ATHLETIC TRAINING EDUCATION JOURNAL
© National Athletic Trainers' Association
www.natajournals.org
ISSN: 1947-380X
DOI: 10.4085/1947-380X-19-078

ORIGINAL RESEARCH

Leadership and Management Perspectives from Athletic Health Care Executives

Lindsey E. Eberman, PhD, ATC*; Jessica R. Edler Nye, PhD, LAT, ATC†; Elizabeth R. Neil, PhD, AT, ATC‡; Kenneth E. Games, PhD, LAT, ATC*
*Indiana State University, Terre Haute; †Grand View University, Des Moines, IA; ‡Temple University, Philadelphia, PA

Context: In today's health care environment, the need to engage personnel in quality improvement to demonstrate value to patient care is vital. Health care executives are responsible for leading within their organizations, and athletic trainers (ATs), similar to other health care executives, have typically risen to positions of authority without leadership training.

Objective: To explore the lived experiences of ATs as health care executives, specific to their path to leadership and their role in leading continuous quality improvement.

Design: Consensual qualitative research.

Setting: Web-based phone interviews.

Patients or Other Participants: A total of 20 participants (age = 41 ± 10 years; experience = 18 ± 10 years) indicated they held a position of authority, had personnel management responsibilities, and had influence over organizational change within their health care systems; however, after completing the interviews, we determined that only 17 participants met the inclusion criteria.

Data Collection and Analysis: The primary investigator completed interviews. We analyzed the data with a 3-person data-analysis team and an internal auditor. Trustworthiness was established through member-checking and multiple-researcher triangulation.

Results: Participants described various forms of preparation including mentors and both self-directed and required resources that assisted in preparing for their management and leadership roles. Participants described how they influenced personnel, including identifying individualized motivators, establishing goals, and building relationships. Participants explained the culture they hoped to establish, characterized by a growth mindset, transparency, and both self-reflective and systems-level improvement practices. Many of the participants depicted characteristics of strong leaders through an individual growth mindset, embodiment of the behaviors they wanted to see in their personnel, and transformational leadership strategies.

Conclusions: Athletic health care executive have the responsibility to lead and transform their organizations. However, few in these positions have had formal training to prepare them for the role. ATs seeking health care executive positions should seek formal training to acquire the skills necessary to create organizational change and serve as transformational leaders.

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Dr Eberman is a Professor and Program Director of the Doctorate in Athletic Training program at Indiana State University. Address correspondence to Lindsey E. Eberman, PhD, ATC, Indiana State University, 567 N 5th Street, Room A-10, Terre Haute, IN 47809. Address e-mail to lindsey.eberman@indstate.edu.

Editor's note: This article was to have been published as part of the recent special issue on leadership (December 2020, 15[4]). We apologize for the error.

Full Citation:
Eberman LE, Edler Nye JR, Neil ER, Games KE. Leadership and management perspectives from athletic health care executives. *Athl Train Educ J.* 2021;16(1):1–12.

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KEY POINTS

- Many athletic health care executives experienced mentorship and sought out, through self-direction, resources to prepare them for their leadership and management roles.
- To successfully meet the expectations of their positions, athletic health care executives worked to influence personnel by identifying individual motivators, establishing goals for personnel, and building both personal and professional relationships.
- The athletic health care executives generally developed a culture of systems-level improvement through transparency and an organizational growth mindset.
- Although not all, many of the athletic health care executives in this study demonstrated characteristics of strong leaders by having an individual growth mindset that allowed them to see failure as an opportunity, embodying the characteristics they wanted to see from their personnel, and demonstrating transformational leadership qualities.

INTRODUCTION

Health care executives are often placed in their positions on the basis of clinical accomplishments; however, few have been trained for the responsibilities of leading in modern health care.[1] Given the rapidly changing health care system, health care executives must be capable of clearly communicating the goals for change as well as how change will improve patient care.[2] Moreover, well-equipped executives will be able to inspire, model, challenge, enable, and encourage the change necessary to improve patient care within the system. Yet, how do executives determine what change is necessary? Quality improvement is the effort to make change that results in better patient outcomes, systems performance, and professional development.[3] The process requires a systematic approach to the analysis of practice that requires a teamed-approach to data collection, analysis, and testing of change.[4]

Leadership and *management* have often been compared and contrasted throughout the literature, and sometimes they have been used synonymously.[5] However, in a recent review of the literature, *management skills* included planning, building, and directing, whereas *leadership skills* focused on potential change by establishing the direction and aligning, motivating, and inspiring personnel.[6] Throughout this article, we will describe health care executives as those who may possess leadership or management skills or both in their position of authority. Health care executives oversee the functioning of a health care facility, including finances, policy, and personnel management and can include supervising and "head" athletic trainers (ATs) in traditional athletic training settings as well as hospital administrators. We will use the aforementioned definitions to differentiate between leaders and managers.

