Exploring Leadership Styles in Nonprofit and For-Profit Acute Care Hospitals

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Abstract

The cost of healthcare is rising with the US spending $3.6 trillion, which was 17.7% of the US GDP in 2018 (National Health Expenditure Data, 2019). As a result, healthcare has become a major focus of public administrators, politicians, employers, and the general public. Healthcare administrators are searching for new ways to meet the challenges. One strategy is mergers and acquisitions. From 1975 to 2017, the number of for-profit hospitals grew 70.5%, predominately through the acquisition and transition of nonprofit hospitals to for-profit centers, creating large for-profit healthcare systems. Nonprofit hospitals are also acquiring hospitals and creating large nonprofit systems.

With more acquisitions and mergers, it is important to understand the impact on leadership, however, there have been few studies in this area. With the trend towards leaders transitioning between business sectors, this study sought to determine if there is a difference in the leadership styles between sectors. Healthcare leaders participated in the Multifactor Leadership Questionnaire designed to determine a leaders' propensity towards utilizing transformational, transactional, and passive avoidant behaviors. Additional insight was gained through interviews with 20 healthcare leaders with experience in nonprofit and for-profit hospitals.

The results revealed no significant difference in transformational behaviors between leaders in the nonprofit and for-profit sectors however for-profit leaders had a stronger tendency towards transactional behaviors in the managing by exception active dimension. The size of the organization appeared to impact the tendency towards transactional behavior. The study considered turnover which was found not to correlate to leadership style.

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Chapter I

INTRODUCTION

Overview

Healthcare has undergone significant change and new challenges since the 1980s with little focus on preparing leaders with the skills necessary to be successful and adaptive in this new environment. The current challenges will stretch healthcare leaders even further, requiring them to learn how to be successful in a world with significant changes predicted in regulations, reimbursement, focus on wellness through population health, technology advances, regulatory uncertainty, and consolidation and growth (Warren, 2017). Turnover in the senior leadership ranks has climbed to 20%, with consolidation and retirements seen as significant contributors (B.E. Smith Team, 2016). From 1975 to 2017, the number of nonprofit hospitals declined. In 1975, there were 3,339 nonprofit hospitals. In 2017, the number of nonprofit hospitals was down to 2,968, a decrease of 11.1%. By contrast, in 1975 there were only 775 for-profit hospitals; however, by 2017, for-profit hospitals had grown to 1322, for an increase of 70.5% (Hospitals, Beds, and Occupancy Rates; Fast Facts on US Hospitals, 2019).

Table 1

Number of Hospitals by Business Model

Business Model	1975 Number of Hospitals	2017 Number of Hospitals	% Change
Nonprofit	3339	2968	-11.1
For-profit	775	1322	+70.5
State-Local Govt	1761	972	-44.8

Total Number of Community Hospitals	5875	5262	-10.3

Hospitals, Beds, and Occupancy Rates (2010); Fast Facts on US Hospitals (2019).

The growth in for-profit hospitals is happening partially by the development of large hospital systems through mergers and acquisitions of smaller nonprofit hospitals, thus changing their business model from nonprofit to for-profit. According to Irving Levin Associates, there were 100 mergers or acquisitions in the hospital industry in 2014 alone (Dietsche, 2016). To gain perspective on hospital system size, Table 2 compares the number of hospitals in the top five nonprofit hospital systems and the number of hospitals in the top five for-profit hospital systems as of the beginning of 2017.

Table 2

Number of Hospitals in the Top Five Largest Healthcare Systems

Nonprofit Hospital Systems	Number of Hospitals in the System
Ascension Health	141
Catholic Health Initiatives	103
Trinity Health	92
Baylor, Scott & White	48
Adventist Health Systems	46
Total	430
For-Profit Hospital Systems	Number of Hospitals in the System
Hospital Corporation of America	169
Community Health Systems	158
Tenet Healthcare	79
LifePoint Health	72
Prime Healthcare Services	44
Total	522

Murphy (2017)

Problem Statement

In an environment of consolidation, it is important to review the changing skillsets and behaviors required of leaders to ensure success in the healthcare field and to stabilize the workforce. Little focus on leadership skills during or after mergers increases

the possibility that the same organizational issues that prompted the merger will arise over time and increase staff turnover, which puts the success of the merger at risk (McAlearney, 2006).

This study built on existing generic leadership research by examining leadership styles in acute care centers with nonprofit business models and for-profit business models to determine if there are similarities and/or differences in leadership styles. System size was evaluated to determine if the leadership behavior is differentiated based on the size of the hospital system. Also, an analysis of the impact on employee turnover, which ultimately impacts organizational productivity, was conducted.

