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Manager Onboarding to Improve Knowledge and Confidence to Lead

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Manager Onboarding to Improve Knowledge and Confidence to Lead

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Section I: Abstract

Background: Primary care (PC) is increasingly the setting for affordable, coordinated, end-to-end patient care, with PC managers in charge of organizational performance. While PC managers are central to high-functioning teams, they often receive inadequate onboarding.

Local Problem: Primary care onboarding competes with other operational priorities and faces time constraints, lack of mentorship, and cost.

Context: At an integrated healthcare system, a need was identified to develop structured, role-specific onboarding for newly hired PC managers to improve knowledge and confidence to lead.

Interventions: Bauer's Four Cs framework for onboarding guided the development of a manager onboarding program for 12 new PC managers. Content drew on best practices from the literature and was informed by the knowledge gap discovered through a needs assessment.

Outcome Measures: Knowledge, confidence to lead, and intent to stay were chosen to assess the impact of onboarding on the competencies of new PC managers to be successful in their roles. The metrics were percent change from pre- to post-implementation. Data to evaluate outcomes were obtained from the pre- and post-intervention surveys.

Results: Confidence to lead increased 13% (t(21) = 2.33, p = .03); knowledge increased 29% ((t(21) = 2.94, p = .01). Intent to stay in the role did not show a significant increase.

Conclusions: Evidence from the literature and the project results suggest strong connections between structured onboarding practices for new managers and preparedness to lead high-functioning teams. Empirical research is needed to examine the implications of onboarding relative to hire date on intent to stay in the role.

Keywords: manager onboarding, manager orientation, primary care manager, increased knowledge, leader confidence, retention

Section II: Introduction

Managers are the foundation for high-functioning care teams. In the patient-centered medical home (PCMH) model for primary care, managers coordinate care across a continuum, from primary care through specialties and from hospital to transition facilities or home care. To successfully lead the care teams who manage patients through these transitions, primary care managers must have a broad understanding of end-to-end patient care and the skill set to give the care team confidence in their leadership.

A new manager is expected to lead but first needs time, opportunity, and specific learning support. Without adequate knowledge of stakeholders, systems and processes, team roles and responsibilities, and clarity about their authority and responsibility, mistakes will be made, patient care impacted, and the care team will lose confidence in the manager's ability to lead. Well-designed and adequately executed onboarding can prevent this downward cascade.

Onboarding is a process "through which organizational outsiders become organizational insiders," acquiring the knowledge, skills, and behaviors needed to succeed in the organization (Bauer & Erdogan, 2011, p. 51). Thorough and targeted onboarding is critical for managers who, as leaders of their organization or unit, are expected to quickly assume operational leadership, align with stakeholders, and engage with the organizational culture (Byford et al., 2017). A mistaken assumption that the manager will "figure it out" can be expected to materialize as poor performance, dissatisfaction and attrition on the manager's side, frustration, disengagement, loss of work continuity, and a drop in overall performance part of the staff.

Background

Conventional wisdom holds that managers are the foundation of success for high-functioning teams and ultimately drive organizational performance in any industry. Thoughtful, well-trained leaders foster team engagement for continuous improvement and success in creating and sustaining high-performing teams (Ghorob & Bodenheimer, 2015; Nembhard & Edmondson, 2006). Nurse managers are the linchpins of healthcare organizations (Warshawsky et al., 2020); however, new managers may not receive the onboarding they need to be high performers themselves. There are reasons for slighting onboarding competing with higher operational and strategic priorities, fiscal constraints, a paucity of available mentors, and the lack of time to train a much-needed new hire. As a result, new managers may be slow to assimilate into the organization and lack clarity in their roles. Knowledge gaps and frustrations that contribute to job dissatisfaction may manifest as intent to leave for the manager and as disengagement, lack of continuity in organizational work, and compromised performance for the frontline care team.

Problem Description

The contribution of primary care to health systems and health is well documented, going back to the seminal study of Starfield et al. (2005). The authors demonstrated that health care systems with more comprehensive primary care improve population health at lower costs and with greater equity than systems that prioritize specialization (Koller & Kane, 2018). There is increasing demand for primary care to provide primary preventative service, complex care coordination, chronic disease management, and subspecialty care to higher complex patients. This demand has led to greater demand for primary care staff, including doctors, nurses, and managers trained in the widening arc of what constitutes primary care.

Ambulatory care curricula, specifically primary care content, are generally not well developed in nursing programs at all levels. Instead, nursing education has long emphasized acute care, specifically inpatient nursing practice. However, an increased focus on the ambulatory care setting as an essential site of healthcare provision has brought to light the crucial role of RNs as ambulatory care providers and led to efforts to revise curricula and create practice transition residency programs to meet the need (Paschke, 2017). Although many nursing programs are expanding their content to include ambulatory care-specific training, no empirical report to date has measured the robustness, consistency, and extent of this transformation (Wojnar and Whelan, 2017). Newly graduated nurses who are ill-prepared to provide ambulatory care present a problem as ambulatory care staff nurses are a pipeline for nurse leaders in primary care ambulatory care settings.

In addition to the knowledge gap in ambulatory care and leader critical mass, the healthcare industry has experienced high turnover rates over the years, creating inconsistent staffing in the care teams and manager positions. A 2018 turnover report by Compdata consulting group from nearly 25,000 participating organizations showed healthcare's turnover at 20.4%, only second to hospitality, the sector with the highest turnover (Compdata, 2018). Poor retention of healthcare managers directly impacts the success of organizational initiatives, patient care outcomes, and front-line care retention. A cross-sectional study on nurse managers' organizational and professional turnover intention discusses structured transition programs such as manager orientation, mentorship, or preceptorship as essential measures to addressing turnover intentions (Labrague, 2020).

Setting

The setting for this DNP project was the primary care service line of an integrated healthcare organization in Washington State, itself a division of one of the nation's largest not-for-profit healthcare organizations. In Washington State, the organization serves over 465,000 members in thirty-one primary care facilities. Primary care contributes to over 75% of the organization's care delivery, with the remainder shared among home care services, four urgent care centers, a 15-bed acute care hospital, and specialty services.

Several iterative efforts to improve staff onboarding over the past four years have failed to produce consistent, standardized onboarding practices that match the roles and responsibilities of primary care managers. The only onboarding for primary care managers at present consists of a four-page checklist. The checklist is limited to general information on the organization and stakeholders, contains training resources only on labor management, and lacks content on primary care core concepts and practices, patient care outcome metrics, staffing models, standard work, and key primary care stakeholders. The checklist is used inconsistently; new managers are often given the checklist and expected to navigate their new roles independently.

In 2019, the new Director of Primary Care assessed current manager onboarding practices, interviewing 20 individuals: recently hired managers, director-level leaders, HR representatives, the director of nursing practice, and leaders from other healthcare organizations. The assessment confirmed inconsistent use of the checklist, inadequate onboarding content applicable to the primary care manager role, and revealed a desire for new managers to have assigned mentors. Time constraints for managers and leaders and competing operational demands were identified as barriers to onboarding.

In the primary care service line, the adverse effects of insufficient onboarding for managers extend the time to proficiency, lack of role clarity, insufficient knowledge to solve simple problems, and low job satisfaction. The primary care team had been impacted by new managers' insufficient understanding of team members' everyday work and desired metrics and the new manager's lack of confidence to lead.

Specific Aim

The existing onboarding practices for new managers in primary care did not adequately cover the levels of onboarding as delineated in Bauer's Four Cs framework (Bauer, 2010). The practices lacked elements specific to primary care, the service line culture, supporting critical relationships, and were inconsistent in assigning mentors. The aim statement was developed to guide the course of the project to mitigate deficiencies and achieve the project goals.

The specific aim of this project was to design and implement a manager onboarding program in the primary care setting, increase knowledge and confidence to lead teams, and increase intent to stay by 10 % post onboarding. Beyond the specific aim, the goals of this project are to equip new managers with the knowledge and confidence to lead their teams, increase job satisfaction and intent to stay, and improve organizational performance.

Available Knowledge

PICO(T) Question

A PICOT question was developed to aid the search strategy and guide the selection of articles for inclusion in the literature review. The PICOT question is: In a primary care setting (P), does implementing onboarding (I) compared to current practice (C) equip managers with the knowledge and confidence to lead high-functioning teams, improve job satisfaction and increase intent to stay (O) within three months of the intervention (T)?

Search Methodology

A systematic literature search was conducted in the CINAHL, Cochrane, PubMed, and Fusion databases. The search terms *manager onboarding, new manager orientation,* and *new manager training*. A secondary search in the Google Scholar database used the single search term *onboarding*. The search was limited to peer-reviewed articles in the English language published from 2010 through 2020. The total search yielded 989,304 articles. For each search term used in the different databases, up to 250 articles returned were reviewed by scanning titles and abstracts. Articles were included if they addressed turnover, job satisfaction, role clarity, mentorship, and had explicit content to address knowledge gaps. Articles were excluded if they did not explicitly address gaps in knowledge, confidence, or turnover in new hires. Eleven articles were chosen for inclusion in the literature review. Only two of the 11 articles addressed onboarding in the primary care setting. Articles were critically appraised with the Johns Hopkins Nursing Evidence-Based Practice Non-Research and Research Evidence Appraisal Tools (Johns Hopkins Hospital/Johns Hopkins University, n.d.) See Appendix A for the Evidence Evaluation Table.

Integrated Review of the Literature

Importance of Mentorship, Preceptorship, and Leadership

A key element of onboarding, as evident in the onboarding literature, is mentorship. Managing a new hire with an experienced, supportive adviser is part of successful onboarding as it helps to reduce role ambiguity. Minnick et al. (2014) conducted an empirical study to determine whether assigning a formal mentor impacted the new hire's learning curve and intent to stay. A survey was conducted of 299 safety professionals in manufacturing, oil and gas, and construction in Pennsylvania. A mentoring program was developed based on the survey

feedback. The study results brought forward the benefits of mentorship in ensuring the continuation of knowledge and providing support to new hires as they socialize with staff and navigate a new environment. It was observed that mentorship has benefits for both the mentee and the mentor. Successful mentees are likely to increase their confidence and job satisfaction, which reflected in the mentor's job satisfaction. A caution from the study was that a mentorship program is not enough. There must be a framework that leverages feedback and dedicates time for mentors to coach their assigned mentees.

Sharma and Stol (2020) conducted a cross-sectional survey to explore the link between the onboarding (referred to as "organizational socialization") of new hires and their intent to stay. The study population was 102 software professionals who responded to a 24-question survey administered online with the SurveyMonkey tool. The survey questions addressed onboarding activities, onboarding success, organizational fit, and intent to stay. Survey responses ($n=102$) were analyzed using the Partial-Least Squares Structural Equation Modeling (PLS-SEM) software to examine correlations among the four variables. The results indicated that support from senior staff or a mentor was the most significant element associated with onboarding success ($p=0.000$; $sd=0.068$). Onboarding success had a positive influence on job satisfaction ($p=0.000$; $sd=0.062$) and the quality of workplace relationships ($p=0.000$; $sd=0.079$). Job satisfaction had a negative relationship with turnover intent ($p=0.010$, $sd=0.140$). The significant relationships between supervisor and mentor support and onboarding success and the positive association of onboarding success with job satisfaction suggested an indirect connection between onboarding success and turnover intention.

Trossman (2016) recorded opinions from five Alabama and North Carolina experts to discuss onboarding programs and their impact on retention and better patient care. The five experts held academic or professional leadership roles in nursing, nursing education, and nursing professional excellence. These experts discussed the inclusion of Team STEPPS, QSEN competencies, and mentorship in an onboarding program centered around the individual new hire. The consensus of the experts was that while task-specific training is vital for successful onboarding, it should be secondary to creating a culture focused on problem-solving, teamwork, and leadership. These elements are core to achieving operational excellence and provide the knowledge and confidence for an individual to perform in any role and any industry. The second point of emphasis was that onboarding should focus on aspects of operational excellence, including teamwork, securing positive patient outcomes, facilitating effective communication, understanding the role of other professionals, and maximizing the utility of available resources. It was recommended that preceptors be engaged to underscore these aspects for new hires and that the preceptors be certified as competent by completing appropriate training such as Team STEPPS. An additional recommendation was that onboarding is delivered in a collaborative environment to foster retention.

Structured Onboarding Best Practices

The primary care manager role has become multifaceted as care formerly considered complex, specialty, and acute is absorbed into primary care to contain healthcare costs. In a cross-sectional study by Warshawsky et al. (2020) completed at the 2019 annual meeting of the American Organization of Nurse Leaders (AONL), a mixed-method approach was used to query participants to identify strategies to successfully onboard and transition nurse managers to their new roles. Four themes of structured onboarding with specialized processes, mentorship and

coaching, knowledge development courses, and program evaluation emerged. From the results, didactic, self-paced transition programs ranging from 100 days to 12 months were recommended. It was further recommended that the programs include AONE nurse manager competencies and be regularly evaluated and updated. Participants supported the assignment of official mentors and preceptors to guide new managers through acquiring appropriate knowledge and gaining the confidence to apply it. The study concluded that the success of nurse managers depends on successful role transition.

Zaire (2017) described a structured onboarding process to prepare clinical staff to provide safe and efficient patient care. The program was implemented in nine primary care federally qualified health centers (FQHC) in Ohio. A fundamental element of structured onboarding incorporated into the program design was a lead Licensed Practical Nurse (LPN) position, with the LPN trained to facilitate the onboarding of clinical staff. The nurse leaders met with the participants weekly to review skills and tasks related to their roles. Competency checklists were used to acquire the data. The nurse leaders also reviewed documentation audits and self and peer evaluations monthly for three months. The leaders reported increased staff confidence and efficiency but did not quantify the increases. Turnover decreased from 32% in 2015 before project implementation to 8% in 2016 post-implementation. The author attributed stability in staffing to the efficiency improvements observed in the primary care centers.

In a descriptive cross-sectional study, Hsu et al. (2011) evaluated a leadership orientation program for new nurse managers about its impact on their competencies. The study included 15 new nurse managers, 101 staff nurses, and 20 nurse administrators. The new managers completed a leadership orientation workshop to equip them with practical coaching strategies to improve their knowledge and skills. The study demonstrated that the preceptorship program gave

new managers quickly acquired experience and improved their coaching competencies. The study highlighted the importance of leveraging the new manager's educational background and equipping them with appropriate resources to ensure successful coaching and leadership of high-functioning teams.