In athletic training, we have explored leadership in a variety of ways, but we have not yet evaluated how ATs, as health care executives, inspire, model, challenge, enable, and encourage quality-improvement practices aimed at supporting the patients' experiences. Previous literature in athletic training has indicated that ATs, as health care managers, needed additional knowledge and skills beyond professional education because there was no formal training[7] and as students they did not typically see it as important in their early training.[8] In this study, we aimed to investigate the lived experiences of ATs as health care executives, specific to their training and path to leadership, as well as their role in leading continuous quality improvement in their respective health care systems.

METHODS

Design

We used qualitative, semistructured interviews to answer the primary research aims. The consensual qualitative research tradition was used to analyze the data. This study was approved by the Indiana State University Institutional Review Board.

Participants

We used criterion sampling to identify eligible participants. First, we used an embedded (nested) technique, whereby a random sample of participants were recruited from the National Athletic Trainers' Association research-participant database for a related study. Participants who opted into that study and met the inclusion criteria were offered the option to complete an interview on a related topic. We also used social media recruitment to supplement our recruitment strategy. Eligible participants were athletic health care executives who were certified ATs in a position of authority, had personnel management responsibilities, and had influence over organizational change within their health care system. We interviewed 20 participants, but we determined that 3 individuals did not meet all the inclusion criteria, and they were excluded from analysis. Participants (age = 42.24 ± 10.49 years; years of experience = 19.24 ± 10.47) varied in experience and settings (Table 1).

Instruments

The overarching purpose statement guided our semistructured interview script (18 items; Table 2). We asked several questions to contextualize the participants in their workplace (5 items) and their path to leadership (2 items). The interview script was developed from the available literature and then reviewed by 3 content experts (21 ± 14 years of experience; Table 3). We used the 5 practices of exemplary leadership as a framework[9] for our questions regarding modeling, inspiring, enabling, encouraging, and challenging the organization

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Table 1. Participant Demographic Characteristics

Participant Name	NPI Number	Current Employment Setting	Years of Experience	Age, y	Highest Degree Earned
Andy	Yes	Health care administration	20	42	Doctorate
Angela	Yes	Hospital outreach	4	27	Master's
Deangelo	Yes	College/university	28	49	Master's
Dwight	Yes	Occupational health/industrial	22	47	Master's
Erin	Yes	College/university	6	28	Master's
Jan	Yes	Hospital	21	43	Master's
Jim	Yes	College/university	30	48	Master's
Katy	Yes	Clinic	18	40	Doctorate
Kelly	No	College/university	35	59	Bachelor's
Kevin	Yes	College/university	40	62	Master's
Meredith	Yes	Clinic and outreach	10	33	Master's
Michael	Yes	Secondary school	5	27	Master's
Pam	Yes	Business/sales/marketing	17	41	Master's
Roy	Yes	Hospital-based clinic	25	47	Doctorate
Ryan	Yes	Secondary school	17	43	Master's
Stanley	Yes	College/university	8	31	Master's
Toby	Yes	Hospital	21	51	Master's

Abbreviation: NPI, National Provider Identifier.

Table 2. Semistructured Interview Script

Question
Describe your health care organization.
What is your reporting structure and is it effective?
Describe the staff you supervise.
Describe your professional path to your current leadership position.
What, if any, types of training and development have you received or sought to meet the leadership expectations of your current position? Was the training and development formal or informal? Please be specific.
What is the vision for your organization?
What is the shared vision for those that you lead?
What strategies do you utilize to engage your staff in professional development?
Definition read to participants: The purpose of continuous quality improvement programs is to improve health care by identifying problems, implementing and monitoring corrective action and studying its effectiveness.
Describe how your organization is engaged in self-reflective practice and/or continual quality improvement (CQI).
What strategies do you use to inspire a shared vision for self-reflective practice and/or continual quality improvement (CQI) within your organization?
How do you measure your successes and failures? In what ways, if any, are these the same between you, your staff, and your organization?
How do you model self-reflective practice and/or continual quality improvement (CQI) to your staff?
How do you enable your staff to engage in self-reflective practice and/or continual quality improvement (CQI)?
What do you do when a staff member does not buy-in to self-reflective practice and/or continual quality improvement (CQI)?
What strategies do you, as a supervisor, use to challenge your staff to be innovative in their practice?
If a staff member takes a "risk" to be innovative in practice and that risk fails, what is the response to that outcome?
How is self-reflective practice/continual improvement encouraged or recognized?
Is there anything else you think we need to know about your leadership of health care delivery?

Table 3. Content Analysis Experts

Experience, y	Settings	Areas of Expertise
33	College/university, clinic	Leadership, Health care navigation
24	College/university, secondary school, clinic	Global leadership, navigating change, Organizational development
6	Academic	Leadership, coaching

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Table 4. The Roles and Experience of the Research Team

	Researcher			
	(L.E.E.)	(J.R.E.N.)	(K.E.G.)	(E.R.N.)
Role	Principal investigator; data analysis team member	Data analysis team member	Data analysis team member	Internal reviewer
Research Experience	Expert qualitative researcher	Experienced qualitative research	Experienced qualitative researcher	Experienced qualitative researcher

relative to self-reflective practice and continuous quality improvement (10 items). At the end of the interview, we asked if there was anything else we needed to know about their leadership of health care delivery (1 item).