Conceptual Framework

A review of the literature suggests effective leadership is essential in the success of an organization and identifying the important characteristics of leaders can improve overall organizational performance (Madanchian, Hussein, Noordin, Taherdoost, (2017). Antonakis and House (2014) suggested there are various leadership theories that could apply; however, the most contemporary theories include transformational, transactional, and laissez-faire styles, which make up the Full Range Leadership Model. According to Day, Fleenor, Atwater, Sturm, & McKee (2014), transformational leadership, the most recommended leadership approach, includes four elements: "(a) idealized influence, (b) inspirational motivation, (c) intellectual stimulation, and (d) individualized consideration" (p. 66). Transactional leadership focuses on exchanges or transactions leading to results and rewards or corrective action. The objectives and expectations are clearly stated and the resources for success are provided. Laissez-faire is considered to be a demonstration of no leadership evidenced by not being available when needed,

avoiding making decisions, and not responding to important issues (Bass & Avolio, 2004). It is a hands-off style that leaves the decision making to the team.

Since transformational leadership is the most recommended style and the availability of a validated tool, the focus of this study was on identifying if transactional leadership or transformational leadership is more prevalent among acute care hospital executives and if the preferred leadership style differs based on the business model or organizational size. Managers, directors, vice presidents, and chief executive officers were categorized as hospital executives.

Research Goals: Focus and Purpose

A mixed methods research design was utilized for this nonexperimental research study. This research sought to determine the leadership styles most commonly utilized at the executive level in the acute care hospital nonprofit business model and the acute care hospital for-profit business model, especially in a period of consolidation. The study assessed the statistical relationship between leadership style, business model, and turnover.

Research Questions

1. What are the common leadership styles of acute care hospital executives functioning in the nonprofit business model?
2. What are the common leadership styles of acute care hospital executives functioning in the for-profit business model?
3. Does leadership style impact staff turnover?
4. Does the size of the hospital system impact leadership style?

Based on the research of nonprofit organizations in Germany (Rowold, Borgmann, & Bormann, 2014), I expected to find a positive correlation between nonprofit leaders in the acute care setting and a transformational leadership style based on their commitment to the community and focus on the mission. Nonprofit hospitals have a stronger focus on service and may utilize their mission as a strong motivator. However, I expected transactional leadership to be more common in for-profit executives in acute care hospitals due to many of the for-profit organizations are larger in size, requiring greater consistency in policy and practice, which minimizes the need for emphasis on employee engagement and places more focus on process and outcomes (Marx, 2017). As for turnover, I expected the leadership style will not impact turnover. Asiri, Rohrer, Al-Surimi, Da'ar, & Ahmed (2016) found transformational leadership correlated with commitment among nurses and transactional leadership built trust. Marx (2017) found a correlation between the size of the organization and the role of leadership therefore I expected to find transactional behavior to increase with organizational size.

Summary of Methodology

To obtain the most comprehensive data for analysis, a mixed-method research design was used. To assess if there was a relationship between leadership style, business model, organization size, and turnover, I surveyed hospital executives in for-profit and nonprofit acute care settings using the Multifactor Leadership Questionnaire (MLQ 5x) to determine their leadership style. Data on factors such as organization size and turnover were self-reported along with the business model in which the leader functions. To better understand the research results, I conducted follow-up open-ended interviews in the for-

profit and the nonprofit acute care setting with executives who have experience in the nonprofit sector, for-profit sector, and both sectors.

Significance of the Study

The US healthcare system has experienced significant pressure to expand services and provide high-quality care while reducing costs creating the need for a shift in the way healthcare is structured. Specifically, many hospitals are looking to merge with other hospitals to gain economies of scale and greater purchasing power. In some instances, hospitals are merging with hospitals operating under a different business model with the potential to make it difficult for leaders to transition to the new culture. The leader's role is to help the organization meet its goals through its people which is vitally important especially during a merger. If a leader cannot make the transition, the success of the merger and business continuity may be jeopardized underscoring the need for a greater understanding of leadership styles in the acute care system.

In an environment of rapid change and shifts in hospital ownership, this research will add to the current body of knowledge regarding common leadership styles in the acute care setting. This examination of transformational and transactional leadership will contribute to the understanding of the relationship between leadership style and business models. Insight into the behavioral shifts needed for a leader to effectively transition from one sector to another will assist a leader who is transitioning to a new business model with information on how to align or adapt their leadership style with the new business model. More information on the leadership style differences in the business setting can improve the transition and create a more stable environment. As hospital systems continue to merge creating much larger systems, this study provides information on the

influence of the culture and organizational size on leadership behavioral tendencies. Also, the study found mergers have an impact on leadership behaviors and highlights the need for further research regarding the impact of mergers and acquisitions on leadership style.

Limitations of the Study

The study included data based on self-assessments of leaders in the acute care setting known to the researcher. The data included a small sample of leaders creating limitations for the study. One limitation included the information gathered only related to the business model and size of the organization; however, it did not include regional data. The study did not include feedback from the study participants' direct reports due to a lack of access. Turnover data for each organization were not available through an independent source; therefore, the turnover data were self-reported by the respondents. Although the survey included a request for this information, many of the participants were unsure of the turnover percentage or did not respond to this question in the survey.