Kurnat-Thoma et al. (2017) designed a 10-factor onboarding program to help reduce staff turnover at a community hospital in Washington, DC. The facility had experienced high voluntary and involuntary turnover levels, attributed to poor quality orientation and minimal onboarding training. After implementing the 10-factor onboarding program of unspecified duration, the overall annual turnover between 2013 and 2014 decreased from 18.2 to 11.9 %. Turnover for new hires decreased from 39.1 to 18.4 % ($p = 0.04$). Survey and interview data showed that onboarding increased role clarity for new employees and presented them with an opportunity to address key concerns about their work early on. The improvements were largely attributed to implementing an onboarding program designed to support new staff by promoting frequent interaction between leaders and peers. The conclusion drawn from the study was that a structured onboarding process focused on providing consistent leadership support increased stakeholder engagement, reduced turnover, and improved the organization's quality and safety indicators.

Meyer and Bartels (2017) used four well-established levels of onboarding—compliance, clarification, culture, and connection—to examine the effects of these levels on perceived utility, organizational commitment, perceived organizational support, and job satisfaction. The lowest level of onboarding is compliance, which addresses the legal policies, followed by clarification, which addresses specific role training and performance expectations. The third level is culture, where the staff is introduced to the organization's norms. The connection is the highest level,

where new hires can forge and sustain positive work relationships with other staff. In a qualitative study using an online survey design, 382 participants employed in the United States, currently employed at the organization where onboarded and onboarding took place at least six months ago were recruited via an online research platform. Participants were 63.6 % individual contributors, (n = 243); 31.4 % were managers, (n = 120); 3.1 % were executive leaders, (n = 12); and 3.1% did not identify their job title (n = 7). The survey results showed that 91.1 % of respondents reported being onboarded at the compliance level, 83.5 % at clarification, 62 % at culture, and 53.1 % at the connection level. The study revealed a correlation between employees' positive perceptions about their utility in the organization and their subsequent commitment to higher levels of onboarding. The results concluded that onboarding plans should aim to engage new hires at the connection level to maximize engagement. However, it was noted that organizations might find onboarding at the culture and connection levels to be time and resource-intensive and costly.

Onboarding is expensive, a consideration that may negatively affect what an organization will commit in terms of time, talent, and resources. Middleton et al. (2018) mapped out the onboarding process applied by a large academic and tertiary care hospital and embarked on a project to reduce onboarding costs by 25 % by eliminating aspects of the onboarding process that returned little value. Stakeholders' interviews revealed that a typical clinical faculty onboarding process took from 12 to 20 months. The length of time needed to complete an onboarding process was cited as a reason manager replaced onboarding with orientation, a much shorter process. The perceived need to adopt "creative disruption" measures to make the onboarding process easy and fast was noted. In addition to eliminating non-value-added steps, the study highlights the need for managers and leaders to delineate patient and faculty-related goals and

adjust the onboarding process accordingly. It was suggested that this measure alone would improve workplace satisfaction for new hires and overall patient outcomes for the hospital.

Klein et al. (2015) provided evidence to support the hypothesis that the outcome of onboarding is dependent on four factors of socialization: actors (i.e., leaders and managers), content shared, socialization stage, and tactics used. Perceptions of employees (n = 373) from 10 organizations were evaluated based on surveys addressing specific onboarding practices. The results related to specific onboarding practices revealed that managers often simply welcome new hires and share some basic content about the workplace but do not socialize new employees sufficiently to be effective in their roles. The data showed that approximately 80 % of the respondents underwent common welcoming practices, such as receiving a welcome kit. However, only approximately 55 % received resource-specific onboarding. While approximately 74 % of the employees reported receiving formal training, only 42 % had training specific to their role. A recommendation from the study was that onboarding practices include individualized content to supply new hires knowledge specific content to execute their roles.

Zink and Curran (2018) maintain that successful onboarding should be targeted to help new staff quickly understand their day-to-day role and how it contributes to the organization's operating plan. An onboarding program in a primary care setting at a leading Magnet-designated children’s hospital in the U.S. was evaluated about new faculty productivity, socialization with other departments, and integration into the department and organizational culture. In a qualitative study using online surveys, the authors investigated elements of the institution’s onboarding program for new clinical research faculty and how these elements responded to specific faculty needs. The study grouped the onboarding program into how it addressed four areas: competence, character, and capability. Competence is how new employees are expected to function;

onboarding consists of standard activities and work for the role. Character unpacks the motivations of the new hire and encourages collaboration with others; onboarding emphasizes the new hires' development plan and expectations to determine necessary development supports. Capability addresses the ability to complete urgent and complex tasks and focuses on efficient skill transfer. The results demonstrated that faculty encountered specific problems with information management technology and the ability to access data. Based on the feedback, adjustments were made in the onboarding process to address specific needs for new hires. Best practices for implementation recommended from the findings employed a combination of short online modules and one-one interactions. It was emphasized that onboarding goals need to be comprehensive, increase new hires' productivity, and support connections to build relationships and improve retention.

O'Connor (2017) expanded on several current onboarding best practices already discussed, such as the use of mentors, appropriate frameworks, and different learning modes. For a prospective case study, a chief nursing officer partnered with a faculty member to implement a year-long onboarding plan for new managers. The onboarding program design was based on several frameworks, including the American Organization of Nurse Executives (AONE) leadership competencies and the principles of Magnet, a framework presented by the American Nurses' Credentialing Center (ANCC) to promote the excellence of nursing practice and patient outcomes. The program included one-on-one mentoring, networking with peers, and ongoing coaching. Results from post-implementation surveys demonstrated that the program increased the new leaders' confidence and competence. A conclusion from the evaluation of the program was that a year of onboarding was too long, even concerning building relationships. A recommendation from the study was that nurse managers need comprehensive onboarding and

ongoing individualized professional development as they have a critical role in creating engaged staff and leading delivery of "quadruple aim" care.

Summary/Synthesis of the Evidence

Kurant-Thoma et al. (2017), Klein et al. (2015), and Meyer et al. (2018) established the benefits of structured onboarding that addresses a new hire's needs at several levels. These and other articles reviewed make strong connections between onboarding, engagement, role satisfaction, and retention. The importance of assigning a mentor or its equivalent to support new staff was described by Minnick et al. (2014), Sharma et al. (2020), and Trossman (2016). The articles reviewed emphasized the importance of developing an onboarding plan tailored to participants' roles in the organization (Hsu et al., 2011; Kurnat-Thoma et al., .2017; Meyer & Bartels, 2017). The studies reviewed consistently indicated that structured onboarding practices with an assigned mentor improve satisfaction, engagement, outcomes, and employee retention.

The studies examined consistently provided evidence that successful onboarding practices promote sound professional, operational, and fiscal performance. Conversely, the lack of efficient onboarding practices resulted in a lack of role clarity, poor engagement, unstable teams, and high turnover rates. The paucity of studies specific to onboarding for managers in primary care made clear the need for future research to identify best practices in role-specific onboarding and develop standardized, validated tools to evaluate effectiveness.

Rationale

Levels of onboarding guided the design and implementation of the manager onboarding in primary care. Bauer (2010) describes the theory of onboarding levels; the four Cs are Compliance, Clarification, Culture, and Connection. These four levels of onboarding determine how new employees perceive the organization and remain committed to it after onboarding. See Appendix B for Sample Level of Onboarding using Bauer's 4Cs.

- **Compliance** is the lowest level of onboarding. It addresses fundamental legal policies, rules, and regulations of the organization, such as dress code and attendance policies. In the organization's current state, compliance is usually covered by the HR department on the first day of general group orientation.
- **Clarification** is the second level of onboarding, where the new hire is educated on the role and expectations. Clarification is critical for the new manager and should generally occur as the manager gets introduced to the new work. Clarification should be individualized to the new hire's specific role by reviewing and connecting the job description included in the position posting, the day-to-day duties, and the expected outcomes— the "what" and the "how" of the role. Clarification leverages the support of the supervisor, mentor, or preceptor. This level of onboarding is insufficient and inconsistent in the current state at the manager level in primary care.
- **Culture,** the third level, introduces the new hire to the norms of the organization and those specific to the new manager's unit or department. In the current state, front-line staff and managers are socialized to the organization's culture through training appropriate to their level in the organizational chart. The PC manager onboarding

project will add culture onboarding specific to the PC service line, including the daily management system elements.

- **Connection** is highest when new managers are introduced to peers, stakeholders, and other professionals to build relationships, connections, and networks essential for success in the new role. This level is not adequately addressed in the organization's current state, as evidenced by out-of-date onboarding checklists with names of individuals who have left the organization or change roles.

Section III. Methods

Context

The project targeted new managers in a primary care (PC) ambulatory setting at an integrated, not-for-profit managed care health organization in Washington State. More than 465,000 adult and pediatric members of the organization are paneled to primary care providers in thirty-one PC facilities. Each primary care provider cares for a panel of 2,100 members, supported by a medical assistant and a wraparound support staff of registered nurses, a social worker, a community resource specialist, and laboratory and radiology technicians.

In this organization, PC managers are responsible for delivering a Patient-Centered Medical Home, a model for meeting the Institute of Healthcare Improvement (IHI) Quadruple Aim of affordable, patient-centered, high quality, and safe patient care. In addition, PC managers are expected to have a broad understanding of the continuum of patient care within and outside their care setting. Primary care is where preventative care is provided, chronic disease is managed, complex care is coordinated with home care and specialty services, hospital follow-up for a safe transition occurs, and increasingly, acute and specialty care are internalized to mitigate rising healthcare costs.

The new director of primary care assessed the existing manager onboarding process over three months in 2019. The needs assessment was part of the new service line leader's quest to understand the opportunities in the new role and how better to support the PC managers' increasingly complex role. Interviews were conducted with human resources leaders, the director of nursing operations, and senior care delivery leaders in Washington and California. Six recently hired managers who had been in their roles for three to six months were sent a voluntary, nine-question online survey via email to assess their knowledge of primary care core concepts and competencies. Three questions were asked about knowledge of PC-specific concepts relevant to the proposed onboarding project. See Appendix C for the 2019 New Manager Survey Responses. All six respondents reported, "a little" to "a moderate amount" of understanding the Patient-Centered Medical Home model. Five of the six respondents were "not so familiar" with the Quadruple Aim. Responses to a question asking how well they understood patient access metrics and how to manage access ranged from "not at all" to "a moderate amount." Narrative responses to questions expressed the desire to have contact with key stakeholders, the need for a better understanding of the everyday work of the clinical team, the need for training on metrics for access management and how to navigate reports, and the need for guidance on available resources. There was a general need to have a checklist that provides a consistent structure for the hiring administrators and their new hires through the onboarding plan. The needs assessment results were shared with the human resources director, executive care delivery vice president, directors of operations, associate regional chief nursing officer, and the six managers who completed the survey. These key stakeholders agreed with the assessment and supported a change to close the gap between the current and desired states.

Interventions

The intervention was to design and implement an onboarding program for new managers in the primary care service to provide the knowledge and confidence needed for their new roles and increase their intent to stay in the PC manager role. The DNP project was approved in April 2020 after the initial service line needs assessment was completed and a proposal presented to the key organizational stakeholders and the DNP committee chair. At that time, the DNP project lead obtained a letter of support and a statement of mutual understanding from the healthcare system where the project would be implemented. To inform the project implementation and select appropriate measures, a clear understanding of the current state versus the desired state was achieved through performing three analyses: microsystem onboarding practices; gaps in the current state; and strengths, weaknesses, opportunities, and threats (SWOT). A literature review was performed to identify relevant studies and applicable best practices. A detailed timeline (Gantt chart), work breakdown structure (WBS), and responsibility/communication were created to guide the project, keep it on track, and increase the likelihood of a successful outcome. A budget was developed, and financial analysis was conducted to project return on investment.

As part of designing a PC-focused manager onboarding, directors of operations who supervise the targeted population of PC managers were asked to share their current onboarding practices with the DNP project lead. The existing HR-prepared onboarding content list and guide (see Appendix D) were also reviewed for gaps. The current practices were studied against the feedback from the 2019 new manager survey and the performance goals for PC managers. A PC manager onboarding content list (see Appendix E) was developed that included some best practices from the literature review and new content informed by new manager survey results

and PC performance goals. Specifically, a comprehensive checklist was developed and introduced to hiring managers and directors to provide structure and ensure accountability at every critical stage of the onboarding process. The new content aims to provide the new manager with the knowledge and confidence to lead their new teams.

Gap Analysis

A gap analysis was conducted in the early planning stage of the project to guide the design of the intervention. As of March 2021, first-year manager turnover was 29.3%, 14.3 points (195%) above the target of 15%. Strategies and tactics identified to close this gap are clarifying roles, implementing consistent leader check-in, assigning mentors, and addressing the inadvertent violation of policies and regulations through thoughtful, structured onboarding.

Survey results of six new PC managers who had been in their roles for three to six months in 2019 showed that all the six respondents had insufficient knowledge (i.e., "little" to "moderate") about the Patient-Centered Medical Home model. Five of the respondents were "not so familiar" with the IHI Quadruple Aim. All six understood "little to a moderate amount" about how to manage patient access, and five responded that they were either "not confident" or only "somewhat confident" in accessing key reports to manage their areas of operations. Strategies to close this gap are adding content on service line concepts and metrics to onboarding and implementing leader and mentor rounding to monitor and reinforce acquired knowledge and transfer to practice.

An external consulting group was engaged in supporting care transformation and operational excellence in the face of the COVID-19 pandemic. The consultants observed gaps in leader operational excellence, inconsistencies in daily management systems, and understanding/application of the quality improvement processes. The approach to closing this

gap is to ensure new managers are enrolled in the existing organizational leadership training series and to introduce them to the core competencies of leading operational excellence during PC service line onboarding. See Appendix F for the Gap Analysis.

Gantt Chart

The Gantt chart was developed in the planning phase to help manage the project milestones and timeline. The nursing process model of assessment, planning, implementation, and evaluation was used to complete the Gantt chart and organize the project into manageable buckets. The implementation start date changed from January 2021 to March 2021 due to disruptions of the COVID-19 pandemic activities. See Appendix G for the Gantt Chart.

Work Breakdown Structure

The work breakdown structure (WBS) for this project enabled visualization of the project by identifying timelines, resources, stakeholders, and deliverables at different levels. The WBS outline, presented as Appendix H, was a product of several consultations and meetings with various stakeholders and the project sponsor.

Responsibility/Communication Plan

The purpose of a communication plan was to provide updates and obtain clarifications and approval at different stages of the project from the agency preceptor, project sponsor, and other stakeholders as needed. The project lead is the statewide Director of Primary Care service line. The project was sponsored by the Vice President of Clinical Operations and Market Integration. The stakeholder responsibilities, milestones, and methods, and modes of communication are described in the Responsibility/Communication Plan as Appendix I.

SWOT Analysis

A SWOT (strengths, weaknesses, opportunities, threats) analysis was performed to guide the project strategy and inform specific elements of the intervention. The purpose of a SWOT analysis is to study the internal and external environments of an organization or system to identify factors that influence how well or poorly it functions and obtain useful information for formulating a strategy (Teoli et al., 2021).