Procedures

Once participants indicated their willingness to participate in an interview, the primary investigator sent an e-mail to schedule an individual Web-based interview. Once a time was agreed upon, participants received a scheduled meeting notification to join the primary investigator on a videoconferencing platform (Zoom Video Communications, Inc, San Jose, CA). At the scheduled meeting time, the primary investigator and participant met on the videoconferencing platform. The primary investigator read a prepared statement to (1) ensure that the participant met the inclusion criteria; (2) offer to answer any questions; (3) obtain verbal consent to conduct the interview and audio record the interview; and (4) to remind the participant of the project's purpose. All participants provided written and verbal informed consent to participate.

Once consent was received, the primary investigator conducted individual semistructured interviews. Each interview ranged in duration from 25–49 minutes (40.4 ± 7.1 minutes). At the conclusion of the interview, the participant was thanked for their time, the audio file was downloaded and saved. We then sent the audio file to an automated transcription service (Rev, San Francisco, CA; https://www.rev.com). The transcription file was deidentified and checked for accuracy against the audio file. At least 15 days after the interview, according to institutional review board protocol, we sent the deidentified transcripts to the participants for member-checking.[10,11] No participants replied with any changes to the information in their interviews.

Data Analysis and Trustworthiness

The data analysis team (Table 4) engaged in a multiphase process to code the data.[10,12] Using an inductive approach in phase 1, the team reviewed 6 transcripts representing the various settings of the participants. The team members independently developed a domain list reflective of the data and met to compare notes and come to consensus. During this meeting, the team created the initial codebook by discussing their respective domains and conceptualizing the core ideas. In phase 2, the initial codebook was applied to 3 of the original transcripts and 3 new transcripts to ensure that the codebook reflected the data. The team met to confirm the consensus codebook. During phase 3, the team applied the consensus codebook to the remaining transcripts. After each transcript was coded, the codes were confirmed by 1 other member of the team and diverging codes were discussed to achieve consensus. We ensured that the core ideas were accurately placed into categories using cross-analysis. We shared the interview script and 6 coded transcripts with the external reviewer and the consensus codebook was confirmed. At the completion of data analysis, we conducted a frequency count of the categories.[12] Categories were assigned *general* if they were identified in all (17) or all but 1 of the cases (16), *typical* if identified in 9–15 cases, *variant* if identified in 4–9 cases, and *rare* if only identified in 3 or fewer cases.[12]

RESULTS

Four domains emerged from the data: (1) preparation, (2) personnel influence, (3) culture, and (4) characteristics of strong leaders. Table 5 details the frequency for the coded data per category.

Table 5. Frequency Counts

Domain, Category, and Subcategory	Counts, N = 17	CQR Assigned Value
Preparation		
Mentorship	12	Typical
Resources	16	General
Self-Direction	16	General
Required	8	Variant
Management Role	5	Variant
Leadership Role	6	Variant
Personnel Influence		
Identified Individualized Motivators	16	General
Established Goals	11	Typical
Built Relationships	10	Typical
Culture		
Improvement Practices	16	General
Self-Reflective Practices	12	Typical
Systems-Level Assessment	16	General
Organizational Growth Mindset	13	Typical
Transparency	13	Typical
Characteristics of Strong Leaders		
Individual Growth Mindset	11	Typical
Embodiment	12	Typical
Transformational Leadership	12	Typical

Abbreviation: CQR, consensual qualitative research.

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Preparation

In the preparation domain, we identified *mentorship, resources, management role,* and *leadership role* as categories. Participants often described mentors who were influential in their preparation to assume a leadership role in their position. These individuals ranged in proximity to their current position, from former supervisors to role-model stakeholders in other organizations. Participants also detailed self-directed and required resources that helped them prepare for their position. Self-directed resources often included advanced education, books, and podcasts, whereas required resources included mandatory, internal leadership development opportunities provided by their organizations. Participants demonstrated preparedness or a lack of preparedness for both their management role and their leadership role. Management roles often surrounded the operational duties of a person in a supervisory position (eg, budgeting, scheduling, policy development). Leadership roles characterized the preparation necessary to be an influencer within their respective organizations. Supporting quotes from each of the categories are available in Table 6.

Personnel Influence

In the personnel influence domain, participants explained how they *identified individualized motivators, established goals,* and *built relationships* to influence their respective staff members. The participants depicted strategies they used to identify what motivated their staff, so that they could effectively influence them to act or change. Participants described wanting to know what motivated their staff to help them be successful, but they also used individualized motivators to help staff create personal performance development plans. Those participants who had more-robust quality-improvement environments were likely to establish objective and measurable goals that aligned with the performance plans, allowing for effective staff assessment. Many participants described how important it was to build relationships with their staff, which helped them communicate that they cared deeply about them as people but also about the development of the organization. Supporting quotes from each of the categories are available in Table 7.

