are organized by the research questions (RQ): Major findings 1 through 3 are in response to RQ1, while major findings 4 through 6 are in response to RQ2.

Research Question 1: Major Findings

What do emerging leaders perceive is their ability to achieve career performance growth after being coached a minimum of 1 year through selected leadership professional development institutes at VHA hospitals in Southern California?

Major Finding 1

One of the major findings was that four of the five EL institute participants indicated that personal growth was the most crucial element they identified as relating to their career performance growth. Most of the participants shared that they experienced improved effectiveness and personal growth after being coached. The literature review supported the idea of workplace coaching and the manner in which it has been used to affect the growth of employees in the workplace (Jenson, 2016).

Major Finding 2

Three of the five VHA LDI participants interviewed reported that coaching enhanced their leadership skills and personal development. Additionally, the participants

reported that coaching provided them an opportunity to learn leadership skills and move forward in career advancement and growth. Many organizations see the ability to provide effective feedback and coaching as one of the most critical leadership skills (Loew, 2015).

Major Finding 3

The third major finding revealed that all three ECFD participants who were already leaders were interested in acquiring executive-level leadership skills. Executive leaders have authority and oversight over organizational goals, planning and development. Leaders are second in command and generally manage individuals and teams.

As a result of coaching and leadership training, VHA ECFD participants viewed ECFD leadership development as a more advanced professional preparation to enhance skills required for leading senior-level employees. The personal desire to acquire progressive leadership skills was to strengthen knowledge, skills, and ability, develop short- and long-term goals and career advancement to an executive position. Boyce et al. (2010) asserted that leadership development programs extend beyond formal curriculums to include developmental job assignments, 360-degree feedback, executive coaching, self-directed studies, training, and career experience.

Research Question 2: Major Findings

What do emerging leaders perceive is the impact on their employment retention after being coached through selected leadership professional development institutes at the VHA hospitals in Southern California for a minimum of 1 year?

Major Finding 4

The information gathered from the one-on-one interviews demonstrated that three out of five VHA EL participants placed a high value on motivation. The participants acknowledged that coaching motivated and provided them with a deeper understanding of the organizational processes for the VHA. Coaching was also attributed with impacting employee retention and motivating the participants to remain with the VHA. Research confirms coaching feels valuable to the coachee and increases job satisfaction and job retention (Verquer et al., 2003).

Major Finding 5

Based on the responses of the seven LDI participants, their recognition was associated with impacting employee retention and motivating the participants to remain with the VHA. Collectively, recognition was noted by all 15 VHA participants in the form of certificates of appreciation, awards, monetary compensation, and a sense of inclusiveness and shared success. According to Sonnino (2016), there are compelling results from related fields, which suggest that healthcare leaders would benefit from coaching programs to resolve challenges in performance and retention.

Major Finding 6

As a result of this study, it was determined that leadership development not only influenced career advancement but also was a crucial element in career retention of ECFD participants. All of the ECFD participants shared a positive experience about their participation in a leadership institute such as ECFD. Perception of leadership development was unanimously viewed as a great influencer on employment retention within the VHA. The research results showed that, in addition to healthcare systems,

educational institutions and professionals would be well prepared to identify ways to offer leadership development programs and make them available as part of the routine career transformation for emerging healthcare leaders (Sonnino, 2016).

Unexpected Findings

Principally, the literature reinforced the major findings of this study. However, the researcher discovered five unexpected findings, which were not anticipated. The unexpected findings were based on data analysis in Chapter IV and supported by the literature review (see a summary of the literature researched in the synthesis matrix in Appendix K).

Unexpected Finding 1

The healthcare service system worldwide has been somewhat slower to embrace coaching as a central leadership development tool for its staff (Risley & Cooper, 2011). The VHA is no different; there are limited opportunities for leadership development. The few programs that provide training and coaching that are available through the VHA are selective. The researcher was aware that a limited number of leaders were coached in the VHA; it was surprising to the researcher that the numbers of leaders selected annually for leadership development were still so low. When the researcher examined the literature (Chapter I, p. 14), it was noted that only 1.5% of VHA leaders were coached (VHA, 2014). However, in this case study, the researcher expected to find an increase and considerably more leaders trained and coached than a scarce 1.5%.

Unexpected Finding 2

The VHA has not established a thriving coaching program to help develop and groom future VHA leaders. The researcher expected to find better preparation for

strategically planning and projecting future career growth needs especially with the huge number of retiring baby boomers. However, what was found by the researcher was that within the VHA a significant challenge is that the leadership pipelines are not robust enough to meet current and future needs, a function of poor course forecasting and unfocused leadership development efforts (VHA Office of Workforce Services, 2015). Forecasting future needs of the organization is not easy. Rapid change in policy can make it hard to see urgent needs much less future needs.

Unexpected Finding 3

The most surprising finding was that all 15 VHA participants interviewed found leadership development and coaching advantageous to their careers regardless of the institute (EL, LDI, or ECFD). All three institutes were seen as valuable despite variations in their curriculum. All 15 VHA participants identified recognition as the single common theme for all VHA participants in the study, and this theme received the most responses for both RQ1 and RQ2 for all three institutes.

Unexpected Finding 4

An analysis of the data shows that EI was mentioned only by ECFD participant interviews as it related to coaching. EL and LDI did not include EI in their curriculum. The curriculum for each institute varied based on the professional leadership level of its participants.

Unexpected Finding 5

Optimism shared by an ECFD participant remained at an all-time high. After 30 years of VHA employment, even the veteran employees in the VHA could benefit from coaching and the VHA institute training. One participant reported being a "better leader

and perceived coaching as valuable as those who were in the organization for less than ten years." Additionally, all EL and LDI participants who had been employed by the VHA were enthusiastic about their coaching experiences regardless of their time and employment with the VHA.