Organization of the Study

Chapter 1 introduces the study and provides an overview of the healthcare industry, the increase in mergers and acquisitions, and the rationale for studying leadership styles in the acute care setting. The Full Range Leadership Theory, which focuses on transformational, transactional, and passive avoidant styles, was the conceptual foundation for this study.

Chapter 2 consists of a review of the literature conducted to develop the study. The stage is set by an overview of the healthcare environment, various healthcare business models, the function of leadership in an organization, the impact of turnover, and a summary of how many leadership theories have developed and manifest themselves

in organizations. A review of studies yielded inconsistent findings on the prevalence of leadership styles in the healthcare industry and the impact of leadership styles.

Chapter 3 describes the methodology used in the study. Quantitative and qualitative data were gathered and analyzed to determine the trends in leadership. A self-report survey determined the leadership tendencies among executives who had experience in the nonprofit or for-profit acute care industry and among executives who had experience in both sectors. The data were utilized to determine if there was a prevalent style in each sector. To expand on the findings, I conducted follow-up interviews with healthcare leaders in the acute care setting.

Chapter 4 provides an analysis of the quantitative and qualitative data gathered. I completed a statistical analysis based on the research questions. For the quantitative data, frequency tables were generated, including the minimum, maximum, mean, and standard deviation. Additional tests were conducted to determine the statistical relevance of the data. The qualitative data were reviewed with a focus on trends and insight from the quantitative data. The analysis was utilized to determine if the research hypotheses were supported.

Chapter 5 includes a discussion of findings and conclusions. The meanings of the findings were discussed in relation to the research questions and further insight was summarized based on the qualitative data. Conclusions and recommendations were presented as well as a summary of the research limitations.

Definition of Terms

Active management-by-exception: Focuses on monitoring task execution for any problems that might arise and correcting those problems to maintain current performance levels (Bass & Avolio, 2004, p. 53).

Acute care center: In acute care, a patient is treated inpatient for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery (CMS Data Navigator Glossary of Terms).

Charisma/inspirational: Provides followers with a clear, energizing sense of purpose: a model for ethical conduct that builds identification with the leader and their articulated vision (Bass & Avolio, 2004, p. 53).

Contingent reward: Clarifies what is expected from followers and what they will receive if they meet expected levels of performance (Bass & Avolio, 2004, p. 53).

Executive-level leaders: Managers, directors, executive directors, vice presidents, and chief executive officers.

For-profit hospital: A hospital with private or public shareholders that can raise capital through investors and must distribute a portion of its profits back to the investors (Daily Briefing Primer, 2015).

Idealized influence: "Leaders that are admired, respected, and trusted. Followers identify with and want to emulate their leaders. . . . The leaders share risks with followers and are consistent in conduct with underlying ethics, principles, and values" (Bass & Avolio, 2004, p. 103).

Individualized consideration: Focuses on understanding the needs of each follower and works continually to get them to develop to their full potential (Bass & Avolio, 2004, p. 53).

Instrumental leadership: A theory of leadership based on the application of a leader's expert knowledge on monitoring of the environment and performance and the implementation of strategic and tactical solutions. The focus is on strategic leadership and follower work facilitation (Bass & Avolio, 2004, p. 103).

Inspirational motivation: "These leaders behave in ways that motivate those around them by providing meaning and challenge to their followers' work. Individual and team spirit is aroused. Enthusiasm and optimism are displayed" (Bass & Avolio, 2004, p. 103).

Intellectual stimulation: Gets followers to question the tried and true ways of solving problems and encourages them to question the methods they use to improve upon them (Bass & Avolio, 2004, p. 53).

Laissez-faire leadership: Exhibiting little or no leadership at all (Bass & Avolio, 2004, p.105).

Management by exception-active (MBEA): "The leader specifies the standards for compliance, as well as what constitutes ineffective performance, and may punish followers for being out of compliance with those standards" (Bass & Avolio, 2004, p. 105).

Management by exception-passive (MBEP): "Avoids specifying agreements, clarifying expectations, and providing goals and standards to be achieved by followers" (Bass & Avolio, 2004, p. 105).

Multifactor Leadership Questionnaire (MLQ): The most utilized and validated tool designed to assess leadership behaviors using a full range of leadership behaviors including laissez-faire, transactional and all the elements of a transformational leader (Muenjohn & Armstrong, 2008).

Nonprofit hospital: A hospital with an obligation to invest all their profits back into the organization to better serve the community and is exempt from paying state and federal taxes on income and property (Daily Briefing Primer, 2015).

Organizational culture: The jointly held beliefs that form a foundation for aligned purpose and action within an organization (Watkins, 2013).

Staff turnover: Voluntary turnover in the hospital.