Strengths

The project had executive sponsorship and engaged stakeholders, including contracted coaches, to support the design, development, training, and ongoing coaching. This quality improvement project was already part of the DNP project lead's portfolio, not added as new work. Frameworks and platforms for the implementation, such as weekly leader rounding, already existed.

Weaknesses

Primary care managers' onboarding experiences varied. Some newly hired managers reported being tasked by their leaders to seek out subject matter experts independently. Other new managers reported not knowing what they needed to learn or whom to learn from. Immediate supervisors and preceptors/mentors faced capacity constraints when assigned to support new hires. There was no mentor or preceptor training to equip current managers/leaders with competencies to support the new managers. No standard practice or reliable structured onboarding process was in place for new PC managers. Taken together, these weaknesses exposed the adverse effects of insufficient onboarding: extended time to proficiency, lack of role clarity, insufficient knowledge to solve problems in the PC manager's domain, and low job satisfaction.

In 2019, the new Director of Primary Care assessed current manager onboarding practices, interviewing 20 individuals: recently hired managers, director-level leaders, HR representatives, the director of nursing practice, and leaders from other healthcare organizations. The assessment confirmed inconsistent use of the checklist, inadequate onboarding content applicable to the primary care manager role, and revealed a desire for new managers to have assigned mentors. Time constraints for managers and leaders and competing operational demands were identified as barriers to onboarding.

In the primary care service line, the adverse effects of insufficient onboarding for managers extend the time to proficiency, lack of role clarity, insufficient knowledge to solve simple problems, and low job satisfaction. The primary care team had been impacted by new managers' insufficient understanding of team members' everyday work and desired metrics and the new manager's lack of confidence to lead.

Finally, manager onboarding requires time to be invested by new hires, mentors/preceptors, supervisors, and trainers. Time constraints were especially severe during the 2020 COVID-19 pandemic surge experienced during the project implementation.

Opportunities

The external opportunities to the organization include the increased reputational benefit of developing and implementing PC manager onboarding, creating a new structure for leaders and improving the onboarding experience for new managers. Implementation in the PC service line creates an opportunity for other service lines to adopt the PC manager onboarding framework or adapt it to their own needs. Reducing turnover for PC managers presents an opportunity to enhance the organization's reputation and ability to attract talent.

Threats

The COVID-19 pandemic was an external threat that disrupted community systems, including closing daycare centers and schools. This disruption impacted the organization's staffing as employees with young families requested modified or reduced schedules to care for their children at home and support their virtual learning. Another impact on staffing due to the COVID 19 pandemic was the organization's decision to pause hiring due to COVID-19's impact on the health system's finances. Finally, the COVID-19 pandemic was unpredictable and generated an unanticipated workload across the organization as policies, processes, and procedures changed to cope with the disease, and staff redeployed for COVID-19 patient care. See Appendix J for the SWOT Analysis.

Budget and Financial Analysis

The basic assumptions for the budget are the fixed costs for partial salary equivalents for the onboarding time of new manager participants, supervisors, mentors/preceptors, trainers, and administrative support. Cost avoidance is projected by shortening the time to proficiency for new hires by 50% from twelve months without onboarding to six months with onboarding. The calculation for cost avoidance is based on the time to 100% proficiency with and without onboarding.

The budget included the cost of the project lead and facilitator to design and develop onboarding content, facilitate the sessions, and manage the entire project. This cost is based on $78 per hour for 32 hours. The cost of logistical planning by the administrative assistant is budgeted at $25 per hour for 10 hours. The cost of a new manager to attend onboarding sessions, meet with their direct supervisor and assign a mentor/preceptor is based on an average new PC manager salary of $55 per hour for 26 hours. Two other items in the budget are the cost of the assigned mentor/preceptor to meet with the new manager and direct supervisor rounding at an

average salary of $55 per hour and $88 per hour respectively for 30 minutes a week for 16 weeks (8 hours). The total project cost per manager onboarded is $6,300. Twelve new managers were onboarded for the project, a total cost of $35,589. Finally, the cost of recruiting and hiring a new manager is estimated at $22,800 (20% of $114,400 per year salary at $55 per hour). See Appendix K for the Budget and Return on Investment.

The budget calculation projected a positive return on investment (ROI) of 498% from implementing the manager onboarding program with the active support of a supervisor and an assigned mentor/preceptor. The ROI was calculated as the ratio of dollars avoided by reducing time to proficiency with onboarding and the cost of hiring one manager divided by the onboarding program investment. The budget and ROI were initially calculated for one manager for a baseline understanding that these values could be multiplied into the final number of participants. Twelve new managers participated in the project for a net profit of $492,411and a positive ROI of 1383%. See Appendix K.

Implementation

The DNP project lead identified 12 new PC managers who had been hired within the previous 16 months. These new managers were sent an introduction email to enroll them in a PC onboarding training. Six of twelve managers had been hired within the last four months of the new onboarding intervention, while the other six were approaching an eight to 16 months anniversary of their hire date in the manager role. Onboarding sessions were delivered to eight PC managers in a10.5 hours of training distributed over four sessions. The sessions were initially scheduled for January through April 2021 but postponed and held between March 23 and May 10, 2021, due to constraints imposed by the COVID-19 pandemic. Twelve hours were added for makeup sessions for four new managers who had missed some group sessions.

The first session had been designed to be held in person; however, due to COVID-19 imposed safety and social-distancing requirements, all sessions were virtual, live, and interactive. The training was facilitated by the DNP project lead and a subject matter expert on the Healthcare Effectiveness Data and Information Set measures and the Vaccines for Children program from the organization's quality department. The curriculum consisted of two modules. The primary care core competencies module comprised the organizational pillars of access, patient and staff experience; quality and safety; affordability; principles/metric of the Patient-Centered Medical Home. The operational excellence and continuous improvement module comprised daily management systems including status reports, linked metrics/visual boards, process observations, leader standard work, and improvement science. The participants were given scenarios to practice outside the session time, for example, access management and interpreting metrics on the PC scorecard for the clinics that were their responsibility. In addition to the training sessions, participants were asked to schedule ongoing one-on-one meetings with their direct supervisors and assigned mentors to discuss expectations, progress, and questions.

Study of the Intervention

The new PC manager onboarding intervention was suggested by the gap between the current and desired state, identified through the DNP project lead's initial assessment of the microsystem as the new director of PC services. The initial assessment, which included a survey of recently hired PC managers, and an analysis of existing onboarding practices, was followed by a literature review to address the PICOT question and investigate best practices. SWOT analysis and gap analysis were performed better to understand the gap between the current and desired state. The literature review and Bauer's 4Cs conceptual framework for onboarding guided the project design, content development, and implementation.

Pre and post-surveys were sent to participants electronically using an anonymous link and coded to ensure the anonymity of the responses. The surveys were completed before the first session of onboarding and after the last session, respectively. Survey results were then imported into an Excel spreadsheet and later entered into Python to analyze any relationships between onboarding and participants' increases in knowledge, confidence, and intent to stay.

Outcome Measures

The three outcome measures for this project are knowledge, confidence to lead, and intent to stay. The three outcome measures were chosen to assess the impact of onboarding on the competencies of the new manager to be successful in their role. The outcome metrics are percent change from pre- to post-implementation, with a 10 % increase targeted for all three measures. Data for all three measures were obtained from the pre- and post-intervention surveys.

The DNP project lead created a 10 question pre-and post-intervention survey tool to measure the impact of the onboarding. A de novo survey was created as no validated tool was identified in the literature review to measure the specific knowledge needed for PC managers to meet the organization's needs.

In addition to measuring the outcomes, the questions on the survey were used to assess role clarity. Three questions were included to evaluate the awareness of key stakeholders, ensure a mentor had been assigned, and elicit feedback on the onboarding experience.

Data Collection Tools

The pre- and post-implementation surveys were the data collection tools used to measure the effectiveness of the project intervention. Both tools had ten questions: five with option answers, four scored on a five-point Likert scale, and one open-ended question for narrative

feedback. The surveys were reviewed by an experienced researcher in the organization's research institute prior to use.

The first three questions on the survey addressed role clarity and the participant's understanding of their new responsibilities. Questions four, five, and eight measured the participant's knowledge of primary care core concepts. Question six measured confidence to interact, collaborate with others, and lead their team. Question seven specifically asked about the new manager's intent to stay in their role. Question nine asked if a mentor had been assigned. The tenth question solicited feedback on the new manager's current onboarding experience. See Appendix L for the Pre/Post Onboarding Survey.

Survey results were analyzed to answer three analysis questions:

1. To what extent (if at all) did confidence to lead teams to increase between pre and post onboarding?
2. Did participants report improvement in knowledge to lead their respective teams between pre and post onboarding?
3. Was there a change in intent to stay among participants between pre and post onboarding?

A dataset consists of 23 observations with 12 respondents (12 respondents participated in the pre- onboarding survey, and 11 respondents completed the post-onboarding survey). All questions on both surveys were fully answered except for the free text feedback question. Since both surveys were sent out anonymously and collected with no identifying characteristics, pre- and post-survey results could not be matched; hence, pre and post responses are treated independently. All responses were scored. Scores for each metric were created by grouping the survey questions as shown in Appendix M. These scores were then used in the analysis to

determine the change in knowledge (maximum score of 90), confidence (maximum score of 30), and intent to stay.

Analysis

Independent t-tests were used in the analysis to test differences between pre and post onboarding. All metrics used were tested for normality and equal variance assumptions before t-tests were performed, and a 0.05 level of significance was used. Means are provided with corresponding standard deviations in the format (M, SD). Where t-tests are used, the test statistics are provided with degrees of freedom in parenthesis and an associated p-value.

Confidence was measured using the confidence score calculated as the sum of the scores from all responses to question number six that asked participants how comfortable and confident they are in influencing, collaborating, and managing up or down. Each question was scored on a 1 to 5 scale, where 1 was extremely uncomfortable, and 5 was extremely comfortable. An independent t-test was conducted to evaluate the hypothesis that confidence scores were higher among participants after onboarding vs. before. The test was significant ($t(21) = 2.33$, $p = .03$), supporting the hypothesis that confidence to lead teams increased after onboarding. See Appendix N Table 1.

Knowledge was measured in three areas: knowledge of available resources and ability to access them; understanding PC core frameworks, processes, and metrics; and awareness of key stakeholders. An overall knowledge score was also calculated as the sum of all three knowledge areas. An independent t-test was conducted to evaluate the hypothesis that knowledge to lead teams was higher among participants after onboarding than before. Using the combined knowledge score as the dependent variable and survey time as the independent variable with two

levels, pre-on-boarding or post-on-boarding, the test was significant ($t(21) = 2.94$, $p = .01$). See Appendix N Table 2.

The intent to stay score was measured based on the participant's rating on a 100-point scale using the likelihood of staying in the role. The time period with the highest rating was adopted as the intended time to stay. A two-way contingency table analysis was conducted to evaluate whether the duration of stay varies depending on the survey time. The two variables were duration of stay (five levels) and survey time (two levels). See Appendix N Table 3.

Due to low cell counts (< 5), the contingency table was collapsed into groups, and the analysis was repeated using Fisher's exact tests on the following table. The repeated analysis collapsed the duration of intent to stay into two categories. The two variables were duration of stay (with two levels) and survey time (with two levels). See Appendix N Table 4.

Analysis was repeated to explore whether participants were certain about their future in the current role. The two variables were intent to stay (with two levels: sure with a known duration vs. unsure) and survey time (with two levels). Fisher's exact tests were performed. See Appendix N Table 5.

Ethical Considerations

The DNP project lead completed IRB training on Human Subjects Research (HSR) through the Collaboration Institutional Training Initiative (CITI) program to ascertain IRB guidelines. See Appendix O for Certificate of Completion. The University of San Francisco determined this evidence-based change of practice project to meet the requirements of a quality improvement project. As a non-research endeavor, IRB review and approval were not required. See Appendix P for the DNP Statement of Non-Research Determination.

Provision Five of the American Nurses Association (ANA) Code of Ethics (ANA, 2015) speaks to nurses' duty to maintain professional and personal growth competencies and strive for excellence in their practice. The objective of the DNP project is to ensure new PC managers have the appropriate competencies to lead their team and embrace their responsibility to promote health and safety. This ANA provision of ethics aligns with the project's objective to support new PC managers as they strive for proficiency in their new roles and develop competencies to influence the delivery of excellent patient care.

This quality improvement project reflects the Jesuit value *cura personalis,* the respect for all that makes up an individual, whether caregiver or patient. *Cura personalis* is consistent with the goals of primary care to focus on the care of the whole person. The project is consistent with the University of San Francisco's commitment to excellence as the standard for teaching, scholarship, creative expression, and service (University of San Francisco, 2001).

This DNP project conforms to four basic principles of healthcare ethics, which were considered throughout the assessment, planning, content development, and implementation. The four principles of beneficence, autonomy, veracity, and justice support healthcare professionals to navigate the ethical dilemmas of healthcare administration and clinical patient care.

Beneficence

Primary care managers are responsible for leading and supporting care teams that provide direct and indirect patient care. These managers need proper onboarding to fully understand the patient's care continuum to successfully lead coordinated, comprehensive, high-quality care. As the linchpin of successful clinical operations, the new manager's mandate is an act of beneficence toward individual patients, their families, and the communities served.

Autonomy

Onboarding managers is often insufficient due to competing operational priorities, time constraints, lack of mentorship, and cost. As a result, new managers may be slow to become proficient in their roles. Their prolonged lack of autonomy, knowledge, and confidence gaps may manifest through suboptimal performance for the frontline care team and poor patient care. A structured onboarding program was designed and implemented to equip new PC managers with the knowledge to empower them and give them the autonomy to lead their teams and support high-quality patient care.

Veracity

Onboarding content included competencies necessary to achieve operational excellence and continuous improvement based on transparent daily management systems. These competencies include patient workflows, metrics, status reports, linked metrics, visual boards, process observations, and performance/coaching management. All are focused on fostering transparency in patient care and processes to support continuous improvement.

Justice

Structured onboarding is an evidence-based critical for assimilating new hires into an organization and supporting their successful transitions into new roles. These practices should be equitably applied to all new hires, regardless of constraints. In addition to being just, onboarding all new hires equips new managers with the resources and tools they need to support evidence-based, equitable patient care.

All DNP manager onboarding project participants were treated with respect and oriented to the organization's principles of ensuring psychological safety for patients and staff. Participants completed a pre and post onboarding survey through an anonymous link to ensure

anonymity. This measure provides psychological safety to protect participants' psychological wellbeing. No personal data was collected or can be identified in the survey results.