Conclusions

After analyzing the major findings of this study, the researcher identified six conclusions. The conclusions address how coaching impacted VHA EL, LDI, and ECFD institute leaders' abilities to achieve career performance growth and how these institutes influenced their employment retention. The conclusions are presented in sequential order and correspond with the major findings that served as the foundation from which these conclusions were drawn.

Conclusion 1

Sense of confidence was only reported by VHA EL institute participants. The EL participant perceived being coached as a critical component for developing one's sense of confidence. An unshakeable, sense of confidence allows one to handle whatever changes come his or her way (Cashman, 1998). The researcher concluded that leaders need to have a strong sense of self-confidence. As a result, VHA institutes need to include this objective as a part of their curriculum.

Conclusion 2

Networking was only reported by LDI participants. Networking was viewed by one LDI participant as "having multiple coaches." Networking gave this participant an opportunity to learn leadership skills and move forward in career advancement and growth. The researcher concluded that networking and support from current leaders in

the healthcare profession is essential in identifying and nurturing employees who have the potential to be effective leaders, resulting in the development of the next generation of healthcare leaders. Preparing employees who will likely become future leaders has never been greater; keeping competent individuals in the organization has become an important task (Yamamoto, 2013).

Conclusion 3

The ECFD participants perceived that individuals who are coached are equipped with personal development necessary to lead and coach others. A conclusion the researcher has is that a participant is more likely to have the skills necessary to develop others thereby impacting many employees in the organization. Coaching is a valuable strategy for the change and development processes of organizations (Bennett & Bush, 2009).

Conclusion 4

The data gathered from the one-on-one interviews demonstrated that three out of five VHA EL participants placed a high value on motivation. The participants acknowledged that coaching motivated retention and provided a deeper understanding of the organizational processes. Additionally, coaching was also attributed with influencing an ECFD participant to remain in employment with the VHA. "Before ECFD, the participant was ready to quit" (Participant 14). The ECFD training was reported to have impacted this participants' retention 100%. A conclusion that the researcher has is that coaching has a partial impact on the organization's retention of employees. Coaching feels valuable to the coachee and increases job satisfaction and job retention (Verquer et al., 2003).

Conclusion 5

All 15 VHA participants responded that recognition was an essential element for retention. Recognition proved to be a key ingredient in coaching for motivation, commitment, enthusiasm, and retention at the VHA. While not the focus of this study, the literature suggested, and the researcher concluded, that there is importance in leaders encouraging the heart and acknowledging contributions by showing appreciation for individual excellence (Kouzes & Posner, 2007).

Conclusion 6

Leadership development was critical to career performance growth and retention of institute participants. Based on the interviews, it was concluded that leadership development was a byproduct of expert coaching through the institutes. The perception of leadership development was unanimously viewed as a great influencer on employment retention within the VHA. It is essential to ensure that the development of skills and competencies is met with job performance success. The literature suggests that organizations have seen an increased enthusiasm for coaching as employees seek to develop and enhance their personal experience in primary areas of interest (Greenawald, 2017). The development of "healthy workplaces" that are responsive to the ever-changing healthcare environment is vital (Kouzes & Posner, 2007).

Implications for Action

Based on the five findings and six conclusions of this researcher, and the participants' perspectives on the impact of coaching on career growth and retention, the researcher summarized the six implications for action. These implications for action are intended for hospital directors, healthcare leaders, human resource staff and healthcare

stakeholders. If healthcare organizations are seeking ways of increasing the success, growth, and retention of their leaders, coaching is a vital approach for developing future healthcare leaders.

Implication for Action 1

The first recommendation for action is for healthcare leaders to assist employees in navigating their personal growth and development. New employees should be placed with a coach immediately upon being hired or at least within a year of employment. Many of the VHA participants emphasized the importance of personal growth. It is important to recognize employee needs and invest in employees by providing the necessary training for all positions. Coaching is a way to engage with people that leads to more competence so that they can contribute to their organization and find meaning in what they are doing (O'Flaherty & Everson, 2005).

Implication for Action 2

Formal coaching training and certification should be incorporated at each VHA to develop a pool of available internal coaching talent among VHA organizational leaders. Leaders once trained and coached should also be taught the basics of coaching employees they supervise to increase the majority of VHA employees' skills and capacity. Additional training programs and coaching are needed to make comprehensive leadership teaching more widely available (VHA Office of Workforce Services, 2015).

Implication for Action 3

Management should develop an insightful personal development program to develop and motivate employees in the workplace. The program would have a variety of services to meet the emotional intelligence, personal, and organizational needs of its

future leaders. A personal development plan (PDP) must be a part of all employees' employment files. The best results would be accomplished by providing a program where an employee was involved with an ongoing coaching training commitment. For best outcomes, the coaching would be accomplished onsite or via telephone or video teleconferencing.

Implication for Action 4

Given the large investments in training and employee retention efforts within organizations, it is imperative that the mission and goals of the organization be distributed companywide to all healthcare leaders. It is critical that all employees are knowledgeable about the expectations of the healthcare organization. Healthcare leaders need to articulate the goals of the organization and communicate it repeatedly through different methods to include coaching. Coaching employees on what is required and assisting them with the knowledge required to be successful will help ensure a collaborative work environment and improve productivity. Coaching leads to improved communication, leaders-employee relationships, creativity, and employee performance, all of which contribute to organizational effectiveness, efficiency, and performance (Gilley & Gilley, 2007).