Transactional leadership: Displaying "behaviors associated with constructive and corrective transactions (Bass & Avolio, 2004, p. 104).

Transformational leadership: A process of influencing in, which leaders change their associates' awareness of what is important and move them to see themselves and the opportunities and challenges of their environment in a new way (Bass & Avolio, 2004, p. 103).

Chapter II

REVIEW OF THE LITERATURE

Healthcare Environment

In 2017, healthcare was a $3.5 trillion industry in the United States alone, which accounts for 17.9% of the U.S. gross domestic product. Medicare spending was $705.9 billion or 20% of the national healthcare spending. Medicaid expenditures were 17% of the national healthcare spending at $581.9 billion, for a total of 37% of national healthcare spending funded from these two government programs (National Health Expenditure, 2018). As for insurance coverage, the Affordable Care Act added an estimated 20 million people to the insurance coverage in 2014 with some joining health insurance plans and some states expanding Medicaid (“17 Statistics”, 2016).

Based on the American Hospital Association 2019 survey, there were 2,968 nongovernment not-for-profit community hospitals and 1,322 investor-owned for-profit community hospitals. *Community hospitals* refer to all nongovernmental hospitals, including specialty hospitals and academic medical centers. Not included in this number are governmental hospitals and any hospital that is not open to the general public such as college infirmaries or prison hospitals (“Fast Facts on US Hospitals”, 2019). In 2018, there were more than 80,000 hospital-acquired physician practices, representing 44% of all the nation’s physicians, which was an increase over the 35,700 hospital-employed physicians in 2012 (Masterson, 2019). In an environment where 56% of the physicians are not employed by a hospital, unique challenges are evident for administrators.

Physicians have a dual role “as both consumers of healthcare resources and controllers of organizational revenues in their ability to direct patients and prescribe care” (McAlearney, 2006, p. 969). Managing the physician and hospital relationship can be extremely difficult, and if not handled effectively it can have significant consequences to the overall success of the organization.

The healthcare environment is constantly changing and creating new challenges for healthcare executives. They must be able to successfully address both clinical and organizational challenges, recognizing that their success impacts not only the organization but the lives of those in the community (McAlearney, 2006). Teel (2018) suggested the five major challenges be addressed by healthcare leaders in the next five to ten years include the rising cost of care, regulatory changes, technological advances, professional education, and ethical dilemmas.

Although financial challenges top the list as the biggest concern among hospital CEOs, there are many challenges. Government mandates create new hurdles and complex payment plans, and there is uncertainty regarding future mandates and funding. In addition to driving the business, patient safety, quality, and patient satisfaction can have a significant impact on government reimbursements through the newly implemented value-based reimbursement system. Technology is playing a key role in healthcare with mandated investments in electronic medical records, as well as staying up to date on clinical technology (Appold, 2016). Population health is a major initiative that is challenging the traditional thinking of healthcare. It is defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can

also be other groups such as employees, ethnic groups, disabled persons, prisoners or any defined group" (Lewis, 2014, para. 7). In other words, the responsibility is expanding and moving from the treatment of disease to the management of health.

These trends lead to another challenge on the list, hospital reorganization. As hospitals attempt to meet the challenges of cutting costs, declining payments, and pressures to improve quality while expanding access and services, many are choosing to partner or merge with other systems. The expectation is the partnerships provide economies of scale and help hospitals expand their capabilities. In 2016, there were approximately 100 partnerships or mergers. The first quarter of 2017 saw an increase of 8% over 2016. This newer trend is not only representative of small independent hospitals merging with larger organizations but larger hospital systems merging or acquiring other larger hospital systems (MacDonald, 2017). Embedded in these challenges are internal and external stakeholder needs, which are often in conflict.

These challenges are particularly difficult considering the historic bureaucratic model and design of hospitals. Hospitals function under a top-down leadership structure where decisions are made at the top levels with strong control mechanisms in place (Hanson & Ford, 2010). However, there is instability at the top. According to ACHE (2018), the CEO turnover rate in healthcare has remained above 18% for the past 5 years ("Hospital CEO Turnover Rate 2017", 2018). Healthcare leaders are increasingly challenged to balance the healthcare needs of the community while maintaining the financial viability of the organization.

Business Models in the Acute Care Setting

In the acute care setting, there are typically three types of hospital ownership, government, nonprofit, or for-profit. Government-owned hospitals are owned and managed by either the local, state or federal government. A government hospital could include a facility owned and managed by the United States Department of Veterans Affairs. A nonprofit hospital differs from government or for-profit hospitals due to its obligation to invest all their excess income back into the organization to better serve the community. A for-profit hospital has private or public shareholders, and as a result, must distribute a portion of its profits back to the investors. This research focused on nonprofit and for-profit leadership styles; therefore, the literature review focuses on these two business models ("Daily Briefing Primer: What's the Difference", 2015).