Section IV: Results

The onboarding sessions were guided by the content list (Appendix E) developed in the planning phase of the DNP project. All the training sessions were delivered virtually via Microsoft Teams due to COVID-19 restrictions on group gathering. The sessions in total took slightly longer than the originally planned 10 hours due to additional time needed to cover some topics. Additional sessions were held to accommodate participants who could not attend the scheduled group sessions due to pre-planned time off. A nurse educator, an experienced primary care manager, and an operations director were invited to different onboarding sessions to share their experiences, observe, and serve as backup facilitators as needed for sustainability. Some originally prepared content was modified to include updates pertinent to current primary care practice optimization initiatives. Changes included patient secure messaging standard work, patient access, and scheduling changes, metrics, and reports to measure success.

The main goal of the onboarding project was to improve the new manager's knowledge, confidence, and intent to stay in their role. A single cohort of twelve new managers participated in the onboarding program. Of the twelve participants, 50% (6) had been in their role for at least four months, 33% (4) for at least 12 months, and 16.7% (2) for at least 16 months.

Post-onboarding, participants reported higher confidence scores ($M = 26.8$, $SD = 2.9$) compared to pre-onboarding ($M = 23.8$, $SD = 3.2$). The Eta square was moderate (0.2), indicating that the onboarding accounted for 20% of the variance in the confidence scores. These results support the notion that confidence to lead teams increased after onboarding, with a lift of 13%. See Appendix Q Figure 1.

Participants also reported a significantly higher overall knowledge score on average (M=68.2, SD=14.7) compared to before (M=52.8, SD=11.4). The Eta square was large (0.27), indicating that the onboarding accounted for 27% of the variance in the knowledge scores. There was also a significant increase in knowledge of organizational procedures and processes ($t(21) = 2.23$, p = .04), and a significant increase in awareness of stakeholders ($t(21) = 2.31$, p = .03). These results support the hypothesis that participants increased their knowledge to lead teams after onboarding, with a lift of 29%. See Appendix Q Figure 2.

Participants did not report a significant change in their intent to stay. The two variables were duration of stay (with five levels) and survey time (with two levels). Survey time and intent to stay for a given period were not found to be significantly related: Pearson $\chi^2(6, N = 23) = 6.5$, p =.16. Even with the repeated analysis by collapsing duration of intent to stay into two categories, survey time and duration of intent to stay were not found to be significantly related: $\chi^2(1, N = 16) = 1.42$, p =.12. There was a lack of evidence to support the claim that onboarding increases a participant's intent to stay in their current role.

In addition to the three primary outcomes, a two-way contingency table analysis was conducted to evaluate whether the proportion of participants who had a mentor officially assigned varied depending on whether they were asked before or after onboarding. The two variables were onboarding time (with two levels) and having a mentor officially assigned (with two levels). Onboarding and having a mentor officially assigned were significantly related, Pearson χ^2 (1, N=23) = 7.33, p = 0.003, Cramer's V = 0.56. Fisher's exact tests were conducted due to low cell counts. These results support the hypothesis that onboarding increased the proportion of participants who had a mentor officially assigned. See Appendix Q Figure 3.

As the project neared completion, the DNP project manager reviewed participant feedback and results and created a sustainability plan. A new page was created on the organization's internal website to serve as an onboarding guide with necessary resources. Resources included an updated new manager onboarding checklist that the PC hiring director/ manager can use to ensure all best practice elements are included in the onboarding process, such as Bauer's 4C elements and assigning mentors. See Appendix R for a screenshot of the Onboarding Website Landing Page.

Section V: Discussion

Summary

The DNP project aimed to increase the new manager's knowledge, confidence, and intent to stay in their role. The project cohort participants reported improved knowledge and increased confidence to lead their teams post-onboarding, but there was no significant increase in their intent to stay. Participants expressed the need to have completed the onboarding sooner, at least within their first three months in the role. Participants articulated the benefits of the onboarding program in their feedback answers to the free text question, "What feedback do you have on your onboarding experience so far?"

Key findings of the onboarding project are the importance of structured onboarding for new PC managers and its impact on their knowledge and confidence to lead high-functioning teams. The new managers who participated in the onboarding sessions also developed collaborative relationships and regularly checked in with each other.

A new manager's onboarding checklist was updated and posted on the care delivery, PC onboarding SharePoint for local district operations directors to follow when hiring new PC

managers. To spread the quality improvement gains from this project, statewide sharing of the "story" with the organization's PC leaders is anticipated.

Interpretation

Onboarding intervention positively impacted two out of the three intended outcome measures: increased knowledge, confidence. There was no significant difference in intent to stay from pre-onboarding to post-onboarding. The project results are consistent with reviewed literature that successful structured onboarding with an assigned mentor promotes sound professional, operational, and fiscal performance by supporting role clarity and providing resources needed to attain competency in the manager role in a shorter time.

Directors of operations started using the 90-day onboarding checklist to guide a structured onboarding plan for their newly hired managers. The checklist includes Bauer's four C's levels of onboarding theory with guidance on timeline and subject matter experts to support each level. Three outcomes, increased knowledge of core competencies, connections to key stakeholders, and assignment of mentors as a direct result of onboarding, support the efficacy of using Bauer's framework, which guided the design and implementation of this project.

Participants reported that the onboarding sessions improved their knowledge of the core competencies of primary care practice, including knowledge of key stakeholders and confidence to lead. There was no statistical evidence that the new manager onboarding changed the participants' intent to stay in their roles. The differences between anticipated and observed outcomes may be attributable to how the question was structured on the survey, with five levels of anticipated duration in the role. See Appendix S.

Participants answered the question for each period by assigning a percentage. The analysis attempted to force one answer by taking the maximum points, i.e., if a respondent gave

80% for 2 years and 50% to the other time periods, their response was counted in the 2-year bucket with the 80% score. In hindsight, this question could have been simplified to collect a more precise response. It is also plausible that the participants' responses to their intent to stay were not solely influenced by onboarding or the lack thereof but also by the global COVID-19 pandemic. This assumption is consistent with higher turnover intentions across the healthcare system in the same period (Raso et al., 2021).

Participant feedback recommended that the onboarding program be available to new managers earlier in their new roles. This feedback is consistent with literature best practices to provide structured onboarding within the first 90 days of hire.

Positive post onboarding results indicate promise that this intervention reduces the time of new managers to gain full proficiency where they can perform required skills unconsciously with ease. Reduction of time to proficiency provides direct savings by avoiding costs related to lost productivity without onboarding.

Limitations

A limitation to the validity of the results was using an unvalidated survey tool to assess knowledge specific to the PC manager's role. The questions in the survey tool were specific to the PC manager's roles and responsibilities in the project setting. If used in organizational settings very different from this project's or with different onboarding practices, the pre-, and post-implementation surveys may produce very different results, diminishing the tool's reliability. A second limitation was the lack of available data for estimating base salaries for projecting the budget and ROI, which have introduced a limitation to the accuracy of financial benefits to the organization.

Due to the impact of the COVID-19 pandemic on the global economy and the organization's financial health, hiring was temporarily paused, and some departments consolidated to manage costs. This hiring pause reduced the availability of new managers and thus the number of project participants. To mitigate the sample limitation, all new primary care managers in their roles for up to 16 months were considered for participation. Those who had been in their roles the longest may have found some parts of the onboarding of only marginal value. Some participants who had been in their roles for several months or more may have found some parts of the onboarding redundant or marginal value. The results may have been different if the participant population had been to managers hired within the previous three months and who were less accustomed to their roles.

The COVID-19 pandemic may have introduced a selection bias in influencing who could participate and their extent. The COVID-19 pandemic imposed severe constraints on resources and increased the demands on PC managers for their time and attention, with the potential for introducing selection bias.

Conclusions

The purpose of this project was to implement evidence-based onboarding best practices to equip primary care (PC) managers with the knowledge and confidence to lead high-functioning teams and support the service line's efforts to achieve the Quadruple Aim goals. A structured onboarding program reduces the new manager's time to role proficiency and equips them with the competencies to lead improvement processes and operational excellence. This program is manifested in the reliable delivery of high-quality, high-value, coordinated, and comprehensive care.

A successful onboarding experience should be comprehensive from the time an offer is extended to the candidate to when the new hire can efficiently perform in the role. Onboarding is an individualized experience, especially when new managers are hired at different times relative to an organization's onboarding schedule. An onboarding program modeled on this one could be modified to meet a new hire's needs through a combination of individual and group sessions. The onboarding content was specifically developed for PC managers for this project, but the design and implementation could be adopted and applied to new managers in any healthcare service line. A sustainability plan with guidelines and resources was created to give PC hiring directors/managers the ability to replicate the steps and use the project's content and spread beyond the PC service line through adaptation to other organizational contexts. PC managers are the linchpins of high-functioning frontline teams; they have a direct impact on organizational performance. This project demonstrated the importance of investing in new managers for their sake and for the betterment and financial benefit of the organization itself.

Section VI: Funding

All participants and stakeholders of this QI project were staff members of the organization and participated during the operational hours they were paid. The DNP project lead paid all extraneous costs, including gift incentives and statistical analysis support.

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Wojnar, D. M., & Whelan, E. M. (2017). Preparing nursing students for enhanced roles in primary care: The current state of prelicensure and RN-to-BSN education. *Nursing Outlook*. https://doi.org/10.1016/j.outlook.2016.10.006

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Zink, H. R., & Curran, J. D. (2018). Building a research onboarding program in a pediatric hospital: Filling the orientation gap with onboarding and just-in-time education. *Journal of Research Administration*, *49*(2), 109–132.

Appendix A

Evidence Evaluation Table

Citation: author(s), date of publication, title, source	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Level & Quality Rating
Hsu, H.-Y., Lee, L.-L., Fu, C.-Y., & Tang, C.-C. (2011). Evaluation of a leadership orientation program in Taiwan: Preceptorship and leader competencies of the new nurse manager. *Nurse Education Today*, *31*(8), 809–814. https://doi.org/10.1016/j.nedt.2010.12.003	To gain an understanding of the relationship that exists between a nursing preceptorship and a **new** nurse manager's competency; it also attempted to establish a predictive model of leader competencies to improve the program.	Pedagogical theory, instruction strategies, adult learning principles, communication skills, value and role clarification, conflict resolution, learning needs, and performance appraisals	Descriptive cross-sectional research design and rigorous questionnaires were used	Fifteen new nurse managers, 101 staff nurses, and 20 nurse administrators were recruited from those engaged in ongoing preceptorship at a General teaching hospital in Kaohsiung, Taiwan	Level III, A
Klein, H. j., Polin, B., & Leigh Sutton, K.. (2015). Specific Onboarding Practices for the Socialization of New Employees. International Journal of Selection and Assessment, 23(3), 263–283.	To explore specific onboarding practices and evaluate the Inform-Welcome Guide framework. Also investigated whether and how newcomers experience these activities, what practices they find most helpful, and how the nature, and timing of these practices contribute to their socialization.	Socialization research and the Inform-Welcome Guide (IWG) framework.	Surveys and three different analytical methods to examine data. (computed zero-order correlations, descriptive statistics comparisons, and Hierarchical Linear Modeling)	Data are presented from representatives of 10 organizations represented by 10 HR managers and 373 new employees from those 10 organizations were interviewed.	Level III, A

Kurnat-Thoma, E., Ganger, M., Peterson, K., & Channell, L. (2017). Reducing Annual Hospital and Registered Nurse Staff Turnover—A 10-Element Onboarding Program Intervention. SAGE Open Nursing, 3, 2377960817697712.	To create and implement a 10-element program intervention focusing heavily on the support of new-hire employees to reduce annual hospital and RN staff turnover.	A structured approach to the onboarding process.	Used an evidenced-based turnover analysis approach that included facility staffing statistics, exit survey data, research literature, and industry exemplars	187-bed community hospital in the Washington DC	Level III, A
Meyer, A. M., & Bartels, L. K. (2017). The Impact of Onboarding Levels on Perceived Utility, Organizational Commitment, Organizational Support, and Job Satisfaction. Journal of Organizational Psychology; West Palm Beach, 17(5), 10–27.	The study was to examine the effects of onboarding levels on perceived utility, organizational commitment, perceived organizational support, and job satisfaction.	Bauer's (2010) theory of onboarding levels	Surveys and questionnaires	382 participants were recruited from the online research platform, Amazon's Mechanical Turk restricted to individuals in the United States	Level III, A
Middleton, L. P., Thompson, L., Starr-High, E., Travis, E., Kurtin, D., Rodriguez, A., & Dmitrovsky, E. (2018). Field Report: Getting New Faculty into the Fold--Fast. Physician Leadership Journal, (6), 40.	To decrease the time to onboard clinical faculty by 25 % and eliminate non-value-added steps. This was to address concerns regarding physician engagement, alignment and productivity.	They utilized employee-driven Kaizen suggestions and Lean tools for improvement	Mapped and studied the entire onboarding process through stakeholder interviews and policies and bylaws review.	Recently hired faculty, department chairs and division heads at University of Texas Cancer Center	Level V, B
Minnick, W., Wilhide, S., Diantoniis, R., Goodheart, T., Logan, S., & Moreau, R. (2014). Onboarding OSH Professionals. Professional Safety, 59(12), 27–33	To examine the current practice on formal mentoring upon hire and, it's influence on the learning curve and/or intent to stay with the company. To develop a mentoring framework based on	Mentoring model	Survey Instrument and the chi-square test	299 female and male members employed as a safety professional in manufacturing, oil and gas, and construction.	Level III, A

	qualitative feedback from practicing safety professionals.				
O'Connor, M. (2017). On-boarding the Middle Manager: Nursing Administration Quarterly, 41(4), 360–367.	To collaborate on planning and implementing an on-boarding program for newly hired middle managers.	Magnet principles (Transformational leadership and exemplary leadership practices), the AONE Leadership Competencies, Circle Practice, and Creative Health Care Management's Relationship-Based Care model.	Assessments using surveys	6 newly hired managers at community-based medical center in central Maryland.	Level IV, B
Sharma, G. G., & Stol, K.-J. (2020). Exploring onboarding success, organizational fit, and turnover intention of software professionals. *Journal of Systems and Software*, *159*, 110442. https://doi.org/10.1016/j.jss.2019.110442	To explore the link between onboarding of new hires and their turnover intention	Organization socialization	Cross-sectional survey using SurveyMonkey tool.	102 software professionals using PLS-SEM.	
Trossman, S. (2016). PRACTICE Stepping into a culture of safety Onboarding programs help retain nurses, strengthen patient care. The American Nurse, 48(6), 1, 6.	The purpose of this article is to discuss onboarding programs and their impact on retention and better patient care.	Included elements of the TeamSTEPPS concepts and QSEN's nursing core competencies,	Recorded expert opinions	5 experts from North Carolina and Alabama	Level V, A