Implication for Action 5

Healthcare organizations must develop programs that intentionally recognize their leaders. The implication for action is for healthcare leaders to create an organization-wide recognition program that is well documented and extended to all employees. The company-wide program should describe the types of available awards and recognition programs available to be given by colleagues, supervisors, and senior leadership to each

employee. Recognition is an important element for retention. Research recommends celebrating the values and victories by creating a spirit of community (Kouzes & Posner, 2007).

Implication for Action 6

Healthcare executive leaders must offer leadership development programs and make them available as part of the routine career transformation for EL, LDI, and ECFD leaders. Further, leadership training needs to be increased to accommodate additional leaders being selected to attend VHA institutes with coaching opportunities. Leadership development would be used to train and retain highly qualified upward bound employees to assume positions of greater leadership within VHA. More importantly, the leadership development curriculum would focus on critical skill competencies such as strategic planning, time management, finances and economies, adaptive leadership, conflict management, and ethical considerations to retain health emerging leaders for future roles. Retention is critical as it offsets employee replacement costs and diminishes the indirect cost related to a decline in productivity. Boyce et al. (2010) asserted that leadership development programs extend beyond formal curriculums to include developmental job assignments, 360-degree feedback, executive coaching, self-directed studies, training, and career experience. Being prepared for the ever-changing healthcare environment is vital (Kouzes & Posner, 2007).

Recommendations for Future Research

Recommendation 1

A researcher should conduct future VHA studies that measure the benefits of incorporating aspects of coaching for entry-level employees. The results of this study

could seek to provide evidence that coaching assists employees if implemented in the beginning of their careers in navigating personal growth and development (Kimsey-House et al., 2011).

Recommendation 2

Future studies should be conducted to determine if VHA leaders who receive coaching are more likely to have the skills to focus on coaching the employees they supervise. The results of this study could provide affirmation that coaching enhanced leadership skills of supervisors but also expanded their skills to coach the employees they supervise thereby expanding and producing additional VHA leaders. Support from current leaders in the healthcare profession is essential in identifying and nurturing employees who have the potential to be effective leaders (Yamamoto, 2013).

Recommendation 3

A researcher should conduct future VHA studies that measure if career-coaching opportunities enhance job performance growth and retention of emerging healthcare leaders who have attended leadership professional development institutes at VHA where career-coaching opportunities are offered.

Recommendation 4

Additional research could be undertaken to compare two types of VHA employees: those who attended institutes for a year or more that included coaching and those who never received coaching in one or more of the available VHA institutes.

Recommendation 5

Additionally, research could examine a cost-benefit analysis that compares the cost of recruitment and training of new employees versus coaching and retention of current employees.

Recommendation 6

Since VHA EL, LDI, and ECFD institutes are held by the VHA in various regions of California, future research should be conducted on the various curriculums in these institutes, comparing career growth and the influence of coaching on retention in these various regions and in other geographical areas where coaching in VHA institutes is provided. The study would also seek to determine which institute produces the highest level of career growth and retention and the degree to which coaching contributes to the retention of VHA leaders.

Recommendation 7

Future research could explore VHA healthcare leaders' emotional intelligence (EI). The study would seek to discover the best way to develop these skills. The literature review shows connections between people with high EI having greater job performance and leadership skills (Goleman, 2000).

Recommendation 8

Conduct a qualitative study on different generational groups (e.g., baby boomers, Generation Xers, millennials) of VHA graduates from EL, LDI, and ECFD institutes to determine any differences in the lived experiences of participants as related to their career performance growth and development as well as their retention.

Recommendation 9

Replicate this study with a larger sample and even separate findings between EL, LDI, and ECFD selected participants. The study's researcher would pay particular attention to gender differences in participants among the three different institutes. The study could be a longitudinal case study over a period of 5 years or more to provide expanded and meaningful long-range (term) data.

Concluding Remarks and Reflections

The researcher is passionate about learning new ways to improve leadership development, especially in the healthcare industry. Discovering the positive effects and the impact coaching had on participants was encouraging and justified the need for these coaching and leadership programs to continue to expand. The researcher believes healthcare needs to provide additional resources and guidance in addition to supporting individuals aspiring to attain healthcare leadership roles. A combination of early, mid, and late career development represented the ideal preparation stages in a leader's career (Sonnino, 2016).

This research was a multiple case study, which sought to describe the perceived impact of coaching on VHA healthcare leaders' career growth and retention. It was beneficial to hear the varied experiences of the 15 healthcare leaders interviewed. The lived experiences through other stories provided invaluable insight to compel transformational change in how the VHA treats or develops its leaders.

Reflections provided greater insight into the study, what was learned, and its impact on the researcher. As a social work healthcare provider, the researcher related to most of the participants in this study. The researcher has gained a tremendous amount of

knowledge from conducting this study. From reviewing current literature on the topic to meeting and learning from participants, it is evident that the healthcare industry must re-commit to continuously provide and uphold an environment that allows future leaders to develop, engage, and be qualified to become the next generation of leaders. Also the current healthcare environment must provide clear communication of the mission, values, and planning for future leadership direction required by healthcare organizations. Healthcare must ensure that current leaders are offered an opportunity to prepare to become the future healthcare leaders.

This study contributed to the sparse literature regarding coaching healthcare leaders. The findings of this study are unique experiences because they add to the body of research, focusing specifically on one or more VHA leadership institutes. By identifying the expectations and perceived impact of coaching, VHA healthcare leaders can begin to understand, increase, and implement coaching models into the VHA organization in order to improve leadership development. Such findings can help all VHA healthcare organizations provide better support and training to aspiring leaders. Being prepared for the ever-changing healthcare environment in its future is vital for the VHA organization (Kouzes & Posner, 2007).