Culture

The culture domain was represented *by improvement practices, organizational growth mindset,* and *transparency* categories. Cultures that engaged in improvement practices often did so with self-reflective practices and/or with systems-level assessment. Self-reflective practices included subjective self-assessment and appraisal of the workplace, whereas systems-level assessment adopted a continuous quality improvement culture in which measures were objective and the personnel were engaged with the process. An organizational growth mindset was indicative of a culture that sought out growth opportunities and embraced failure as an opportunity to learn and grow. A culture of transparency was depicted by openness and an environment that embraced the voices or perspectives of all its stakeholders, especially its staff. Supporting quotes from each of the categories are available in Table 8.

Characteristics of Strong Leaders

The characteristics of strong leaders domain included categories of *individual growth mindset, embodiment,* and *transformational leadership*. Participants with an individual growth mindset discussed self-directed persistence and advocacy for one's self within the workplace. Embodiment was characterized by modeling the behaviors that the leaders wanted to see from their staff, specifically those related to self-assessment and systems-level improvement practices. This included being able to "walk in the shoes" of staff members, demonstrating vulnerability and sharing failures with staff and taking actions to decrease resistance to workplace expectations. Transformational leadership was identified in the participants who talked about encouraging, inspiring, and motivating employees to innovate and change. Strong leaders who described changing the mindset or philosophy of a staff or who listed innovation among their organization's core values were identified as demonstrating transformational leadership. Supporting quotes from each of the categories are available in Table 9.

DISCUSSION

Preparation

Many leaders inducted into their roles have not had formal experiences in their professional preparation to meet the duties and responsibilities of their new positions. Several participants in our study described a lack of formal preparation regarding leadership, and given the curricular space and intellectual availability in professional preparation programs, this may be for the best. The Athletic Training Strategic Alliance has explicitly stated that a clinical doctorate should be reserved for advanced practice,[13] and it is possible and practical that postprofessional degree programs should fill this gap of developing advanced-practice leaders in athletic training education, similar to how nursing has developed advanced-practice leaders through doctoral preparation.[13] Professional preparation can and should be the level of education at which we focus on teaching the health care lexicon and the process of quality improvement,[14] so ATs can better align themselves within the American health care system and engage in dialogue with other health care professionals. Ideal leadership development includes comprehensive leadership curricula, which may include personal competencies (eg, introspection, listening, empathy, awareness, altruism), differentiating competencies (eg, finances and economics, team building, conflict management, negotiation), and task-oriented knowledge (eg, health care regulations, legal issues, organizational and systems quality improvement, being a change agent).[1] It is simply not achievable to expect professional programs to integrate this content into an already-substantial curricula. Therefore, it may be beneficial to introduce these concepts in professional education and provide discrete experiential learning opportunities, then rely on postprofessional education and continuing professional development to practice and reinforce these competencies.

Many participants filled their lack of leadership preparation through self-directed learning and mentorship. Self-directed learning integrates external management, cognitive responsibility, and motivational issues associated with adult learners.[15] Learners are motivated to assume responsibility and self-monitor the process of gaining new knowledge in areas they believe to have worthwhile outcomes.[15] The stated benefits to self-directed learning are thought to include the development of persistence, independence, self-discipline, self-confidence,

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Table 6. Supporting Quotes for the Preparation Domain, Categories, and Subcategories