Zaire, P. (2017). Structured Onboarding Process to Promote Safety. *AAACN Viewpoint*, *39*(1), 10–11. http://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=ccm&AN=122029540&site=ehost-live&scope=site&custid=s3818721	The goal of this project was to create, implement and evaluate a standardized and structured onboarding process for clinical staff in a primary care setting.	The clinical nurse manager utilized the nursing process to complete the improvement project.	Quality improvement project.	This improvement project was implemented at a Federally Qualified Health Center (FQHC) in a primary care setting.	Level V, A
Zink, H. R., & Curran, J. D. (2018). Building a Research Onboarding Program in a Pediatric Hospital: Filling the Orientation Gap with Onboarding and Just-in-Time Education. Journal of Research Administration, 49(2), 109–132.	To create a comprehensive research faculty onboarding program to help new hires understand how to be successful in their day-to-day job and how their work contributes to the overall organization.	Distinguished onboarding from orientation to design the onboarding program. Used quality commitments, standards and expectations to form a common language around onboarding throughout the organization	Interviews, surveys and brainstorming	A multidisciplinary advisory committee from 14 departments designed an onboarding program with mentorship, online modules and classroom-setting for newly hired research faculty at Children's Mercy Hospital	Level V, A

Appendix B

Sample Level of Onboarding Using Bauer's 4Cs

Connections (Vital relationships)	Clarification (Role Clarity and expectations)
Candance One on one with direct supervisor Candance One on one with direct supervisor Shadowing & Rounding with mentor or preceptor One on one with ancillary leaders One on One with support partners such as HRBP, NPPD, QI etc	30, 60, and 90-day expectations Calendar for the first 30 days List of key stakeholders Org chart Leadership style conversation Decision making conversation
Culture **(How we do things around here)**	**Compliance** **(Legal and policy-related rules and regulations)**
Locations where your direct reports work Standard work/workflows for roles in the department Common roadblocks Strategic alignment Dashboards and metrics conversations Staffing models	Mandatory training Licensees and certifications Formal learning Vital policies Access

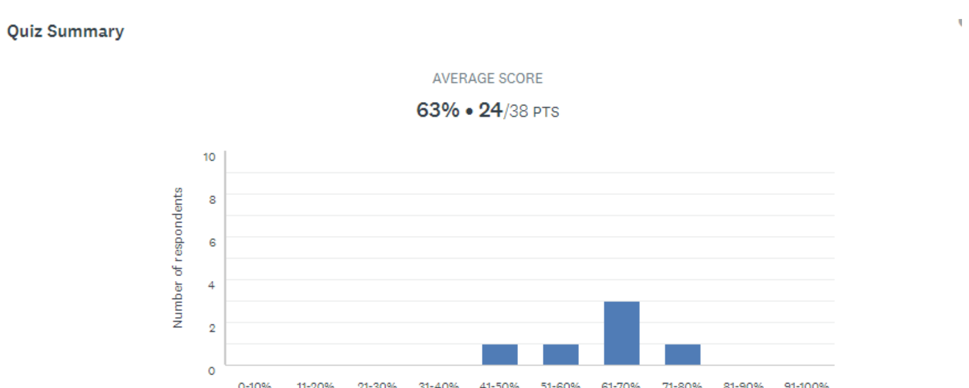
Appendix C

2019 New Manager Onboarding Survey Responses

Quiz Summary

AVERAGE SCORE

63% • 24/38 PTS



STATISTICS		
Lowest Score 45%	Median 66%	Highest Score 74%

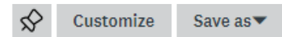
Mean: 63%

Standard Deviation: 10%

Question Ranking

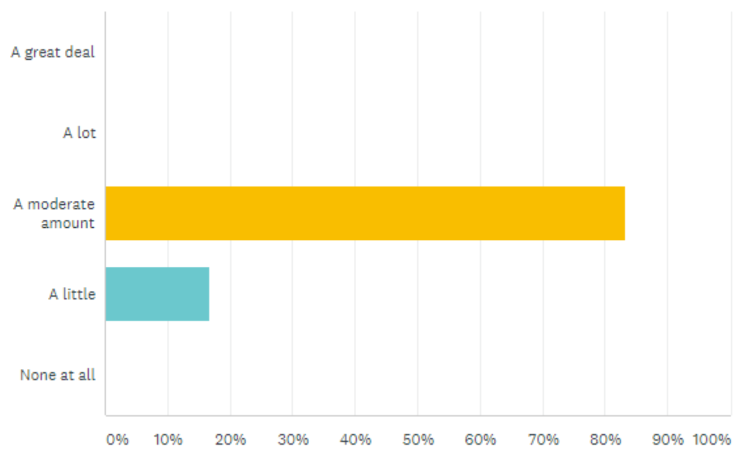
QUESTIONS (8)	DIFFICULTY	AVERAGE SCORE
Q1 How well do you understand the Patient-Centered Medical Home model?	1	46%
Q2 How well do you understand the access metrics and comfortable managing access?	2	50%
Q8 How well are you familiar with the quadruple aim?	3	53%
Q7 Do you know how to access the Primary care SharePoint and/or other reports in tableau to deliver on the KP promise?	4	63%
Q3 How comfortable are you accessing, understanding and utilizing press ganey reports to improve service ?	5	67%
Q6 How well do you understand the staffing model?	5	67%
Q5 How well do you understand the role and the scope of your direct report(s)?	7	70%
Q4 How confident are you managing staff in a union environment ?	8	88%

Q1



How well do you understand the Patient-Centered Medical Home model?

Answered: 6   Skipped: 0



QUIZ STATISTICS			
Percent Correct 0%	Average Score 1.8/4.0 (46%)	Standard Deviation 0.41	Difficulty 1/8

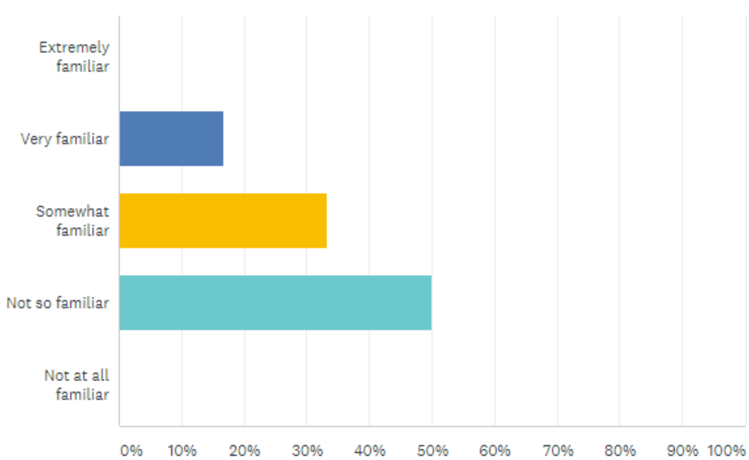
ANSWER CHOICES	SCORE	RESPONSES	
✓ A great deal	4/4	0.00%	0
A lot	3/4	0.00%	0
A moderate amount	2/4	83.33%	5
A little	1/4	16.67%	1
None at all	0/4	0.00%	0
TOTAL			6

Q8

Customize Save as

How well are you familiar with the quadruple aim?

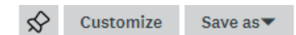
Answered: 6 Skipped: 0



QUIZ STATISTICS			
Percent Correct 0%	Average Score 2.7/5.0 (53%)	Standard Deviation 0.82	Difficulty 3/8

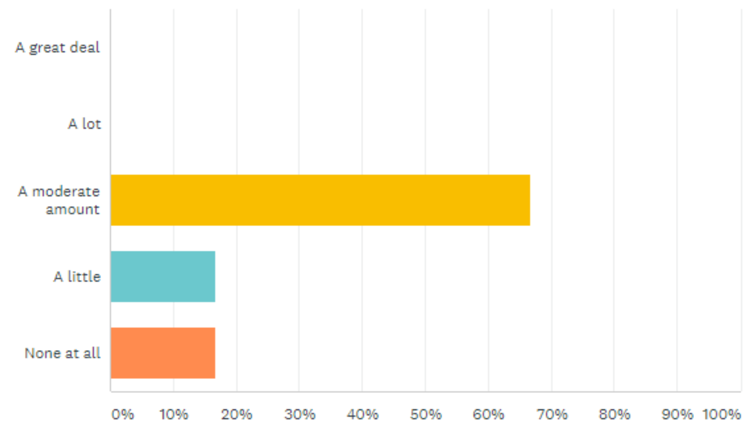
ANSWER CHOICES	SCORE	RESPONSES	
✓ Extremely familiar	5/5	0.00%	0
Very familiar	4/5	16.67%	1
Somewhat familiar	3/5	33.33%	2
Not so familiar	2/5	50.00%	3
Not at all familiar	1/5	0.00%	0
TOTAL			6

Q2



How well do you understand the access metrics and comfortable managing access?

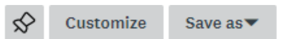
Answered: 6 Skipped: 0



QUIZ STATISTICS			
Percent Correct 0%	Average Score 2.5/5.0 (50%)	Standard Deviation 0.84	Difficulty 2/8

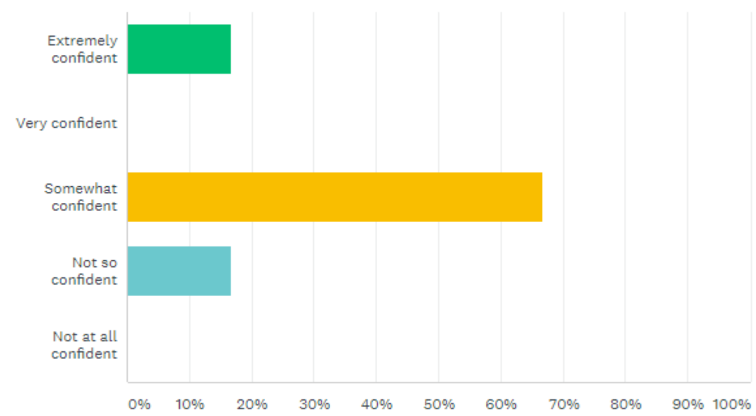
ANSWER CHOICES	SCORE	RESPONSES	
A great deal	5/5	0.00%	0
A lot	4/5	0.00%	0
A moderate amount	3/5	66.67%	4
A little	2/5	16.67%	1
None at all	1/5	16.67%	1
TOTAL			6

Q7



Do you know how to access the Primary care SharePoint and/or other reports in tableau to deliver on the KP promise?

Answered: 6 Skipped: 0

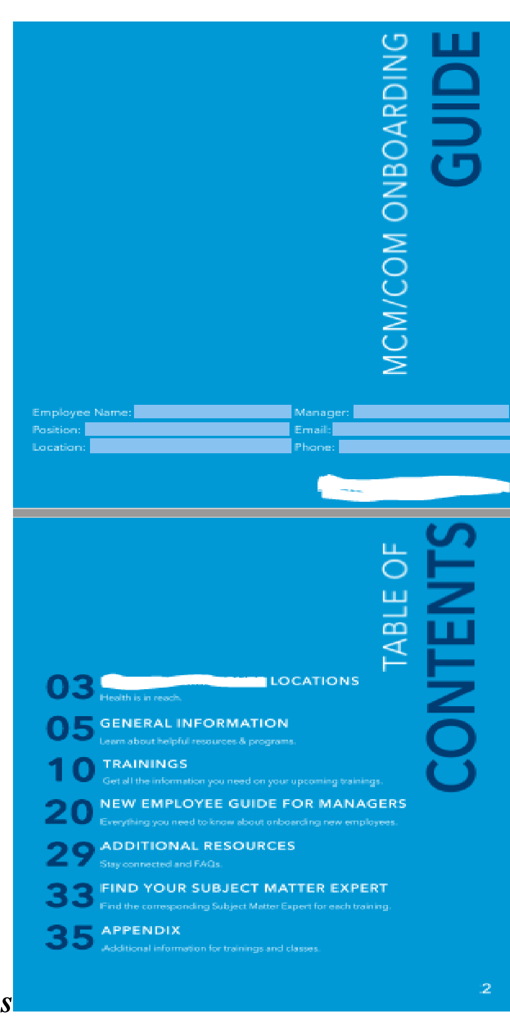


QUIZ STATISTICS			
Percent Correct 17%	Average Score 3.2/5.0 (63%)	Standard Deviation 0.98	Difficulty 4/8

ANSWER CHOICES	SCORE	RESPONSES	
Extremely confident	5/5	16.67%	1
Very confident	4/5	0.00%	0
Somewhat confident	3/5	66.67%	4
Not so confident	2/5	16.67%	1
Not at all confident	1/5	0.00%	0
TOTAL			6

Appendix D

Current Onboarding Content List for New Managers



MCM/COM ONBOARDING
GUIDE

Employee Name: Manager:
Position: Email:
Location: Phone:

TABLE OF
CONTENTS

03 LOCATIONS
Health is in reach.
05 GENERAL INFORMATION
Learn about helpful resources & programs.
10 TRAININGS
Get all the information you need on your upcoming trainings.
20 NEW EMPLOYEE GUIDE FOR MANAGERS
Everything you need to know about onboarding new employees.
29 ADDITIONAL RESOURCES
Stay connected and FAQs.
33 FIND YOUR SUBJECT MATTER EXPERT
Find the corresponding Subject Matter Expert for each training.
35 APPENDIX
Additional information for trainings and classes.