There are similarities and differences between hospitals under the nonprofit business model and those under the for-profit business model. Similarities include the need to deliver high-quality care, a sustainable bottom line for investment and growth, and the need to create an environment where employees and physicians want to work, ideally as a team, to maintain strong operations. Many of the goals and challenges are the same in the nonprofit and for-profit healthcare environments (Chaney, 2016). One difference between the two models includes the distribution of profits, with for-profit entities returning a portion of the profits to shareholders, and nonprofits reinvesting profits into the organization. For-profits also can raise capital through investors; however**,** they must pay taxes. Nonprofits are exempt from paying taxes; however, they are required to submit an accounting of how they have benefited the community each year.

The estimated value of the annual tax exemption for not-for-profit hospitals is $12 billion ("Daily Briefing primer: What's the Difference", 2015).

A newer concept impacting businesses is the blurring of the lines between nonprofit and for-profit organizations. Dees and Anderson (2003) stated that as nonprofits strive to determine cost-effective ways to solve social issues, there is a greater focus on business practices, leading them to behave like for-profit entities. They identify four major types of sector-bending: imitation, interaction, intermingling, and industry creation. *Imitation* refers to incorporating the use of business strategies and tools into nonprofit organizations. Examples include the use of business terms such as *marketing* and *customers* as well as balanced scorecards and strategy frameworks. *Interaction* refers to the increase in interactions and relationships between nonprofits and for-profits as competitors as well as collaborators. *Intermingling* involves organizations that combine nonprofit and for-profit elements under an umbrella organization. *Industry creation* refers to nonprofits, for-profits, and hybrid organizations that may compete in the same industry by capitalizing on market forces to produce a social good. In healthcare, "research has shown that nonprofits appear to be slower than for-profits both to grow to meet demand and to contract in response to changes in the environment and declines in demand" (Dees & Anderson, 2003, p. 19).

While industry shifts are driving businesses to behave in similar ways, Chaney sums up the major differences between not-for-profit leaders and for-profit leaders in the application of their skills and focus. He believes the culture drives the decision-making, as both models need attention to the bottom line and a focus on service. "The culture at for-profits is business-driven. The culture at nonprofits is service-driven" (Chaney, 2016,

para. 4). According to Tarsik, Kassim, and Nasharudin (2014), culture is a large determinant of the role and behavior of a leader in an organization. In the absence of regulation, for-profit entities would have a stronger focus on the financial impact of decisions while nonprofits would have a stronger focus on service or the patient. An example of the difference is that it is more likely for a for-profit hospital entity to include monetary performance incentives within the executive compensation package. These are less likely to be seen in the nonprofit hospital compensation packages. However, the cultures may not be as different as some may suggest. The cultural difference may be more of a nuance than an extreme difference, yet the small nuances may still impact the organizational decisions in different and dramatic ways. In for-profit organizations, the economic pressures to please shareholders and the financial burden of paying taxes creates a need for strong operational discipline with a focus on structure, predictability, and accountability. In addition, while contracting for services, for-profits look for ways to leverage services while nonprofits look for partnerships (Chaney, 2016).

Another subtle difference is the nonprofit's focus on benefitting the community; therefore, they may offer a wider variety of services while for-profit organizations attempt to focus predominantly on profitable services (Masterson, 2017). This difference in culture and focus may impact leadership styles. The for-profit organization's focus on structure, predictability, and accountability, may lend itself to a transactional leadership style, in which the objectives are clear and pay incentives are aligned with meeting the objectives. The nonprofit organization's focus on benefitting the community may lend itself to a transformational style wherein the leader motivates the staff by articulating their personal values and beliefs encouraging their followers to commit to a vision that is

larger than themselves and one that benefits the community. Ultimately, the impact of these shifts in focus and operations on leadership style has not been widely examined.

The Function of Leadership in an Organization

According to Antonakis and House (2014), "an organization is a system that transforms human effort and physical resources into products or services" (p. 747). The leader's role is to accomplish the goals of the organization through its people, which requires interpersonal as well as strategic knowledge and skills (Antonakis & House, 2014). While there are many definitions of leadership, influence is a common theme. Hitt, Miller, and Colella (2015) defined leadership "as the process of providing general direction and influencing individuals or groups to achieve goals" (p. 244). Influencing individuals to achieve goals requires a vision, responding to internal and external environments, monitoring activities, and implementing solutions (Antonakis & House, 2014). Vroom and Jago (2007) stated that all leaders had at least one thing in common, someone was following them; without a follower, there is no leadership. Leaders must demonstrate behaviors that influence people to follow them; however, these behaviors may vary. How leaders influence others may be a result of culture, the business model, or their developed leadership skills.