Domain–Category: Subcategory	Supporting Quotes
Preparation–Mentorship	"I would say that one associate athletic trainer, he's been here for 25 years, just as an older professional. He's definitely privy, and then the background in the academic program. He's been around a long, long time and I'd say a mentor in that way, as far as, years of experience goes." –*Stanley* "I learned this from a great mentor. It's the game of life. It's not the I's, it's the we's, and it's recognizing others as they're part of the successes that are made." –*Toby* "For me . . . I've relied on mentors a lot. I really never standardized my approach to that, like types of mentors or I guess the people morphed over the years. I still use mentors. I used them a lot more in the first 10 years of my career, that's for sure." –*Deangelo*
Preparation–Resources: Self-Directed	"I've read a lot of books on leadership. I don't know that any of them have been specific to health care, but certainly, that is one thing; I'm always reading something for fun and then something for growth and some sort of professional skill. It typically tends to be leadership." –*Katy* "I took a lot of classes. Any chance I got to go to a meeting with somebody I would do." –*Andy* "It was kind of a position where I came in at entry level, I worked my way into developing a program for that system and I was working towards, I did a lot of leadership development, looking more into being a part of practice management, at the time." –*Erin*
Preparation–Resources: Required	"I've been part of executive coaching: our medical director, surgical director, and I. All three of us were part of executive coaching with the same coach with the intent to help us individually to be better leaders and then also collectively as a leadership team, improve our leadership effectiveness and impact. And that was an investment through the organization in us as leaders." –*Pam* "Our hospital system has a very robust kind of manager, director. So, basically anybody manager and above kind of has a set pathway as far as webinars and classes and things like that, that we're expected to complete. It's everything from doing payroll and budget, to disciplinary action if you have the need with your employees. A lot of it is already planned for you when you become a manager or director, or anything above." –*Jan*
Preparation–Management Role	"The other athletic trainer has been here for a year and a half now, and although I'm technically the head and she's the associate, it's very much interprofessional working together. Really my main supervisory roles are with administrative stuff like budgetary paperwork. All that stuff, she's in charge of a few teams, I'm in charge of a few teams, and then we meet together to discuss and work together." –*Michael* "I try to have her make sure that she does implement what she learns at conventions and implement what she does or what . . . yeah, essentially what she learns into the training room. We may have conversations regarding athletes, we may have conversations regarding some continuing [education] stuff, but it's not anything that I actually direct her to do. She's been in the game a long time and we try to, I try to give her some autonomy to do her." –*Ryan*
Preparation–Leadership Role	"Really, what I did to drive my path was to get involved, participate in meetings, learn the language of the health system. I would say as an athletic trainer I spoke a different language than healthcare administration leaders . . . and what does productivity mean and what is a pro forma and a lot of the business aspects of healthcare that I was aware of but not necessarily understanding. I took a lot of classes. Any chance I got to go to a meeting with somebody I would do." –*Andy* "I think that in a leadership role, even in athletic training, becoming an athletic trainer, there's a certain point where you . . . It's all about managing people. You've got to learn to manage people. They don't teach us that in school. They don't teach you business, they don't teach you communication and personal management. I think that's critical for those athletic trainers." –*Dwight* "I think I'm a strong believer that, after going through the [Sports Medicine Institute] program . . . that especially in athletic training, we need to expand our horizons outside of athletic training and outside of health care. We need to understand, you know, at the college level, and at the professional level, it's a business. So, you need to think like a businessman. When you're making decisions, it needs to be . . . You're thinking like a Fortune 500 CEO, because realistically, I'm the CEO of . . . In today's world, what would it be? I don't know, a medium-size business? You know, with salaries, and medical bills, and everything." –*Jim*

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Table 7. Supporting Quotes for the Personnel Influence Domain and Categories

Domain–Category	Supporting Quotes
Personnel Influence–Identified Individualized Motivators	"I'm real big on forwarding any conferences or even webinars that I get that interest either myself, or I know it interests the other athletic trainer I work with, or even the strength conditioning coaches." –*Michael*
	"And then the last thing we talk about is what's their purpose? So trying to find out what makes each one of them tick. We try to then, based on what they find most appealing or what they really want to focus on, we create different committees within our structure. So some people are interested in kind of employee engagement and they work on." –*Roy*
Personnel Influence–Established Goals	"I also do goal setting with them. That was another big thing for me is goal setting. I did that a lot when I was a head associate athletic trainer. I would make sure every 6 months that all my graduate assistants had some type of goal, long-term, short-term, and then their paths to getting to their goal" –*Meredith*
	"I think having as many open lines of the communication as possible, then going to people with far more experience than me to try to determine the best course of action given what the goals are of that clinician or that professional." –*Stanley*
	I would say the benchmarks for our quality improvement processes, if you aren't hitting a certain benchmark, you won't be considered for merit increases. So, everybody has a benchmark to hit, a minimum benchmark to hit. We have where we want to be as a team, but if you aren't hitting those minimums you aren't going to be considered for a merit increase, and you aren't going to be considered for other special things that happen throughout the year. I would say, just a monthly reminder of where we are as a staff for some of our quality improvement projects. You know, we have kind of a thermometer of where we are every single month with our quality improvement projects. –*Jim*
Personnel Influence–Built Relationships	"Sometimes it's just more of a team building type experience, where we went and we just went bowling one time, or we went, and did I don't know what you call it. One of those kind of paint-by-number things where you go to a studio and you all paint the same picture, and they basically tell you how to paint the picture. So, for me, because we have such a unique team, I guess, I know that's not all professional development, but for me it all kind of plays together as far as development of the team and engagement of the team." –*Jan*
	"I think it all comes down to relationship and it's good to be a leader but you also have to be colleagues and there's only 2 of us, it's not like I have a staff of 5 and myself to have to worry about and we all work 1 sport during the season." –*Ryan*

and goal-centeredness[16,17]; however, some would argue those traits were present first, guiding self-direction.[18] Self-directed learning may also result in missed or haphazard learning because individuals simply do not know what they do not know. Ideally, self-directed learning includes collaborative constructivism, because meaning from experiences cannot be made in isolation from the shared world.[19]

Mentorship is a critical part of preparing for an executive role.[20] A *mentor* is a counselor or guide, and a mentor with real-life experience can help an emerging health care executive develop leadership style.[1] *Mentorship* is a gifting of time and resources, without an expectation of return on the investment.[21] Many participants in this investigation described the importance of mentors and how they helped create opportunities and served as a sounding board for their progression. As health care executives develop themselves, a critical component of their role is in future leadership development;[1,22] the process of "paying it forward" and preparing future leaders.