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APPENDICES

APPENDIX A

Demographics

VHA Emerging, Leadership Development, Executive Career Field Development

Participant Number

Which Institute Completed

Five or more years of employment with VHA

VHA Work Location –Long Beach or Los Angeles

VHA Leadership Position Currently Held

Other Leadership Position Held

Coaching Status
Internal
External
Both

Gender
Male
Female

Age
18-24
25-34
35-44
45-54
55-64
65+

Education
HS Graduate or less
Some College/Assoc. Degree
College Graduate

Race/Ethnicity
White/ not Hispanic
Black/ not Hispanic
Hispanic
Other/not Hispanic

APPENDIX B

Invitation Letter

Invitation letter for EL, LDI, and ECFD in a VHA Organization in southern California

Date:

Dear Potential Study Participant,

My name is Jerelyn Dugas, and I am a doctoral candidate in Brandman University's Organizational Leadership program. For my dissertation, I am researching the impact of career coaching on the career performance growth and retention of healthcare's emerging leaders who participated in a coaching program institute such as EL, LDI or ECFD for a minimum of one year at Veterans Healthcare Administration Hospitals in southern California in the last five years. My research focuses solely on the employees themselves and their perspectives in regards to the impact of coaching on their professional career.

I am writing to ask if you would be willing to consider participating in this research study and to be interviewed to provide your perspective on coaching and how it affects your career growth and retention as an employee in the VHA Hospital. I am asking your assistance in this study by participating in an interview that includes demographic information. The interview will take approximately 45 to 60 minutes and will be scheduled at a time convenient for you.

If you agree to participate in an interview, you may be assured that your responses will be completely confidential. A coding system will be used so that no names will be attached to any notes, recording, or transcripts from the interview. The interview will be audio-recorded with your consent, and the audio recording will be destroyed once the interview has been transcribed. All information will remain in a locked file accessible only to this researcher, and no other individuals will have access to the interview information. You will be free to stop the interview and withdraw from the study at any time.

I am available by email and phone to discuss this research. It would be an honor to be able to hear about your experiences and perspectives regarding your participation as a VHA leader. I know that your time is incredibly valuable and I appreciate your consideration of this request.

Sincerely,

Jerelyn Dugas
Doctoral Candidate, Brandman University
Email: jdugas@mail.brandman.edu

APPENDIX C

Informed Consent Form

INFORMATION ABOUT: The impact of career coaching on the career performance and retention as perceived by healthcare's emerging leaders who participated in a coaching program institute for a minimum of one year at Veterans Administration Hospitals in southern California.

RESPONSIBLE INVESTIGATOR: Jerelyn Dugas, Doctoral Candidate

PURPOSE OF THE STUDY: You are being asked to participate in a research study conducted by Jerelyn Dugas, a doctoral student from the Doctor of Education in Organizational Leadership program at Brandman University. The purpose of this qualitative case study is to explore and describe the impact of career coaching on the career performance and retention as perceived by healthcare's emerging leaders who participated in a coaching program institute for a minimum of one year at Veterans Administration Hospitals in southern California.

In participating in this research study, I agree to partake in a recorded semi-structured interview, which will be conducted in person at my workplace. The interview will take up to one hour, and will be audio-recorded. During this interview, I will be asked a series of questions designed to allow me to share my experiences as a member of EL, LDI or ECFD. The interview will take place from February thru March 2018.

I understand that:

a) There are minimal risks or discomforts associated with this research. It may be inconvenient to spend up to one hour in the interview. However, the session will be held at my workplace to minimize this inconvenience. Some interview questions may cause mild emotional discomfort. I understand that the investigator will protect my confidentiality by keeping the identifying codes and research materials in a locked file drawer that is available only to the researcher and that digital information will be password-protected and only available to the researcher.

b) There are no major benefits to me for participation, but a potential benefit may be that I will have the opportunity to share my expertise with other leaders in VHA healthcare field. The information from this study is intended to inform researchers, policymakers, and educators on best practices. I understand that I will not be compensated for my participation.

c) Any questions I have concerning my participation in this study will be answered by Jerelyn Dugas, Brandman University Doctoral Candidate. I understand that Mrs. Dugas contacted by phone at (xxx) xxx-xxxx or email at

jdugas@mail.brandman.edu. Mrs. Dugas' dissertation chair, Dr. Lisbeth Johnson, can also be contacted at ljohnso3@brandman.edu.

d) I understand that I may refuse to participate or withdraw from this study at any time without any negative consequences. I can also decide not to answer particular questions during the interview. Also, the investigator may stop the study at any time.

e) I understand that the study will be audio-recorded, and the recordings will not be used beyond the scope of this project.

f) I understand that the audio recordings will be used to transcribe the interviews. Once the interviews are transcribed, the audio and electronic interview transcripts will be kept for a minimum of two years by the investigator on an electronic storage device in a locked file cabinet.

g) I also understand that no information that identifies me will be released without my separate consent and that all identifiable information will be protected to the limits allowed by law. If the study design or the use of the data is to be changed, I will be so informed, and my consent re-obtained. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may write or call of the Office of the Executive Vice Chancellor of Academic Affairs, Brandman University, and 16355 Laguna Canyon Road, Irvine, CA 92618, (949) 341-7641. I acknowledge that I have received a copy of this form and the Research Participant's Bill of Rights.

I have read the above and understand it and at this moment voluntarily consent to the procedures(s) set forth.