Ulrich and Smallwood (2013) believed leadership impacts organizations in five important ways: building employee competence and contributions, shaping the organization's identity, creating and enhancing the customer experience, increasing investor value, and ensuring the organization is a good community citizen. The leader has the responsibility to utilize the organization's resources wisely, which requires sustained patterns of effective leadership behaviors (Ulrich & Smallwood, 2013). With the rapid

pace of change, coping and successfully leading through change is essential for leaders. Leaders who excel in times of change can motivate others while remaining positive and have effective problem-solving skills (Antonakis, 2001). “Frequently, the role of the leadership is largely determined by the culture of the organization” (Tarsik et al., 2014, p. 2). The culture drives behaviors and resource utilization and can be influenced by change.

According to Schein (2010), there is a direct correlation between leadership behavior and culture. Culture is made up of beliefs, values, and assumptions, which are largely influenced by the leader. The leader embeds mechanisms into the organization, which reinforce and form the way members of the organization think and behave. The primary embedding mechanisms include

- “What leaders pay attention to, measure, and control on a regular basis
- How leaders react to critical incidents and organizational crises
- How leaders allocate resources
- Deliberate role modeling, teaching, and coaching
- How leaders allocate rewards and status
- How leaders recruit, select, promote, and excommunicate” (Schein, 2010, p. 236).

During mergers or acquisitions, culture clashes are common, and leaders must understand the cultural dynamics and how the changes may impact the organization. The infusion of new ideas and assumptions along with the predominant leadership behaviors ultimately create a new culture. Whether the new culture is effective depends on the acceptance internally and the relationship to the environment, in which the organization functions.

When nonprofit and for-profit organizations merge, the style difference may impact the success of the organization. With leadership style having a significant impact on culture, one may expect the styles of internal leaders in different business models with different cultures to be different and perhaps ineffective in the new business model. Based on the cultural observations and differences in the nonprofit and for-profit business models, Chaney (2016) suggested for-profit organizations focus on structure, predictability, and accountability, which may necessitate transactional leadership. The nonprofit organizational focus on benefitting the community may lend itself to a transformational style; therefore, creating a culture clash when the organizations merge.

The Concern of Turnover in Healthcare

Turnover is a concern for all organizations. One current contributing factor may be the low unemployment rate, providing employees with more employment options. As of January 2019, the unemployment rate was 4% (Bureau of Labor Statistics, n.d.). According to the Work Institute's 2019 study on retention, it is estimated that by 2023, one in three workers will decide to voluntarily leave their jobs. The top four preventable reasons usually associated with employees leaving may be areas where managers can have a significant impact: job characteristics, work environment, career development, and work-life balance. Data from over 250,000 employees indicated that improved manager and supervisor behavior could have a significant impact on reducing turnover (Work Institute, 2019).

As the healthcare industry experiences significant change, pressure for cost efficiencies, and consolidation to obtain economies of scale, the impact on the employee experience can be significant. Overall, turnover in healthcare grew from 15.6% in 2010 to

20.6% in 2017, with the healthcare unemployment rate at 2.5%. This rate creates an environment where healthcare workers have many opportunities for employment, ultimately adding to the retention challenge (Rosenbaum, 2018). Wells (2018) obtained the 2015 statistics for acute care hospitals, indicating that the turnover rate was 18.2%. Turnover in for-profit acute care hospitals was 18%, nonprofit acute care turnover was at 18.3%, and government acute care hospitals had a turnover rate of 19%. The hospitals with the highest turnover rate (19.5%) had 350–500 beds. The estimated cost of turnover for a healthcare employee is $60,000 due to increased staffing costs, training, increased staff workloads, absenteeism, and accident rates. The current statistics suggest the average hospital has turned over 85.2% of its employees since 2013, creating a significant cost to the system (Wells, 2018). It is estimated that a 1% increase in turnover will cost the average hospital approximately $300,000. Many of the factors that lead people to seek other employment are related to manager behaviors, including workload assignments, lack of job role clarity, lack of career opportunities, and poor communication (Thompson, n.d.).

The turnover is not limited to the frontline contributor level or those serving in non-leadership roles. Many hospitals are dealing with leadership turnover as well. Two-year nonclinical administrative turnover is at 42.5%, and clinical administrative turnover is 47.4%. Over 5 years, turnover rates climbed to 66.9% for clinical administrators, and 66.3% for C-suite executives (White, 2017). According to the ACHE Hospital CEO Report, annual turnover at the chief executive officer has been steady at over 18% for the past 5 years, compared to the S&P 500 Index CEO turnover average of 10.8% (Cheng, 2018). CEO tenure has declined from a previous average of 10 to 15 years to an average

of 4 years today. Deborah Bowen, President and CEO of ACHE, suggests the changing hospital environment, as well as consolidations, play a significant role in the CEO turnover (QLK Team, 2016).