In contrast, many participants described formal leadership development that they engaged with through their organization. Leadership development is $366 billion global industry[23] and is of particular interest in health care due to the size of major health care organizations. Activities such as executive coaching, internal leadership training, and external training programs were seen as critical in developing some participants in their leadership roles. Effective leadership development programs often included facilitating a supportive culture, engaged mentorship, extended learning periods with support after the program, encouragement of ownership, and commitment to continuous quality improvement.[24]

On the contrary, those who struggled to describe their leadership positions beyond that of the operational tasks associated with an administrative position had limited leadership training and development. This has substantial implications for those that have positional authority but no personnel influence. *Positional authority* is often associated with a title or rank[25]; in the case of our participants, these were individuals who had a title of "Head Athletic Trainer" yet had no ability to influence other ATs within their facility, whether for structural reasons or because they had not yet found ways to be effective. *Influence* is the ability to effect and change those around you.[25] These concepts, for some of our participants, were mutually exclusive. Additional training and a strong appreciation for an organizational growth mindset is needed to advance a manager beyond the roles of completing operational administrative tasks and into the role of leader.

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Table 8. Supporting Quotes for the Culture Domain, Categories, and Subcategories

Domain–Category: Subcategory	Supporting Quotes
Culture–Improvement Practices: Self-Reflective Practices	"I'm working on putting new policies and procedures together as we just, we adopted her mental health policy last year. That was a huge project for us. Our conference required them before NCAA [National Collegiate Athletic Association] or anybody else did, which now that all the toolkits are coming out et cetera. Especially we've already got ours. But saying that we will review that spring every, every year at the end of the year we have a retreat, we get everybody, we packed up, we go someplace, we sit down, and we'd discussed what we're doing, et cetera. And one of the things that we will do is we'll review that mental health policy and figure out where our holes were, places that we didn't have our policy left gaps, et cetera. We found one clearing. One was we are really, really good." –*Kevin*
	"I think the power in the word *no*, because it's not always about *yes*, causes or helps people to self-reflect because they have to think about why that happened." –*Meredith*
Culture–Improvement Practices: Systems-Level Assessment	"I like the fact that we get people engaged in identification of areas that they'd like to learn more about, self-reflective practice. And then the fact that we talk about it on a weekly basis, even while surrounding incident reporting, it keeps it on our minds. And so, I think that establishes it as something that we value and then as such, that becomes inspirational." –*Deangelo*
	"For our outreach program specifically, that's always been a really difficult task because it's a PRN [as needed] role and so it's very difficult to assess quality when every single high school, it's up to them to have their own electronic health record system. If they have their own then great, but the majority of them don't so then our staff has to have paper that they have to write down and so, it makes it harder to analyze the results of the previous year and then to implement change." –*Angela*
	"We run anywhere between 3 to 5 QI projects a year. Here, within athletic medicine. We have a continuous QI project on concussions, making sure that we're doing everything we're supposed to be doing with concussions, and that we're reaching a 98% benchmark of how we're handling concussions. We do peer review, and we have incident review, that we'll pick and choose certain incidents to review overall, and then also discuss, as a team. . . . We've had an external student athlete health and welfare advisory council, but now we're trying to formalize it a little bit more and make an external review board for student athlete health and welfare, very similar to what's done at hospitals or other places." –*Jim*
Culture–Organizational Growth Mindset	"Some of them we've challenged them and said hey yes this is how we did it in the past, let's reflect and see how we can do it better or how do you think that we should approach this differently so that we're not always frustrated about things. And some of it's really positive but we are coming to find what they are telling us and how they want change doesn't reflect their actions and so that's what we look more to is how does what they're telling us and how they want to change or how they think that they're not happy with their work conditions, but then what do their actions say? Are they working towards that common goal of ours, and we will eventually, maybe not so much in a formal process but we will evaluate that before the summer begins." –*Erin*
	"One of the things also is important. Is intra, within the company, intrastaff evaluations where they have to have the autonomy and freedom to go to each other and say, "Hey, you could have done this better" or "you were the primary stakeholder on this, and this went wrong, so let us come together as a team and help make this right." The biggest part, I will tell you in what you're asking, is you have to let them know it's okay to make mistakes, it's just what you do about it. You have to have a caring component, not a criticism component behind you as a leader, and so do your directors. They have to feel it's okay, and they have to be okay with not being okay, And understand that no one's perfect, but it is that part of within the company, and in the departments and divisions of the company. It's the intra- and inter-division, division. It's that critical thinking, but it's also that reflection on what went right, what went wrong. I think that that is a key thing. Like" Like in our organization, we don't use the word failure. In our organization we use the word lessons learned. What was the lesson learned from this, and that's critical? It's verbiage and nomenclature which you choose, as well as how you address it." –*Dwight*
	Well one thing is I fought hard for money for education and they want to go, I don't have to urge them on to do professional development. They want to go, they're eager to learn. –*Kelly*