Signature of Participant or Responsible Party **Date**

Signature of Witness (if appropriate) Date

Signature of Principal Investigator **Date**

Brandman University IRB _____ 2018

APPENDIX D

Research and Interview Questions Matrix

Semi-structured Interview Questions	Research Question
1.Why did you make the decision to apply for one of the three VHA Institutes, the emerging leaders (EL), leadership development institute (LDI) and executive career field development (ECFD) Institutes used for coaching and training for leadership development? (Questions were asked based on the one institute the participant attended.)	RQ1
2. To what extent did coaching through this Institute assist you in your career or professional growth?	RQ1
3.What are your overall goals for career growth? a. Probe: Is coaching a leader like yourself critical to attaining those goals? Why?	RQ1
4. Would you share some specific examples of coaching experiences you had through the Institute that influenced your career expectations at the VHA?	RQ1 and RQ2
5. Have you been recognized or acknowledged for your performance as a leader in the VHA? a. Please elaborate. b. What part did coaching through the Institute you attended play in this recognition?	RQ1
6. What leadership lessons or skills did you learn through coaching that strengthened your leadership promotional or career growth opportunities? a. Probe: Please give examples? b. Is there anything you wished you had learned?	RQ1
7. What impact, did coaching have on your job satisfaction and retention in the VHA workplace? a. Probe: Please give examples?	RQ2
8. Has coaching helped you learn how to prepare for future leadership growth in the VHA? a. Probe: Give examples of the leadership preparation strategies you learned.	RQ1 & RQ2
9. Has leadership coaching improved your personal development in leading people on the job?	RQ1

a. Probe: Please share some examples.	
10. What affect or influence did coaching have on your degree of organizational commitment to remain as a leader in the VHA? a. Probe: Please share why?	RQ2
11. A. Is there anything else that you would like to share that leaders in the VHA need to know about coaching and career growth? a. Probe: Please elaborate. b. Are there any suggestions you have for VHA leaders about the role of coaching and career growth?	RQ1
12. Do you have any awards, recognitions, letters of commendation, EL, LDI, EFCD Institute or coaching training materials or Institute professional development agendas that you could share with me? The information you share will remain anonymous.	

APPENDIX E

Audio Release Form

RESEARCH STUDY TITLE: The impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in a coaching program institute for a minimum of one year at Veterans Administration Hospitals in southern California.

BRANDMAN UNIVERSITY
16355 LAGUNA CANYON ROAD
IRVINE, CA 92618

I authorize Jerelyn Dugas, Brandman University Doctoral Candidate, to record my voice. I give Brandman University and all persons or entities associated with this research study permission or authority to use this recording for activities associated with this research study.

I understand that the recording will be used for transcription purposes and the information obtained during the interview may be published in a journal or presented at meetings/presentations.

I will be consulted about the use of the audio recordings for any purpose other than those listed above. Additionally, I waive any right to royalties or other compensation arising or related to the use of information obtained from the recording.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to the outlined terms. I at this moment release any and all claims against any person or organization utilizing this material.

_____ _____
Signature of Participant or Responsible Party Date

_____ _____
Signature of Witness (if appropriate) Date

APPENDIX F

Participant Bill of Rights

BRANDMAN University

BRANDMAN UNIVERSITY INSTITUTIONAL REVIEW BOARD

Research Participant's Bill of Rights

Any person who is requested to consent to participate as a subject in an experiment, or who is requested to consent on behalf of another, has the following rights:

1. To be told what the study is attempting to discover.
2. To be told what will happen in the study and whether any of the procedures, drugs or devices are different from what would be used in standard practice.
3. To be told about the risks, side effects or discomforts of the things that may happen to him/her.
4. To be told if he/she can expect any benefit from participating and, if so, what the benefits might be.
5. To be told what other choices he/she has and how they may be better or worse than being in the study.
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study.
7. To be told what sort of medical treatment is available if any complications arise.
8. To refuse to participate at all before or after the study is started without any adverse effects.
9. To receive a copy of the signed and dated consent form.
10. To be free of pressures when considering whether he/she wishes to agree to be in the study.

If at any time you have questions regarding a research study, you should ask the researchers to answer them. You also may contact the Brandman University Institutional Review Board, which is concerned with the protection of volunteers in research projects. The Brandman University Institutional Review Board may be contacted either by telephoning the Office of Academic Affairs at (949) 341-9937 or by writing to the Vice Chancellor of Academic Affairs, Brandman University, 16355 Laguna Canyon Road, Irvine, CA, 92618.

Brandman University IRB Adopted November 2013

APPENDIX G

Baldridge Framework

Table G1

Baldridge Framework Healthcare Criteria for Performance Excellence for Leaders

Performance improvement strategies	Core values & concepts in high-performing organizations
• Leadership • Strategy • Customer Focus • Measurement, analysis and knowledge management • Workforce • Operations • Results	• Systems perspective • Visionary leadership • Patient-focused excellence • Valuing people • Organizational learning and agility • Focus on success • Managing for innovation • Management by fact • Societal responsibility and community health • Ethics and transparency • Delivering value and results

From *About the Baldrige Excellence Framework (health care)*, Baldridge Performance Excellence Program, 2013. Retrieved from National Institute of Standards and Technology (NIST) website: https://www.nist.gov/baldrige/about-baldrige-excellence-framework-health-care

APPENDIX H

Baldridge Framework for Healthcare Process Improvement

Table H1

Baldridge Framework for Healthcare Process Improvement for Leaders

Process improvement evaluation (4 dimensions)	Process improvement results (4 dimensions)
• **Approach:** How do you accomplish your organization's work? How effective are your key approaches?	• **Levels:** What is your current career performance growth?
• **Deployment:** How consistently are your key processes used in relevant parts of your organization?	• **Trends:** Are the results improving, staying the same, or getting worse
• **Learning:** How well have you evaluated and improved your key processes? How well have improvements been shared within your organization professional development institutes?	• **Comparisons:** How does your performance growth compare with that of other organizations, or with benchmarks or industry leaders?
• **Integration:** How do your processes align with your current and future organizational needs and retention? How well are processes and operations harmonized across your organization?	• **Integration:** Are you tracking results that are important to your organization that consider the expectations and needs of your key stakeholders? Are you using the results in organizational decision-making?