2

s

NEW MANAGER

Development Roadmap

The new manager development roadmap is specific to you so you can complete national on-boarding programs, register for required regional courses, and meet with critical partners to your work. Please use the roadmap below in conjunction with other resources you have received from your manager, HR Business Partner, and others to begin leading your team to success:

DAY 1

- Attend Welcome Day
- Being Leadership University / Navigate Journey

WITHIN 30 DAYS

- Meet Your Peer Navigator (ask you manager about connecting you with this person)
- Attend the virtual Leader Launchpad
- Attend your Clinical Trainings (if needed)
- Meet with you:
  - Manager
  - Team
  - HR Business Partner (HRBP)
  - Employee Labor Relations Partner (ELRC)
  - Finance Business Partner

WITHIN 60 DAYS

- Attend Managing at Day 1
- Attend Managing at Day 2
- Schedule your 45-minute CliftonStrengths Deep Dive with Steve Lerer
- Continue the Navigate Program

WITHIN 90 DAYS

- Complete the Navigate Program
- Attend Care Delivery Orientation (if needed)
- Complete a SWOT/SBAR Analysis for your area
- Register for virtual Lead at Manager Program

3-6 MONTHS

- Create a Virtual Learning Path
- Create Your Goals and IDP
- Schedule a Skip Level Meeting
- Attend Hiring for Service

6-12 MONTHS

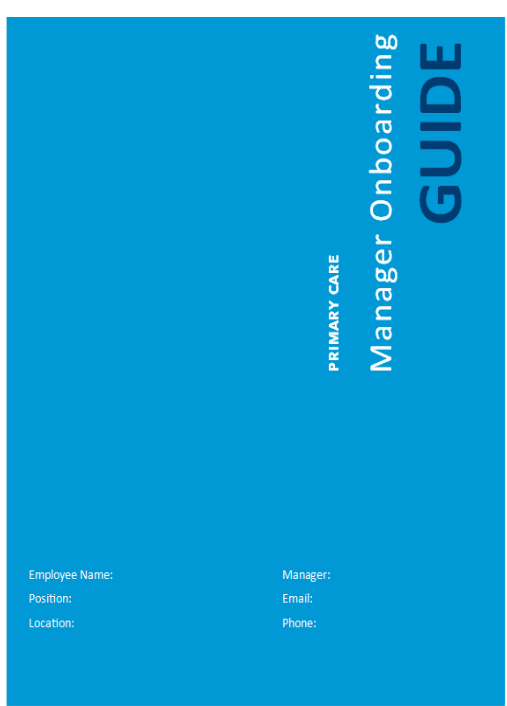
- Attend elective courses
  - Delegating for Success
  - Building Trust
  - Conflict Management
  - Leading with Influence

12+ MONTHS

- Participate in additional programs
  - Activate (Front line leaders with 1+ years of experience)
  - Elevate (Diverse leaders with 2+ years of experience)
  - Accelerate (mid-level leaders)

Appendix E

PC Service Line Onboarding Content



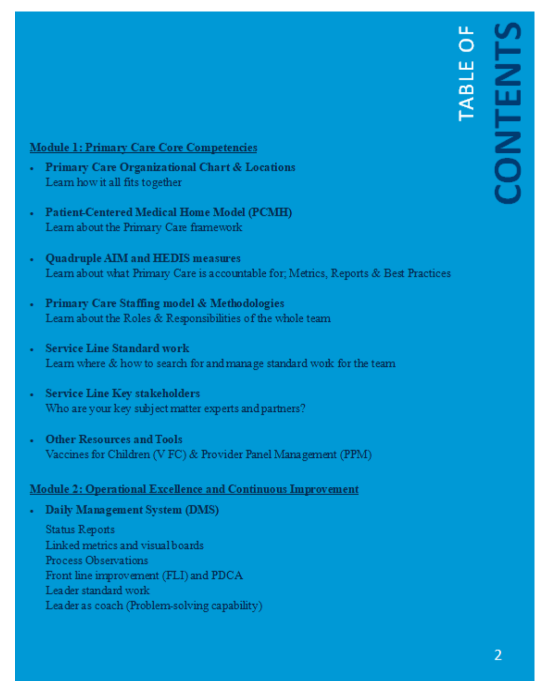


TABLE OF CONTENTS

Module 1: Primary Care Core Competencies

- **Primary Care Organizational Chart & Locations**
  Learn how it all fits together
- **Patient-Centered Medical Home Model (PCMH)**
  Learn about the Primary Care framework
- **Quadruple AIM and HEDIS measures**
  Learn about what Primary Care is accountable for; Metrics, Reports & Best Practices
- **Primary Care Staffing model & Methodologies**
  Learn about the Roles & Responsibilities of the whole team
- **Service Line Standard work**
  Learn where & how to search for and manage standard work for the team
- **Service Line Key stakeholders**
  Who are your key subject matter experts and partners?
- **Other Resources and Tools**
  Vaccines for Children (V FC) & Provider Panel Management (PPM)

Module 2: Operational Excellence and Continuous Improvement

- **Daily Management System (DMS)**
  Status Reports
  Linked metrics and visual boards
  Process Observations
  Front line improvement (FLI) and PDCA
  Leader standard work
  Leader as coach (Problem-solving capability)

2

Appendix F

Gap Analysis

Gap Analysis		
Area under Consideration:	**Manager Onboarding in Primary Care**	
Desired State	**Current State**	**Action Steps**
First year Turnover target 13%	15.3% overall manager turnover as of July 2020	Senior leadership and other partner stakeholders consistent rounding to increase connections level of onboarding with new managers Assign mentors /preceptors as support advisers to new managers Address role clarity Address policies and related regulations in the onboarding plan to prevent involuntary turnover due to policy violations.
Knowledge of theoretical and practical understanding of core service line concepts and metrics such as PCMH model, Quadruple Aim, Access metrics, and HEDIS measures respectively	In a 2019 survey of 6 new PC managers who had been in their roles for 3 to 6 months, All the six respondents understood little to moderate amount about Patient-Centered Medical Home model and Five out of six	Address core service line concepts and metrics associated. Assess and reinforce knowledge on how to access, interpret and manage to these metrics.

	respondents were not very familiar with the quadruple aim.	
Core competencies of leading operational excellence (Continuous improvement skills through problem solving, teamwork and leadership)	Managers are not familiar with the new concept of operational excellence	Ensure new managers are enrolled the organizational leadership training series Introduce new managers to the core competences of leading operational excellence during PC service line onboarding. Give opportunities in onboarding session(s) to practice some of their learnings and build confidence.

Appendix G

Gantt Chart

EL-DNP Program Project Timeline Develop and Implement a Manager Onboarding in Primary Care at a large healthcare system in Washington state	Target Date	2020								2021												Status
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Obtain a letter of support from the agency (KPWA)	May 25 2020																					Completed on time
Complete agency statement of mutual agreement	June 12 2020																					Completed on time
Assessment	Jun-20																					
Assessment of curret state																						Completed on time
Complete a gap and SWAT analysis																						Completed on time
Formulate process, outcome and balancing measures																						Completed on time
Literature review																						Completed on time
Planning	Sep-20																					
Complete prospectus and manuscript																						Completed on time
Develop an Implementaion plan	Nov-20																					
Create a charter with timeline																						Completed on time
Identify stakeholders and participants																						Completed on time
Implementation	Jan-21																					
Review onboarding plan with key stakeholders																						Completed on time
PDCA																						Completed on time
Design a communication plan																						Completed on time
Administer pre-implementation survey																						Completed late in Mar
Deliver onboarding to a cohort of >10 new managers																						Started late in Mar to May
Round with participants for reliability																						Started late in Apr to Aug
Administer post-implementation survey																						Completed early in May
Complete the analysis for the project results																						Complete late in August
Evaluate project and write final report.	Jul-21																					In progress- to complete by Nov

Appendix H

Work Breakdown Structure

1 Developing and Implementing a Manager Onboarding in Primary Care

1.0 Assessment phase

1.0.1 Interview stakeholders

1.0.2 Collect and compile current resources

1.0.3 Report to leadership for sponsorship

1.0.4 Literature search and review

2.0 Planning phase

2.0.1 Develop a project charter + scope

2.0.2 Develop a timeline

2.0.3 Review stakeholders

2.0.4 Schedule meetings

3.0 Developing phase

3.0.1 Review list of content with the agency preceptor & HR partner

3.0.3 Present draft to agency sponsor and key stakeholders

3.0.4 Identify stakeholders through operational leaders & HR

3.0.4 Arrange for implementation logistics such as scheduling, location, meals, guests etc

4.0 Implementation phase

4.0.2 Administer pre-implementation survey

4.0.2 Deliver onboarding session(s)

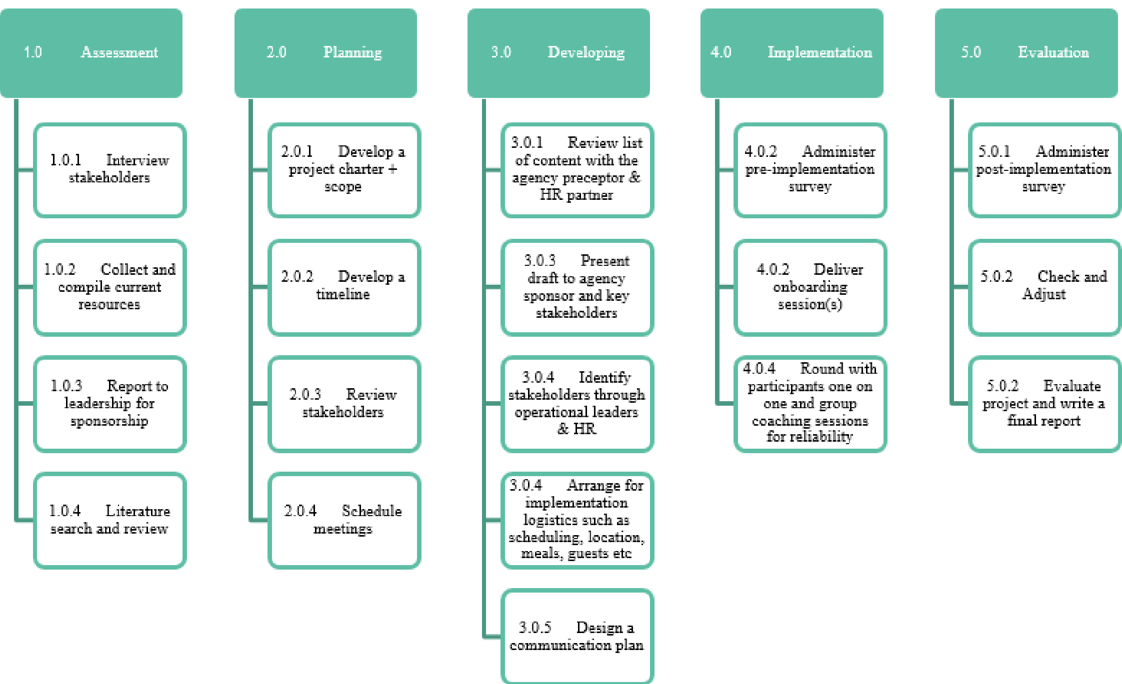
4.0.4 Round with participants one on one and group coaching sessions for reliability

5.0 Evaluation

5.0.1 Administer post-implementation survey

5.0.2 Check and Adjust

5.0.2 Evaluate project and write a final report


Developing and Implementing a Manager Onboarding in Primary Care
1.0 Assessment
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1.0.2 Collect and compile current resources
1.0.3 Report to leadership for sponsorship
1.0.4 Literature search and review
2.0 Planning
2.0.1 Develop a project charter + scope
2.0.2 Develop a timeline
2.0.3 Review stakeholders
2.0.4 Schedule meetings
3.0 Developing
3.0.1 Review list of content with the agency preceptor & HR partner
3.0.3 Present draft to agency sponsor and key stakeholders
3.0.4 Identify stakeholders through operational leaders & HR
3.0.4 Arrange for implementation logistics such as scheduling, location, meals, guests etc
3.0.5 Design a communication plan
4.0 Implementation
4.0.2 Administer pre-implementation survey
4.0.2 Deliver onboarding session(s)
4.0.4 Round with participants one on one and group coaching sessions for reliability
5.0 Evaluation
5.0.1 Administer post-implementation survey
5.0.2 Check and Adjust
5.0.2 Evaluate project and write a final report

Appendix I

Responsibility/Communication Plan

Stakeholder	Role	Communication Dates/cadence
Faculty committee chair	Guide and approval completing of the prospectus before the project can be implemented.	Approval to be obtained and documented by 11/ 27/20
Agency preceptor	Review, approve and supervise the project implementation plan	Approval to be obtained verbally or in an email by 12/4/20
Project owner supervisor/sponsor	Executive sponsor of the project	Review implementation plan in a one-on-one meeting by 12/08/20
HR representative	Review project content and approve	Obtain approval in an existing one on one meeting by 12/08/20
NPPD representative	Content expert on nursing staff standard work and VFC. Need to review onboarding content	Review via email and sign off by 12/04/20
Quality subject matter expert	Content expert on quality standard work, VFC and HEDIS. Need to review onboarding content	Review via email and sign off by 12/04/20
District Directors of Operations	Hiring manager and supervisors of the project target population of new managers	Review new updated onboarding plan in any of the existing meetings and coach them on their leader support role by 12/08/20

Administrative assistant	Coordinate stakeholder calendars and manage scheduling especially the new manager participants.	Review proposed schedule in existing weekly meeting by 11/21/20
New PC managers	Project target population	Extend invitation to the onboarding sessions and confirm participation via email by 12/15/20

Project Charter

Project Name:

Primary Care Manager Onboarding to Improve Knowledge, Confidence to Lead high function teams and Intent to stay.

Training Period:

Jan – April 2021

AIM Statement: Design and implement a new manager onboarding program in primary care and increase knowledge and confidence to lead teams, as well as increase intent to stay by 10 % by September 2021**.**
Brief description: Although managers are central to the success of highly functioning teams in charge of organizational performance, they often receive inadequate onboarding due to competing operational priorities, time constraints and lack of mentorship. Currently, the only onboarding for managers in PC consists of a four-page checklist that has some outdated content, stakeholders and point of contact information. The checklist is also inconsistently used and updated with inconsistent content from one operational area to another. In many

cases, new managers are handed the checklist and expected to navigate their new role on their own.

Scope of project: All new managers in primary care that have been in their role for less than a year will be considered for participation. This wide time range is intentional because there isn't an existing structured PC service line onboarding for managers, and the goal is to include as many of those newer managers as possible.

Risks:

-Capacity constraints of immediate supervisors to support new hire

-Nonexistent mentor training to support the new managers

-Competing operational priorities due to the global COVID 19 pandemic continues to generate additional workload to the stakeholders and limit their bandwidth to potentially participate in the project.

Budget:

Cost of Onboarding /Investiment		
Cost of onboarding (Director of PC delivering the training salary x 8 hours of onboarding combined sessions)	Administrative tasks to plan and evaluate program = 2 hours a week x 16 weeks x $78	$2,496
	Actual delivering of the training = $78 x 10 hours	$780
Subject matter expert visiting trainer	Average hourly salary $50 x 4 hours	$200
Cost of logistical planning by the administrative assistant (scheduling meetings/sessions, booking venue, ordering food etc)	Admin c hourly salary- $25 x 10 hours over 16 weeks of planning and implentation	$250
One meal on the one face to face session	Calculated for 3 people (1 participant, trainer and a Subject matter expert visiting trainer)	$75
Direct supervisor rounding with new manager 30 minutes a week for 16 weeks	Average hourly salary $88 x 8 hours	$704
Mentor /preceptor time (Mentor/preceptor salary x 30 mins per week x 16 weeks)	$55/per hour x 8 hours	$440
Cost of new manager to attend new onboarding (8 hours x salary)	$55 x 10 hours	$550
Cost of new manager to meet with direct supervisor and mentor/preceptor	$55 x 16 hours	$880
Total cost of onboarding		**$6,375**

Content included: Primary care specific content TABLE OF CONTENTS Module 1: Primary Care Core Competencies - **Primary Care Organizational Chart & Locations** Learn how it all fits together - **Patient-Centered Medical Home Model (PCMH)** Learn about the Primary Care framework - **Quadruple AIM and HEDIS measures** Learn about what Primary Care is accountable for; Metrics, Reports & Best Practices - **Primary Care Staffing model & Methodologies** Learn about the Roles & Responsibilities of the whole team - **Service Line Standard work** Learn where & how to search for and manage standard work for the team - **Service Line Key stakeholders** Who are your key subject matter experts and partners? - **Other Resources and Tools** Vaccines for Children (V FC) & Provider Panel Management (PPM) Module 2: Operational Excellence and Continuous Improvement - **Daily Management System (DMS)** Status Reports Linked metrics and visual boards Process Observations Front line improvement (FLI) and PDCA Leader standard work Leader as coach (Problem-solving capability) 2	**Content excluded:** General staff orientation activities such as Day one training, Epic, HR- specific training such as managing in the union environment, Kronos, general care delivery manager activities such as Reliability training, Onelink, and CRA-finance.