The leader's role is to accomplish organizational objectives through people. With turnover remaining a serious concern among acute care centers, an examination of the impact of leadership style may provide insight into retention strategies for managers. According to Asiri et al. (2016), both transformational and transactional leadership styles can impact the organizational commitment of nurses in the acute care setting. Using the MLQ and the three-component model of employee commitment, the study's findings suggest a positive association between a transformational leadership style and a nurse's desire to remain employed by an organization due to increased employee empowerment and participation in decision-making. Transactional leadership brought high levels of trust between the nurse and the nurse manager also leading to stronger organizational commitment. Rowold et al. (2014) posited transformational leadership was a stronger predictor for nonprofit organizations than in for-profit organizations; however, there has been limited research in this area.

Leadership Theory and Leadership Styles

There are many definitions of leadership, and it is believed to be the "most observed and least understood phenomena on earth" (Tarsik et al., 2014, p. 2). Leadership theories have evolved from the great man theory, trait leadership theories, behavioral approaches, contingency theories, and charismatic leadership to the most popular modern leadership theories of laissez-faire, transactional, transformational, and instrumental leadership. Studies on leadership have also included the leadership constructs of

consideration, initiating structure, and leader-member exchange (LMX). According to Day et al. (2014), transformational leadership has become the most recommended leadership approach. Anderson and Sun (2017) posited that many modern leadership styles overlap with transformational and transactional leadership and call for researchers to develop an integrated Full Range Leadership Model. Antonakis and House (2014) began to move theory in this direction; however, their research is still early. Therefore, based on the work of Bass and Avolio (2004), the modern leadership theories of transactional and transformational leadership using the current Full Range Leadership Model were the focus of this study. To be successful, a leader must understand how to apply the most effective leadership style to match the evolving situation (Tarsik et al., 2014). While this study focused on transactional and transformational leadership, an understanding of how leadership theories emerged and changed over time could provide insight into transactional and transformational leadership theories and their application today.

One of the first studied leadership theories was the great man theory. The great man leadership theory speculated that great men are the ones that had the most significant impact on history. It was through the actions of great men that society evolved and improved. According to the great man theory, reliance was on a man who was believed to born with special gifts or powers, which led to the success of the organization (Antonakis, 2001). This theory supports the concept that leaders are born and not made and those in leadership are deserving due to their special endowment, thus assuming not everyone can aspire to become a leader. It not only discounts the value of leadership training, but many of the characteristics were also considered masculine, discounting the

value and potential for female leaders. There has been a significant shift away from this type of thinking and the limitations imposed by the great man theory to more inclusive theories.

When many realized that a leader need not always be heroic and since the term *great man* was gender-specific, new leadership theories emerged, specifically the popularity of the trait leadership theory. The main theme of trait leadership theories included the belief that leaders were born with innate leadership traits. The theories attempted to identify traits that could be attributed to strong leadership. The criticism of this theory included a lack of methodology to determine the traits, and with no criteria to determine leadership traits the lists of traits grew so large that they became meaningless (Hitt, et al., 2015). While traits contributed to successful leadership, Bass (1990) argued that situations influenced leadership; therefore, leadership was a combination of leadership traits and the environment in, which they were applied. According to Antonakis (2001), leadership skills can be taught, adding a new dimension to leadership theory.

With the conflict over leadership trait theories, the behavioral leadership approach emerged. The behavioral leadership theories were founded on the belief that there is a correlation between supervisory behaviors, morale, and productivity. It proposed that leadership styles are either job centered with a focus on tasks to be completed or employee-centered and focused on interpersonal relationships (Hitt et al., 2015). Studies were conducted at the University of Michigan and Ohio State supporting this theory. However, Fleishman (1957) analyzed the behavioral leadership theories and felt the evidence demonstrated a strong influence of the work environment or situation on the

leadership style, marking a transition of leadership theory from behavioral leadership to a contingency approach (Antonakis, 2001).

With studies indicating the situation had a strong influence on leadership, contingency theories emerged with two of the theories becoming the most well-known. Fiedler's contingency theory of leadership effectiveness focused on the interaction of the leader's behavior and situational characteristics. The leader's behavior was either task-oriented or people-oriented, and their behavior may vary based on the leader's level of control over situations. Elements that contributed to the leader's control included leader-member relations, task structure, and position power. Critics of Fiedler's theory were concerned over the lack of flexibility. The theory posits that leaders demonstrate either one style or the other, and if a leader's style does not match the situation, the leader must be changed ("Fiedler's Contingency Model", n.d.).

The second most well-known contingency theory was introduced by Evans and House and is known as the path-goal theory (Hitt et al., 2015). Path-goal theory "suggest[s] that leader effectiveness depends on the degree to, which a leader enhances the performance expectancies and valences of her subordinates" (Hitt et al., 2015, p. 253). This theory differed from Fielder's theory in that it focused on enhancing performance by the manager's ability to tailor their behavior to the needs of the employees. However, empirical research on this theory has produced mixed results to support its effectiveness, the theory is quite complex with multiple interconnected hypotheses, and it does not address the need for the employees to participate in the leadership process (Alanazi, Khalaf, & Rasli, 2013).