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Table 8. Continued

Domain–Category: Subcategory	Supporting Quotes
Culture–Transparency	"We spend a lot of time, and I usually spend a lot of time, before implementing anything, going through drafts and talking about, "What can we do to make this more efficient?" So, if it's documentation, how can I make your documentation more efficient? You know, like this year, we spent a good amount of money on dictation." –*Jim* "So, I think sometimes I do share what I'm trying to do within our program to help them understand where we're at. So, the vision that I talked to you about, I did share that with my staff and give them an opportunity to respond. I try not to tell them this is what's going to happen. I give them room to say, "Well, I think we should add this to our vision" as a team. I do try and share what my goals are and what I have for our outreach program, so they understand what their role is in that." –*Angela* We spend a lot of time, and I usually spend a lot of time, before implementing anything, going through drafts and talking about, "What can we do to make this more efficient?" So, if it's documentation, how can I make your documentation more efficient? You know, like this year, we spent a good amount of money on dictation. And, developing a dictation system for our staff so they can dictate . . . because you can always speak faster than you can type, but being able to dictate . . . And, that allows them to be more detailed in their documentation. So, that's probably the biggest thing for me, it's just being efficient in what we do, and not just doing something to do it, but have a reason and really looking at and testing how efficient can we be? –*Jim*

Creating Change through Culture, Leaders, and Personnel

To effectively create an environment capable of change, the workplace needs effective leaders who have influence over both culture and personnel. In considering the characteristics of strong leaders, some of our participants described themselves as having overcome obstacles. This is consistent with previous literature[1] that identified resilience and willingness to address failure as an opportunity for growth as characteristics of strong leaders. Moreover, effective leaders embody the characteristics they wish to see in their personnel. Modeling the way is among the 5 practices of exemplary leadership.[26] In this particular study, we looked at how leaders modeled, inspired, enabled, encouraged, and embraced challenges when facilitating quality improvement. When the participants, who were characterized as leaders, described how they facilitated continuous quality improvement, they talked most about modeling vulnerability, openness, and a willingness to adapt to the demands of the workplace environment. Effective leaders also addressed a desire to change both the environment and personnel. These characteristics depicted a transformational leadership style, where individuals elevate others, facilitate others, and engage in forward thinking.[1] Leadership in the 21st century is rapidly evolving, and a transformational leadership style may be critical to adapting to new trends and policies.[22,27,28]

A function of transformational leadership includes engaging individuals (ie, influencing personnel).[27,29] As a leader, health care executives are responsible for identifying what really motivates health care workers. Identifying the motivators allows the leaders to establish goals and benchmark for success.[1] These principles align both effective leadership strategies and basic steps of personal quality improvement. Specifically, a plan-do-study-act cycle includes self-auditing, goal setting, data collection, and analysis, all to set direction and enable progress.[30,31] However, health care executives in modern health care can no longer focus on individual personnel development alone but must work to build strong relationships around a central mission, to improve patient outcomes through teamwork.[22]

Some participants in the study perceived themselves to be leaders due to their position title, whereas their role was predominantly managerial (organizing, planning, directing)[6] with little leadership responsibility (motivating, engaging, and inspiring personnel).[6] When pursuing the questions relative to inspiring, modeling, enabling, and challenging continuous quality improvement within their organizations, it became clear these participants either did not possess a reasonable level of influence to which their position entitled them or they were ill-equipped to exert influence. This created challenges for the participants when discussing their leadership responsibilities. This identifies an interesting phenomena within athletic training and beyond. Sometimes in athletic training and throughout health care, individuals are placed in positions of authority on the basis of age, productivity, or other skills, yet they are inadequately prepared to lead others.[32]

The characteristics of strong leaders and their ability to influence personnel are critical to developing a culture capable of change. As leaders enact their influence, they can create an environment with an organizational growth mindset engaged in systems-level improvement practices and transparency. An organizational growth mindset is one that embraces failure, encourages lifelong learning, seeks out challenges, pushes people beyond their limits, and values feedback.[33] Participants in our study described looking for failures and considering those as opportunities for self-improvement, embraced teamwork, and believed new skills and contributions were attainable, similar to that which is described in the literature.[33] Specifically, *transparency*, an open dialogue in the pursuit of truth and that ignores traditional hierarchy, helps to create an environment that solves problems sooner, embraces teamwork more easily, embraces authenticity, develops trust and loyalty, and results in overall better performance.[5,34] An organizational growth mindset is facilitated by leaders who embody

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Table 9. Supporting Quotes for the Characteristics of Strong Leaders Domain and Categories