Appendix J

SWOT Analysis

<table>
<tr><th>Strengths</th><th>Weaknesses</th></tr>
<tr><td>● Executive sponsorship
● Project is already part of the owner’s work portfolio
● Engaged stakeholders
● Existing framework & platforms to implement project
● There are existing contracted coaches to support the project
● Improvement office can provide backup coaching as needed
● Literature review supports benefits for manager onboarding</td><td>● Inherent wide variations of new manager onboarding experience
● Capacity constraints of immediate supervisors to support new hires
● Nonexistent mentor training to support the new managers</td></tr>
<tr><th>Opportunities</th><th>Threats</th></tr>
<tr><td>● Enhanced organizational reputation due to new and improved structured onboarding culture
● Attraction of external talent into the organization</td><td>● Closing of schools and daycare centers as a result of COVID 19 has and continues to impact staffing
● COVID- related budgetary impact on the decision to pause on hiring.
● Staff have been repurposed to focus on Covid-19 threats and Covid-19-related patient care.</td></tr>
</table>

Appendix K

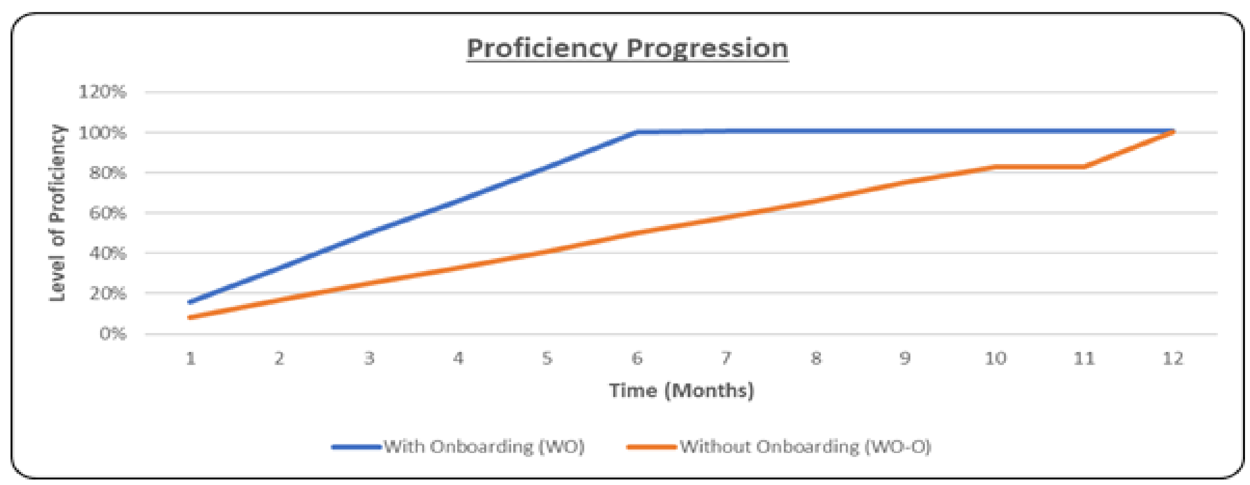
Budget and Return on Investment

Assumptions for the ROI/Budget

Assumptions	USD
Average Hourly Manager Salary	$55
Average Monthly Manager Salary	$8,800
Cost of recruiting and hiring a new manager	$22,880

Competence Levels	Level of Proficiency
Unconscious Incompetence (One doesn't know what they don't know)	25%
Conscious Incompetence (One knows what they do not know)	50%
Conscious Competence (One knows how to do the skill but requires conscious thought)	75%
Unconscious Competence (One performs skill with ease and uncounsciously)	100%

Time to Proficiency (Months)	Level of Proficiency		Lost Productivity With Onboarding (WO)		Lost Productivity Without Onboarding (WO-O)	
	With Onboarding (WO)	Without Onboarding (WO-O)	WO (%)	WO (USD)	WO-O (%)	WO-O (USD)
1	16%	8%	84.00%	$7,392	92.00%	$8,096
2	40%	16%	60.00%	$5,280	84.00%	$7,392
3	56%	24%	44.00%	$3,872	76.00%	$6,688
4	62%	32%	38.00%	$3,344	68.00%	$5,984
5	86%	40%	14.00%	$1,232	60.00%	$5,280
6	100%	48%	0.00%	$0	52.00%	$4,576
7		56%			44.00%	$3,872
8		64%			36.00%	$3,168
9		72%			28.00%	$2,464
10		80%			20.00%	$1,760
11		88%			12.00%	$1,056
12		100%			0.00%	$0
Total				**$21,120**		**$50,336**



Budget

Item	Hourly salary/ number of hours	Total Budget cost per item for 1-3 months (1 manager)	Total Actual cost (12 manager participants over 22.5 hours of onboarding)
Cost of onboarding (Director of PC delivering the training salary x 8 hours of onboarding combined sessions)	Administrative tasks to plan and evaluate program = 2 hours a week x 16 weeks x $78	$ 2,496	$ 2,496
	Actual delivering of the training = $78 x 10 hours	$ 780	$ 1,755
Subject matter expert visiting trainer	$50 x 4 hours	$ 200	$ 200
Cost of logistical planning by the admin support	$25 x 10 hours over 16 weeks of planning and implementation	$ 250	$ 250
Mentor /preceptor time (Mentor/preceptor salary x 30 mins per week x 16 weeks)	$55/per hour x 8 hours	$ 440	$ 5,280
Cost of new manager to attend new onboarding (10 hours) and meet with supervisor and Mentor/supervisor (16 hours)	$55 x 26 hours	$ 1,430	$ 17,160
New manager's supervisor 1:1 rounding	$88 x 8 hours	$ 704	$ 8,448
Total cost of onboarding		**$ 6,300**	**$ 35,589**

ROI

Unit	ROI (Onboarding 1 new PC manager) = Net Profit / Cost	ROI (Onboarding 12 new PC manager) = Net Profit / Cost
Cost Avoidance (Saving) by reducing time to proficiency WO ($21,120) and cost of hiring ($22,880)	$44,000	$528,000
Cost of Onboarding (Cost of Investment)	$6,300	$35,589
Net Profit	$37,700	$492,411
Return on Investment (ROI)	**498%**	**1383.60%**

Appendix L

Pre/Post Onboarding Survey

Manager Pre & Post Onboarding Survey

New Hire Onboarding

Q1 Overall, how well do you understand your role, including responsibilities of your job

- Not well at all
- Slightly well
- Moderately well
- Very well
- Extremely well

Q2 How accurately was your role described to you during your interviews (i.e., Are you doing what you expected you'd be doing)?

- My role was not described to me during interviews
- Not accurately at all
- Slightly accurately
- Moderately accurately
- Very accurately

Q3 How challenging would you say your current role is?

- Extremely challenging
- Very challenging
- Moderately challenging
- Slightly challenging
- Not challenging at all

Q4 Do you know how to access and to utilize the resources on;

	Not knowledgeable at all	Slightly knowledgeable	Moderately knowledgeable	Very knowledgeable	Extremely knowledgeable
Primary care SharePoint	○	○	○	○	○
Press Ganey reports	○	○	○	○	○
Tablaeu Dashboard	○	○	○	○	○
Datix for Unusual Occurrences	○	○	○	○	○
Nursing Practice and Professional Development	○	○	○	○	○
Overall knowledge of resources above	○	○	○	○	○

Q5 How well do you understand the following ?

	Not well at all (1)	Slightly well (2)	Moderately well (3)	Very well (4)	Extremely well (5)
Patient-Centered Medical Home (PCMH)?	○	○	○	○	○
Access metrics and comfortable managing access	○	○	○	○	○
Press Ganey reports to improve member experience	○	○	○	○	○
Managing staff in a union environment	○	○	○	○	○
The roles and the scope of your direct report(s)	○	○	○	○	○
The staffing model	○	○	○	○	○
Quadruple Aim	○	○	○	○	○
Overall understanding of the above	○	○	○	○	○

Q6

How comfortable and confident are you in;

	Extremely uncomfortable	Somewhat uncomfortable	Neither comfortable nor uncomfortable	Somewhat comfortable	Extremely comfortable
Leading your team	○	○	○	○	○
Interacting with the providers (Functional accountability)	○	○	○	○	○
Interacting with other managers	○	○	○	○	○
Interacting with your immediate leadership	○	○	○	○	○
Interacting with other senior leaders	○	○	○	○	○
Overall comfort & confidence in your role	○	○	○	○	○

Q7

How likely are you to stay in this role;

	Not likely	May be likely	Not sure	Likely	Most likely
1 year from today	○	○	○	○	○
2 years from today	○	○	○	○	○
3 years from today	○	○	○	○	○
4 years from today	○	○	○	○	○
5 years from today	○	○	○	○	○

Q8

Do you know your key stakeholders contacts?

	No	Yes
Quality	○	○
Population health such as Chronic disease management)	○	○
Nursing Practice & Professional development	○	○
Unusual occurrences (safety)	○	○
Workplace injuries	○	○
Infection prevention & Employee Health	○	○
Legal issues	○	○
Press Ganey (Member Service)	○	○
Human Resource Business Partner	○	○
Primary Care Appointing Center supervisor	○	○
I know my key stakeholder contacts	○	○

Q9

Do you have a mentor officially assigned to you?

○ No

○ Yes

Q10

What feedback do you have on your onboarding experience so far?

Appendix M

Question Grouping and Scoring

Outcome	Questions and Scoring	Max Score
Confidence	**Q6 How comfortable and confident are you in?** – Influencing your team – Influencing provider (Functional accountability) – Collaborating with other managers – Managing up with your immediate leadership – managing up with other senior leaders – Overall comfort and confidence in influencing above stakeholders **Scoring:** – Extremely uncomfortable (1) – Somewhat uncomfortable (2) – Neither comfortable nor uncomfortable (3) – Somewhat comfortable (4) – Extremely comfortable (5)	30
Knowledge	**Q4 Do you know how to access and to utilize the resources on?** – Primary care SharePoint – Care delivery SharePoint – Press Ganey reports – Tablaeu Dashboard – Datix for Unusual Occurrences – Nursing Practice and Professional Development – EPIC Quality Reports – Overall knowledge of resources above **Scoring** – Not knowledgeable at all (1) – Slightly knowledgeable (2) – Moderately knowledgeable (3) – Very knowledgeable (4) – Extremely knowledgeable (5)	40
Knowledge	**Q5 How well do you understand the following?** – Patient-Centered Medical Home (PCMH)? – Access metrics and comfortable managing access – Press Ganey reports to improve member experience – Managing staff in a union environment – The roles and the scope of your direct report(s) – The staffing model – Quadruple Aim – Overall understanding of the above **Scoring** – Not well at all (1) – Slightly well (2)	40

Outcome	Questions and Scoring	Max Score
	– Moderately well (3) – Very well (4) – Extremely well (5)	
Knowledge	**Q8 Do you know your key stakeholders contacts?** – Quality – Population health (Chronic disease management for DM) – Nursing Practice and Professional development – Unusual occurrences (safety) – Workplace injuries – Infection prevention and Employee Health – Legal issues – Press Ganey (Member Service) – Human Resource Business Partner – Primary Care Appointing Center supervisor **Scoring** – Yes (1) – No (0)	10
Intent to Stay	**Q7 How likely are you to stay in this role in?** – Less or equal 1 year – 2 years – 3 years – 4+ years – Not sure **Scoring** 0-100% per year category (time of stay with max score adopted as intent time)	100%

Appendix N

Pre and Post Onboarding Summary Statistics

Table N1

Summary Statistics for Confidence Score Pre and Post Onboarding

Survey Time	N	Mean	STD	Min	25%	50%	75%	Max
Pre onboarding	12	23.8	3.2	19	22	24	26	30
Post onboarding	11	26.8	2.9	21	25	28	29	30
% □		**13%**						

Table N2

Summary Statistics for Knowledge Scores Pre and Post Onboarding

Knowledge of available resources and the ability to access them								
Survey Time	**N**	**Mean**	**STD**	**Min**	**25%**	**50%**	**75%**	**Max**
Pre onboarding	12	23.5	5.2	13	21	23	26	32
Post onboarding	11	30.5	6.2	23	25	29	37	39
% □		**30%**						*$t(21)=2.94$, $p = .01$
Knowledge of organizational procedures and processes								
Survey Time	**N**	**Mean**	**STD**	**Min**	**25%**	**50%**	**75%**	**Max**
Pre onboarding	12	22.4	5.4	15	19	23	25	31
Post onboarding	11	28.8	8.0	19	22	30	36	40
% □		**29%**						*$t(21)=2.23$, $p = .04$
Key stakeholder awareness								
Survey Time	**N**	**Mean**	**STD**	**Min**	**25%**	**50%**	**75%**	**Max**
Pre onboarding	12	6.9	2.6	3	5	8	9	10
Post onboarding	11	8.8	1.2	7	8	9	10	10
% □		**27%**						*$t(21)=2.31$, $p = .03$
All Knowledge Areas								
Survey Time	**N**	**Mean**	**STD**	**Min**	**25%**	**50%**	**75%**	**Max**
Pre onboarding	12	52.8	11.4	36	43	53	62	72
Post onboarding	11	68.2	14.7	49	57	62	83	89
% □		**29%**						*$t(21)=2.79$, $p = .01$

Table N3

Summary Statistics for Intent to Stay in Role Pre and Post Onboarding

Survey Time	1 Year	2 Years	3 Years	4 or More	Unsure	Total
Pre						
N	8	1	1	0	2	12
%	67%	8%	8%	0%	17%	100%
Post						
N	3		1	2	5	11
&	27%	0%	9%	18%	45%	100%
Total N	**11**	**1**	**2**	**2**	**7**	**23**
%	**48%**	**4%**	**9%**	**9%**	**30%**	**100%**

Table N4

Summary Statistics for Intent to Stay in Role Pre and Post Onboarding (Excludes Unsure)

Survey Time	1- 2 Years	3+ Years	Total
Pre			
N	9	1	10
%	90%	10%	100%
Post			
N	3	3	6
&	50%	50%	100%
Total N	**12**	**4**	**16**
%	**75%**	**25%**	**100%**

Table N5

Summary Statistics for Intent to Stay in Role Pre and Post Onboarding (Sure vs. Unsure)

Survey Time	Sure	Unsure	Total
Pre			
N	10	2	12
%	83%	17%	100%
Post			
N	6	5	11
&	55%	45%	100%
Total N	**16**	**7**	**23**
%	**70%**	**30%**	**100%**

Appendix O

IRB Certificate of Completion

Completion Date 20-May-2020
Expiration Date 20-May-2023
Record ID 36680128

This is to certify that:

Christine Asiimwe

Has completed the following CITI Program course:

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Human Subjects Research (HSR) (Curriculum Group)
Human Subjects Research (HSR) (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

University of San Francisco

Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w55171a8e-50aa-465b-87aa-e41b8f4d3da3-36680128

Appendix P

DNP Statement of Non-Research Determination Form

Doctor of Nursing Practice
Statement of Non-Research Determination (SOD) Form

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

General Information

Last Name:	Asiimwe	First Name:	Christine
CWID Number:	20533514	Semester/Year:	Summer 2020
Course Name & Number:	N791E Practicum II: Micro-Systems		
Chairperson Name:	Dr. Elena Capella	Advisor Name:	Dr. Elena Capella

Project Description

1. ***Title of Project***

Implementation of a Manager Onboarding Program in Primary Care to Improve Intent to Stay, Knowledge and Confidence to Lead Teams.