From *About the Baldrige Excellence Framework (health care)*, Baldridge Performance Excellence Program, 2013. Retrieved from National Institute of Standards and Technology (NIST) website: https://www.nist.gov/baldrige/about-baldrige-excellence-framework-health-care

APPENDIX I

Interview Protocol: Script and Questions

Introduction
My name is Jerelyn Dugas, and I am a doctoral candidate at Brandman University in the area of Organizational Leadership. I am researching the impact of career coaching on the career performance growth and retention as perceived by healthcare's emerging leaders who participated in a coaching program institute for a minimum of one year at Veterans Administration Hospitals in southern California. My research focuses solely on the employees themselves and their perspectives in regard to the effectiveness of coaching. I am conducting approximately 15 interviews with individuals like you. The information you provide, along with the others, hopefully, will provide a clearer picture of the perceptions of coaching and how it affects productivity, career performance and retention.

Informed Consent (required for Dissertation Research)

I would like to remind you any information that is obtained in connection with this study will remain confidential. All of the data will be reported without reference to any individual(s) or any institution(s). After I record and transcribe the data, I will send it to you via email so you can make certain that I accurately captured your thoughts and ideas.

1. Did you receive the Informed Consent and Brandman Bill of Rights I sent you via email?

2. Do you have any questions or need clarification about either document?

We have scheduled an hour for the interview. At any point during the interview, you may ask that I skip a particular question or stop the interview altogether. For ease of our discussion and accuracy, I will record our conversation as indicated in the Informed Consent.

Do you have any questions before we begin? Okay, let's get started, and thanks so much for your time.

Background Questions:
Before the interview begins, I have a few background questions I will be asking you. These demographic questions were included in the invitation letter you received (see Appendix A).

Interview Questions

1.Why did you make the decision to apply for one of the three VHA Institutes, the emerging leaders (EL), leadership development institute (LDI) and executive career field development (ECFD) Institutes used for coaching and training for leadership development? (Questions were asked based on the one institute the participant attended.)

2. To what extent did coaching through this Institute assist you in your career or professional growth?

3. What are your overall goals for career growth?
a. Probe: Is coaching a leader like yourself critical to attaining those goals? Why

4. Would you share some specific examples of coaching experiences you had through the Institute that influenced your career expectations at the VHA?

5. Have you been recognized or acknowledged for your performance as a leader in the VHA?
a. Please elaborate.
b. What part did coaching through the Institute you attended play in this recognition?

6. What leadership lessons or skills did you learn through coaching that strengthened your leadership promotional or career growth opportunities?
a. Probe: Please give examples?
b. Is there anything you wished you had learned?

7. What impact, did coaching have on your job satisfaction and retention in the VHA workplace?
a. Probe: Please give examples?

8. Has coaching helped you learn how to prepare for future leadership growth in the VHA?
a. Probe: Give examples of the leadership preparation strategies you learned.

9. Has leadership coaching improved your personal development in leading people on the job?
a. Probe: Please share some examples.

10. What affect or influence did coaching have on your degree of organizational commitment to remain as a leader in the VHA?
a. Probe: Please share why?

11. A. Is there anything else that you would like to share that leaders in the VHA need to know about coaching and career growth?
a. Probe: Please elaborate.
b. Are there any suggestions you have for VHA leaders about the role of coaching and career growth?

12. Do you have any awards, recognitions, letters of commendation, EL, LDI, EFCD Institute or coaching training materials or Institute professional development agendas that you could share with me? The information you share will remain anonymous.

Conclusion of Interview

Those are all the questions I have for you. I will send you a copy of the transcription once it is ready. Please review and respond to it for accuracy and let me know if you want to revise or add to any response within 2-3 days of receipt. Thank you for your time; it is greatly appreciated.

APPENDIX J

Interview Questions Pilot Test Feedback Form

As a doctoral student and researcher at Brandman University, your assistance is appreciated in designing this survey instrument. Your participation is crucial to the development of a valid and reliable instrument. Below are some questions that I would appreciate you answering after completing the survey. Your answers will assist me in refining both the directions and the survey items.

You have been provided with a paper copy of the interview questions, just to jog your memory if you need it. Thanks so much.

1. Were the directions straightforward and complete, and you understood what to do? If not, would you briefly state the problem.

2. Was the Introduction sufficiently clear (and not too long) to inform you what the research was about? If not, what would you recommend that would make it better?

3. Please list any questions, by number, which were ambiguous to you. If there were any items that caused you to say something like, *"What does this mean?"* Which item(s) were they?

4. Please make any suggestions that will make the format of the interview questions easier to follow or easier to understand.

5. Can you give me any other suggestions that would improve the interview questions?

6. How many minutes did it take you to completely answer the interview questions, from the moment you first started reading until the time you completed it?

Thank you for taking the time to respond to the interview questions and for providing your valuable feedback. Please deliver or email your completed feedback form to Jerelyn Dugas (jdugas@mail.brandman.edu) by _____. Please feel free to contact me with any suggestions or questions. Thank you again for your help.