Domain–Category	Supporting Quotes
Characteristics of Strong Leaders–Individual Growth Mindset	"The failure part is a little more difficult because I tend to be a bit persistent, and I don't necessarily look at failure as a bad thing; it's just the way it's not supposed to be done. I guess for me no is a failure, and it's that opportunity to try again. I'll try and try and try until somebody just says stop. Failure is a hard question for me because I don't accept failure. That's a personal thing." –*Andy* "I think it's looking at what's happening, identifying that, brainstorming on opportunities for change or for better the program. I think it's giving everyone . . . It's giving all the stakeholders involved voice. I think when people have a voice, and especially when something that they brought is implemented, I think it helps them buy in more. But even at the . . . I mean, the residents are a big part of it, but preceptors, mentors, residents, myself, medical director. I think it's everyone having buy-in, and then everyone having a voice, all of the stakeholders having a voice, and then inspiring based on where that voice is, right? Being able to identify what they're saying and what they bring to the table, and embracing it, not just blowing it off." –*Toby*
Characteristics of Strong Leaders–Embodiment	"Having benchmarks for myself of what I'm doing, where I'm going, who I'm talking to, how I'm communicating. My benchmark for myself is being in an administrative position of making sure that every week that I visit every practice. Every practice or . . . Basically, I visit every athletic trainer at their practice at least once a week. It's a benchmark I set for myself. I've also set for myself a benchmark of attending 85% of the home contests that we have, in support of my group. I just wanting to be present, be available for them." –*Jim* "By not being right all the time. I think because I try to be a humble leader, I am often self-reflecting. I have a planner, actually, that is all about self-reflection and goals and kind of not just the why, but the why behind the why and they why behind that why. Really, just looking within yourself and how you can be a better person. Setting weekly goals and writing down things that are routine and trying to better yourself. I think that they can see through the things that I'm trying to do because I don't just settle for one thing. Let's figure out how we can make it this better." –*Meredith* This is recent through my executive coaching, I think I have become comfortable being vulnerable and saying, "Guess what? I don't think I showed up the best way," or, "I'm not really sure I had the best response in that situation. I want to talk about that more." So, welcoming feedback myself and then also circling back when I reflect on something that I think didn't go well or even with someone else. So, "Hey, I don't know if you showed up the way you wanted to. Can we talk about that?" –*Pam* "Well, I try to lead more by example. I'm not too verbal on those things. Personally, like through the podcasts and books, constantly reading and trying to improve the way I practice and the way I present myself to student athletes and staff and coaches, as far as communicative patterns, just trying to be positive. If things arise or conflicts or concerns to try to think out a solution or have a solution available, as opposed to just complaining about things. But nothing formal or super direct, and I'm not a big rah-rah guy, just try to walk the walk instead of preaching." – *Stanley*
Characteristics of Strong Leaders–Transformational Leadership	"I knew that I wanted an industrial athletic training program to supplement our traditional outreach athletic training program, and so I found somebody who was an expert in that and groomed him along the way and prepared him to take on that role. Had him develop that program and had him do the things that would be needed for when it was time to pull the trigger to run that program, it was an instant go, and that's what happened. He went quickly from a resource athletic trainer to a supervisor running that side of the program. To this day now he continues to do that, and he can do that with very little supervision." –*Deangelo* "And trying to have a sense of community. As athletic trainers in a secondary school, many times you feel like you're out on an island all by yourself. What we're trying to do is create this sense of community that, yes, while your day-to-day operations is out of the school, and you're by yourself, you're never by yourself, because you can always text, you can always call somebody else that has probably had some experience dealing with an issue that you're dealing with. So that you don't have to feel alone trying to manage a difficult coach or had a difficult phone call with the family or that kind of thing. So, I think that's what we've really tried to focus on" –*Roy*

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listening, awareness, persuasion, conceptualization, foresight, stewardship, and a commitment to grow people and the community.[33,34] Participants in our study described these leadership values and behaviors resulting in a culture with an organizational growth mindset, whereby employees are empowered to use their strengths collaboratively to improve the health care system in which they work and, more directly, their patient care.

As we consider the future directions of research in athletic health care executive leadership, we must consider training and preparation as paramount. Although previous researchers have identified that some skills, such as emotional intelligence, teamwork, and collaborative care, are the foundation to leadership in health care, these are basic principles necessary to incorporate in professional-level education.[1,22] The Strategic Alliance, and parallel organizations in other professions such as nursing,[35] have left "space" for postprofessional education that may effectively fill the leadership gap in athletic health care. Advanced-practice leadership development in health care can address issues of finance and economics, team building, communication, conflict management, negotiation, vision development, adaptation, the ability to develop others and serve as a change agent.[1,22,36] Future research should investigate the role of postprofessional education in the development of practice leaders who embody the characteristics of leaders prepared for the challenges and opportunities of current and future athletic health care.

LIMITATIONS

Research, particularly qualitative research, has inherent biases; however, the consensual qualitative research approach and multiple-analyst triangulation makes effort to minimize those biases, requiring consensus in developing the codebook. Our investigation provided a broad view of athletic health care executives from all settings. Future investigations should seek to further generalize these findings and to identify any differences between settings. We did not collect data relative to the athletic training health care executive's workplace responsibilities, including the number of direct reports or the size of the overall organization. Future research should consider evaluating the impact of direct reports and organization size on the experiences of athletic training health care executives.

CONCLUSIONS

ATs are serving in health care executive positions, in traditional, hospital/clinic, and emerging settings, in which they have oversight to lead and create change within their organization. However, few of these ATs have had formal training to prepare them for executive positions. ATs with aspirations to rise to these health care executive positions should seek formal training to ensure that they possess the skills and mindset necessary to create organizational change and serve as transformational leaders.

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