2. ***Brief Description of Project***

Clearly state the purpose of the project and the problem statement in 250 words or less.

Ambulatory care curriculums are not well developed in nursing programs, so there is already a gap in nursing leadership in ambulatory care settings like primary care (PC).
There is literature evidence that proper onboarding of managers improves knowledge and confidence to lead teams, retention, and job satisfaction, as well as engagement, better patient care outcomes, higher productivity, and cost-saving. Conversely, lack of adequate onboarding leads to a lack of role clarity, poor engagement, high turnover rates, which can be costly to the organization.

3. **AIM Statement: What are you trying to accomplish?**

- What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well-defined, and at a minimum describe the target population, the desired improvement, and the targeted timeframe.
- To improve (your process) from (baseline)% to (target)%, by (timeframe), among (your specific population)

Complete this statement:

To increase ___Knowledge, Confidence leading teams and intent to stay________(process/outcome). By 10%_______

Between:___Pre onboarding survey score___(baseline %, rate, #, etc.).____

And: _____Post onboarding survey score___(goal/target %, rate, #, etc.)

by: _____September 2021___(date, 3 - 6-month timeframe)

in: _____Primary care managers___(population impacted)

Aim Statement: In the primary care setting, implement a manager onboarding program to increase knowledge, confidence leading teams and intent to stay by 10 percent by September 2021.

4 Brief Description of Intervention (150 words).

Develop and Implement a structured onboarding for all managers new to primary care who have been in their role for less than a year.

4a. How will this intervention be implemented?

- Where will you implement the project?
- Attach a letter from the agency with approval of your project.
- Who is the focus of the intervention?
- How will you inform stakeholders/participants about the project and the intervention?

This project will be implemented at a large health care delivery system in Washington state.

Project letter of support rotated pdf

The project intervention is focused on all managers new to primary care. The onboarding session(s) will be delivered in-person or virtually to individuals or a group. Stakeholders and participants will be informed through emails, one-on-one phone calls, and at new and already established individual and group meetings.

5. Outcome measurements: How will you know that a change is an improvement?

- Measurement over time is essential to QI. Measures can be outcome, process, or balancing measures. Baseline or benchmark data are needed to show improvement.
- Align your measure with your problem statement and aim.
- Try to define your measure as a numerator/denominator.
  - What is the reliability and validity of the measure? Provide any tools that you will use as appendices.
  - Describe how you will protect participant confidentiality.

There have been improvements over the years in the onboarding and orientation of newly hired managers at this large health care delivery system. These improvements have explicitly been around general care delivery orientation for all staff and Human Resources content. There is currently no structured onboarding for new managers in their specific service lines/departments, including the Primary Care (PC) service line.

Process measure

1. 90% of all new managers hired into PC enroll and complete PC onboarding within their first 90 days of hire.

Outcome measures

1. 10% increase in confidence to lead teams between the participants' pre and post onboarding surveys.
2. 10% increase in knowledge to lead teams between the participants' pre and post onboarding surveys.
3. 10 % increase in intent to stay between the participants' pre and post onboarding surveys.

Balancing outcomes

1. Organizational manager turnover rates
2. Engagement survey results
3. Performance in PC metrics of their respective areas of management.

A survey tool with a combination of questions from generic onboarding tools on Qualtrics and survey monkey will be customized to fit the organization and administered to participants to measure knowledge, confidence leading teams, and intent to stay. The results will be collected, analyzed, and reported anonymously to protect the participants' confidentiality. Here is the link to the draft survey. https://usfca.co1.qualtrics.com/jfe/form/SV_7Pa8Zw0XqU4Jiwl

DNP Statement of Determination

Evidence-Based Change of Practice Project Checklist*

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Manager Onboarding in Primary Care

Mark an "X" under "Yes" or "No" for each of the following statements:	**Yes**	**No**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	X	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. All participants will receive standard of care.	X	
The project is not designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does not follow a protocol that overrides clinical decision-making.	X	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does not develop paradigms or untested methods or new untested standards.	X	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does not seek to test an intervention that is beyond current science and experience.	X	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.	X	
The project has no funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	X	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	X	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	X	

Answer Key:

- If the answer to all of these items is "Yes", the project can be considered an evidence-based activity that does not meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files.
- If the answer to any of these questions is "No", you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: http://answers.hhs.gov/ohrp/categories/1569

DNP Statement of Determination

Evidence-Based Change of Practice Project Checklist Outcome

The SOD should be completed in NURS 7005 and NURS 791E/P or NURS 749/A/E

Project Title:

Implementation of a Manager Onboarding Program in Primary Care to Improve Intent to Stay, Knowledge and Confidence to Lead Teams.

☒ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). **Student may proceed with implementation.**

☐ This project involves research with human subjects and **must be submitted for IRB approval before project activity can commence.**

Comments:

Student Last Name: Asiimwe

Student First Name: Christine

CWID Number: 20533514

Semester/Year: Summer 2020

Student Signature: CKASIIMWE **Date:** 10/15/2021

Chairperson Name: Dr. Elena Capella

Chairperson Signature: Elena Capella

Date: 10/16/21

DNP SOD Review Committee Member Name: Dr. Jonalyn Wallace

DNP SOD Review Committee Member Signature: Jonalyn Wallace **Date:** 10.18.2021

Appendix Q

Pre/Post Onboarding Results

Figure Q1

Confidence Score Pre and Post Onboarding

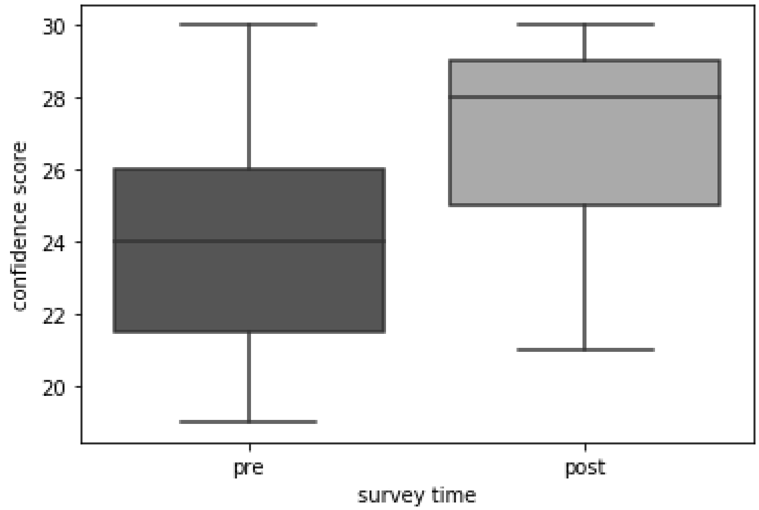


Figure Q2

Knowledge Score Pre and Post Onboarding

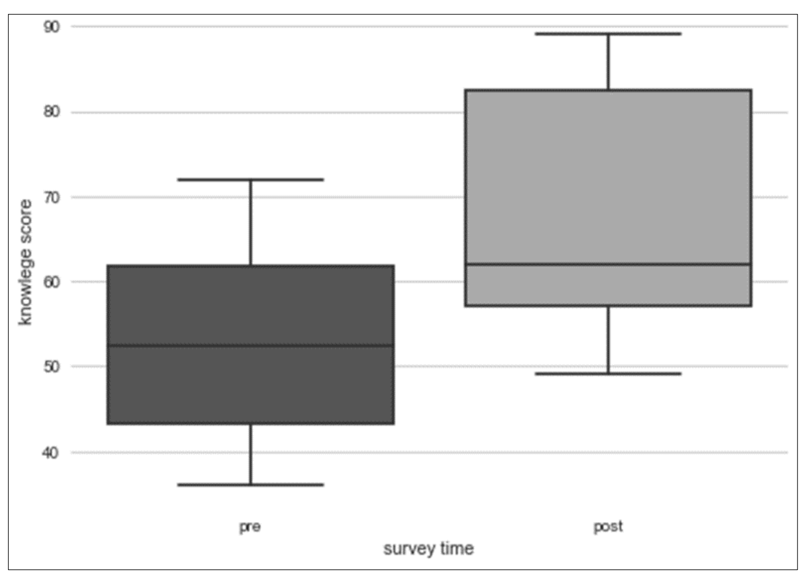
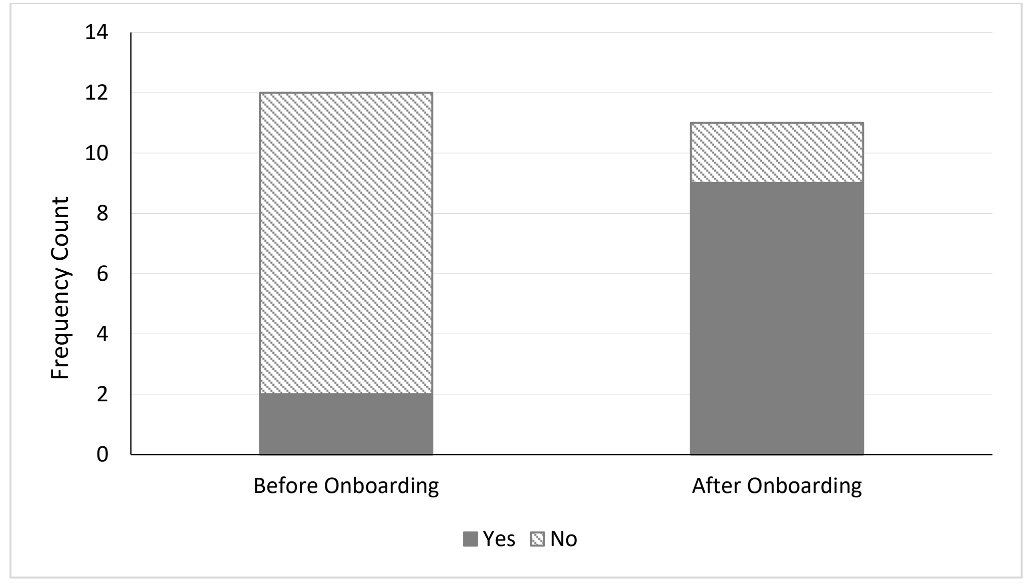


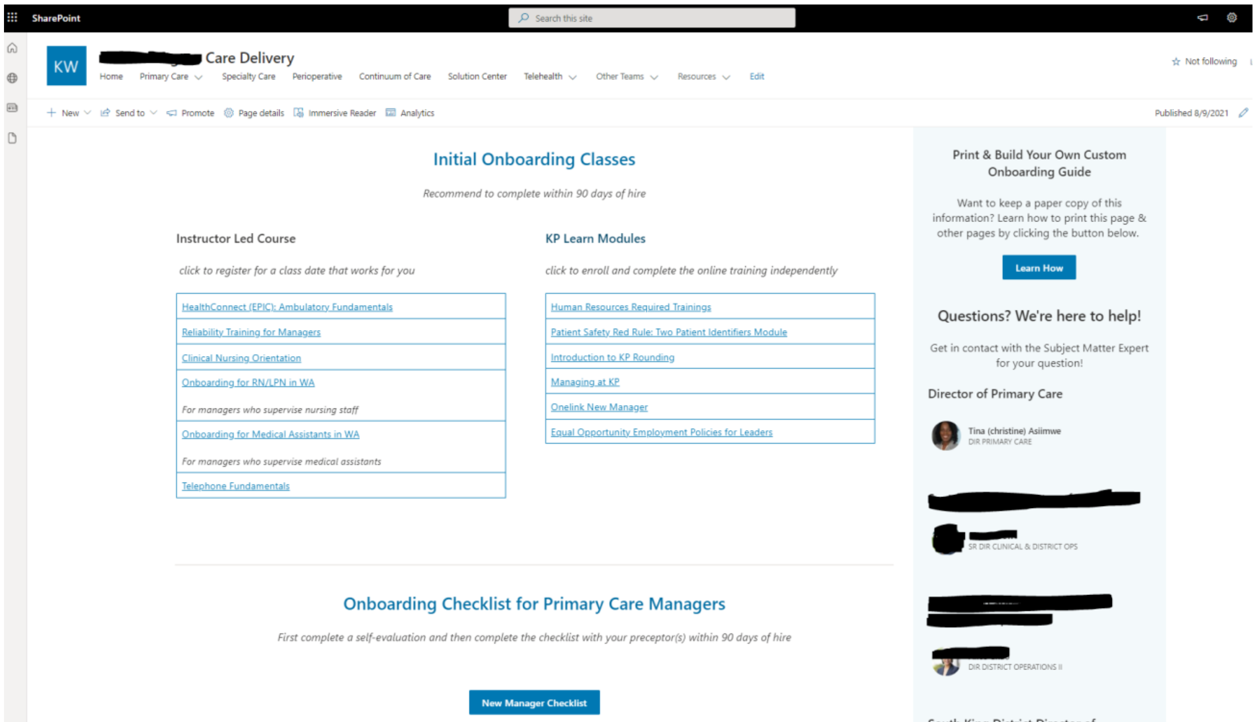
Figure Q3

Assigned Mentor Pre and Post Onboarding



Appendix R

Onboarding Website Landing Page



Appendix S

Question on Intent to Stay in Role

Outcome	Questions and Scoring	Max Score
Intent to Stay	**Q7 How likely are you to stay in this role?** – Less or equal 1 year – 2 years – 3 years – 4+ years – Not sure **Scoring** 0-100% per year category (time of stay with max score adopted as intent time)	100%