Sincerely,

Jerelyn Dugas
Principal Investigator
Brandman University Doctoral Candidate

APPENDIX K

Synthesis Matrix

J. Dugas Dissertation Matrix	Career Coaching	Job performance	Job effectiveness	Perceived impact/Change	Development	Methodology	Gap
American Hospital Association (2015).	X				X		
Ammentorp, J. (2013).	X				X		
Anderson, A. R. (2013).		X	X				
Anderson, D. & Anderson-Ackerman, L.A. (2010).				X	X		
Ashe-Edmunds, S. (2017).		X			X		
Baldrige Performance Excellence Program (2013).			X	X	X		
Baldrige Performance Excellence Program (2017).			X	X	X		
Baldrige Performance Excellence Program (2015).			X	X	X		
Basher, Z. N. & Ricci, C. (2010).				X	X		X
Bass, B. M., & Bass, R. (2009).	X				X		
Batson, V. D., & Yoder, L. H. (2012).	X			X	X		
Bennett, J., & Bush, M. W. (2009).	X				X		
Besheer, Z., & Ricci, C. (2010).				X	X		X
Bierly, P. E. et al. (2000).					X		
Blattner, J., & Bacigalupo, A. (2007).	X				X		
Boyatzis, R., Smith, M., & Blaize, N. (2006).	X				X		
Boyce, L. A., Zaccaro, S. J., & Wisecarver, M. Z. (2010).	X				X		
Bozer, G., & Sarros, J. C. (2012).	X		X		X		
Brent, M., & Dent, F. E. (2014).	X				X		
Buchbinder, S. B., & Shanks, N. H. (2012).		X			X		
Burn, J. M. (1978).					X		
Cacioppe, R. (2012).	X				X		
Carter, A., Blackman, A., Hicks, B., Williams, M., & Hay, R. (2017).	X			X			
Cascio, W. A., & Boudreau, J. (2008).				X	X		
Cashman, K. (1998).					X		
Centers for Medicare & Medicaid Services. (2018).							X
Chamberlain, M. (2012).	X				X		

Cifu, D. X. et.al. (2013).					X		
Copeland, N. (1942).					X		
Corso, A. (2015).	X			X	X		
Cournoyer, A. M. (2015).				X	X		
Coutu, D., & Kauffman (2009).	X				X		
Creswell, J. W. (1998).						X	
Creswell, J. W. (2008).						X	
Creswell, J. W. (2013).						X	
Creswell, J. W. (2014).						X	
Creswell, J. W., & Plano Clark, V.L. (2011).						X	
Cummings, G., Hewko, S. J., Wang, M., Wong, C. A., Laschinger, H. S., & Estabrooks, C. (2015).	X	X		X			
Dalton, G. W., &Thompson, P. H. (1986)					X		
Darling, J., & Heller, V.(2012).	X				X		
Day, D. V. (2000).	X				X		
Day, D. V., Fleenor, J. W., Atwater, L. E., Sturm, R. E., & McKee, R. A. (2014).				X	X		
DeChant, P. (2016).		X			X		
DeLaney, Y. (2012).	X				X		
Denzin, N. K. et al. (2011).							X
Du Toit, A., & Sim S. (2010).	X				X		
Dye, C. F. (2010).				X	X		
Edelson, M. (2006).	X						
Ellinger, A. D., & Bostrom, R. P. (1999).	X			X	X		
Ellinger, A. D., Ellinger, A. E., & Keller, S. B. (2003).	X			X			
Elloy, D. F. (2011).	X			X			
Ennis, S., Otto, J., Goodman, R., & Stern, L. (2012).	X			X	X		
Evered, R. D., & Selman, J. C. (1989).	X				X		
Fiedler, F. E.(1964).					X		
Fielden, S. (2005).	X		X				
Fields, R. (2011).	X			X			
Flaherty, J. (2005).	X						
Fournies, F. F. (1987).	X	X					
Friedman, L. H., & Kovner, A. R. (2017).	X				X		
Galantino, M. L. et al. (2009).	X						
Garman, A. N., Whiston, D. L., & Zlatoper, K. W. (2000).	X			X			
Gilitinane, C. (2013).		X	X				
Gilley, J. W., & Gilley, A. M. (2007).		X	X		X		
Gilley, J., Boughton, N. W., & Maycunich, A. (1999).		X	X				

Gladis, S. (2007).	X			X	X		
Goldschein, E., & Bhasin, K. (2011)					X		
Goleman, D. (2000).					X		
Goleman, D. et al. (2002).					X		
Grant, A. M. (2007).	X						
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Gray, D. E. (2006).	X				X		
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Greenawald, E. (2017).	X		X	X	X		
Greenleaf, R. K. (1970).					X		
Greenleaf, R. K. (1977).					X		
Gunderman, R., & Kanter, S. L. (2009).	X			X	X		
Gurbutt, D. J., & Gurbutt, R. (2016).	X			X			
Hadikin, R. (2004).	X						
Hagen, T. (2014).	X			X	X		
Hamlin, R. G. et al. (2009).	X			X	X		
Hargrove, R. (2008).	X			X	X		
Hayes, E., & Kalmakis, K. A. (2007).	X				X		
Hays, S. (2008).	X				X		
Health Leaders Media Industry Survey (2009).				X			X
Hemphill, J. K. (1950).	X			X	X		
Henochowicz, S., & Hetherington, D. (2006).	X				X		
Hernon, P., & Rossiter, N. (2006).					X		
Hersey, P., & Blanchard, K.H. (1969).					X		
Hersey, P., &Blanchard, K. H. (1977).					X		X
Hicks, R., & McCracken, J. (2009).	X				X		X
House, R. J. (1996).	X			X			
Hunt, J. M., & Weintraub, J. R. (2007).	X				X		
Ingram, D. (2018).					X		
International Coach Federation (2017).	X				X		
Ive, Y.(2008).	X				X		
Jenson, C. (2016).	X			X	X		
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Johnson, R. (2018)		X		X	X		
Joo, B. K. (2005).	X				X		X
Kampa-Kokesch, S., & Anderson, M. Z. (2001).	X				X		
Kaufman et al. (2017).				X	X		
Kiel, F., Rimmer, E., Williams, K., & Doyle, M. (1996).	X				X		
Kilburg, R. R. (2001).	X				X		
Kimsey-House, H., Kimsey-House, K., Sandahl, P., & Whitworth, L. (2011).	X				X		
King, P.& Eaton, J. (1999).	X				X		

Kivela, K. et al. (2014).	X						
Kondalkar, V. G. (2013).	X		X				
Koonce, R. (2010).	X				X		X
Kouzes, J. M., & Posner, B. Z. (2013).				X	X		
Kouzes, J. M., & Posner, B. Z. (2007).				X	X		
Kram, K. E. (1985).					X		
Le Comte, L. McClelland, B. (2017).		X		X	X		
Ledlow, G. R., & Coppola, M. N. (2011).				X	X		
Liljenstrand, A. M., & Nebeker, D. M. (2008).	X				X		
Lowe, L. (2015).	X						
Lok, P., & Crawford, J. (2004).			X	X	X		
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Man, M. et al. (2016).	X						
McCall, M. W., Lombardo, M. M., & Morrison, A. M. (1998).	X				X		
McCleskey, J. A., (Jun 2014).				X	X		
McDermott, M., Levenson, A., & Newton, S. (2007).	X		X	X			
McGovern, J., Lindemann, M., Vergara, M., Murphy, S., Barker, L., & Warrenfeltz, R. (2001).	X			X	X		
McKinley, M. G. (2004).				X	X		
McMillan, J. H., & Schumacher, S. (2010).						X	
McNally, K., & Lukens, R. (2006).	X				X		
Merriam, S. B., & Tisdell, E. J.(2016).						X	
Mintzberg, H. (1989).							X
Moore, B. V. (1927).	X				X		
Mutjaba, B. (2007).	X	X		X			
Natale, S. M., & Diamante, T. (2005).	X				X		X
Nieminen, L. et al. (2013).	X			X			X
Noelker, L. S., Ejaz, F. K., Menne, H. L., & Bagaka's, J. G. (2009).	X		X				
Northouse, P. G. (2013).	X			X	X		
Numerof, R., & Abrams, M. (2003).	X			X	X		
O'Flaherty, C. & Everson, J. (2005)	X						
Olden, P. C. (2015).				X	X		
O'Toole, T. P., Cabral, R., Blumen, J. M., & Blake, D. A. (2011).		X	X				
Palmer, S. et al. (2003).	X	X					
Patten, M. L. (2014).						X	
Patton, M. Q. (2015).						X	
Peltier, B. (2001).	X						
Peterson, D. B., & Hicks, M. D. (1996).	X				X		

Petzel, R. A. (2013).	X			X	X		X
Redshaw, B. (2000).	X				X		
Risley, K., & Cooper, H. (2011).	X		X		X		
Roberts, C. (2010).					X	X	
Rost, J. C. (1991).	X				X		
Rothwell, W. et al. (2015).		X	X		X		
Runy, L. A. (2008).				X			X
Salovey, P., & Mayer, J. D. (1990).					X		
Salter, T. (2013).	X						X
Saporito, T. J. (1996).	X				X		
Schneider, S., Kingsolver, K., & Rosdahl, J. (2014).	X				X		
Seeman, M. (1960).							X
Sonnino, R. E. (2016).				X	X		X
Squazzo, J. (2010).				X	X		
St John-Brooks, K. (2014).	X				X		
Stake, R. (2010).							
Starcevich, M. (2001).	X	X			X		
Stefl, M. (2008).			X	X			
Stewart-Lord, A. Baillie, L., & Woods, S. (2017).	X						
Stober, D. R., Wildflower, L., & Drake, D. (2006).	X						
Stoller, K. J. (2013).			X	X			
Stone, P. W., et al. (2009).		X		X			X
Thom, D. H. et al. (2013).	X				X		
Throgmorton, C. et al. (2016).	X				X		
Tichy, N. M. (2002).	X				X		
Trochim, W. (2006).							
Underhill, B., McAnally, K., & Koriath, J. (2007).	X				X		
U.S. Department of Veterans Affairs. VA history (2013).					X		X
U.S. Department of Veterans Affairs. VA History (2016).					X		
U.S. Department of Veterans Affairs, (2018).		X	X		X		X
Verquer, M. et al. (2003).					X		
Veterans Access, Choice and Accountability of Act of 2014 (2014).					X		
Veterans Health Administration (2014).					X		
VHA Office of Workforce Services. VHA Interviews (2015).					X		
Vidal-Salazar, Ferron-Vilchez, & Cordon-Pozo, (2012).	X						
Wagner, S. (2006).			X	X	X		

Wallis, A. & Kennedy, K. I. (2013).		X			X		
Whaley, A., & Gillis, W. E. (2018).				X			
Wheeler, L. (2011).	X	X		X			
Whitmore, J. (2009).	X	X		X			
Whitmore, J. (2017).	X				X		
Whitworth, L., Kimsey-House, H., House, H., Sandahl, P., Sandahl, P., & House, H. (1998).	X				X		
Witherspoon, R., & White, R. P. (1996).		X		X			
Wolf, G., Bradle, J., & Greenhouse, P. (2006).	X				X		
Yamamoto, H. (2013).				X	X		
Yin, R. (2003).						X	
Yoder, L.(1995).		X	X				
Yukl, G., & Van Fleet, D. D. (1992).				X	X		X

APPENDIX L

National Institute of Health Certification

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Jerelyn Dugas** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 05/14/2016.

Certification Number: 2074031.