Charismatic leadership is built on emotions and typically works well during stressful times. As cited by Antonakis (2001), Weber suggested charismatic leaders are often perceived as larger than life and they often break norms or tradition. House believed charismatic leaders have strong personal abilities, are willing to take risks, and are often challenging the status quo as they push for social change. They are admired by their followers, who gain a sense of belonging to a cause that is bigger than themselves. House's views on leadership theory had a significant influence on the modern theories of laisse-faire, transactional, and transformational leadership. According to Anderson and Sun (2017), the similarities between charismatic leadership and transformational leadership are great, and with such a convergence of theory, many studies and researchers have combined the two theories.

Bass and Avolio (2004) described the modern theories of laisse-faire, transactional, and transformational as a continuum of a full range of leadership, in which leaders may move along the continuum based on the need of the team and the situation as shown in Figure 1.

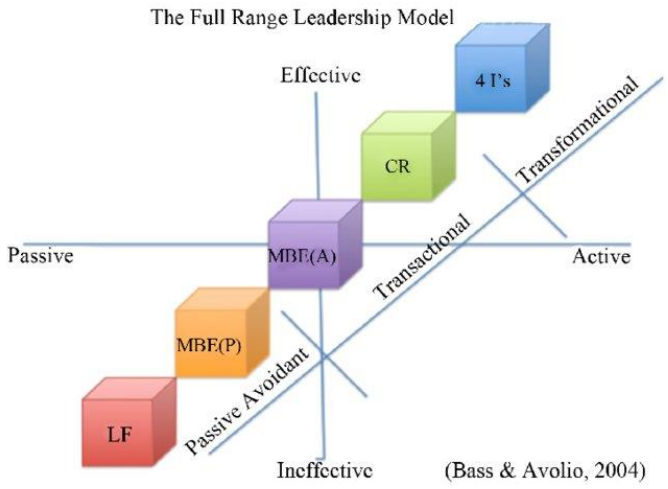

Figure 1. Full Range Leadership Model (Garcia, Duncan, Carmody-Bubb, & Ree, 2014)

The laissez-faire leadership style is characterized as exhibiting as little leadership as possible. Little or no direction is provided by the leader, giving employees the freedom to determine goals and make decisions for themselves. Problem-solving is done with little interaction or direction from the leader, and the leader agrees to the decisions of the employees. The style is effective when employees are highly skilled, have access to the expertise either through other team members or consultants, take pride in their work, have extensive experience, feel secure in their roles, and have the drive to be successful, and the leader is available to provide recognition. This style is not effective if the manager is utilizing it purely to cover up for their inadequacies. The disadvantages of this style include the potential for a more individualistic environment rather than a team environment, employees overstepping their boundaries if the parameters are not clear, and a possible lack of responsibility or accountability (Khan, Khan, Qureshi, Ismail, Rauf, Latif, & Tahir, 2015). With the healthcare industry in the midst of change and under increasing scrutiny to produce high-quality outcomes, the concern with the laissez-faire leadership style is that employees may lack personal and team role clarity, resulting in poor teamwork, low accountability, little recognition, and passive behavior.

Transactional leadership is focused on the leader-follower relationship. It is based on a series of exchanges or transactions to achieve results. The leader focuses on ensuring "the path to accomplishment of the objective is clearly understood by the people, to eradicate potential hindrance within the system and to inspire the people to achieve the scheduled goals" (Khan, Bukhari, & Channar, 2016, p. 1). Downton believed the "fulfillment of transactional obligations creates trust and a stable relationship where mutual benefits can be exchanged" (as cited in Antonakis, 2001, p. 51). Leaders who

demonstrate transactional leadership may have difficulty understanding the need for change and often continue with the same practices to accomplish a goal (Tarsik et al., 2014). Transactional leadership has three components: contingent reward, active management by exception, and passive management by exception. Contingent reward incorporates elements of the path-goal theory and is based on clear expectations of what needs to be accomplished. A reward is established for good performance, mutually agreed upon by the manager and the employees. The reward may be emotional or financial. Employees know the leader will tell them their expectations, provide the resources needed to complete the assignment, provide support, and promise a reward for completing the assignments. Contingent reward is most effective when working with talented people who understand the requirements of their job (Stafford, n.d.).

Active management by exception is focused on corrective action, in which the manager's time is spent looking for mistakes to be corrected and the focus is on compliance with the rules to avoid mistakes. In passive management by exception, managers wait for errors to be serious before acting. Their employees may view them as not focused on continual improvement, but rather as only responding to challenges or problems when they become serious (Boyett, 2006). Management by exception can be effective when employees have the ability to deliver the required results (Stafford, n.d.). In summary, transactional leaders focus on what needs to be done (Antonakis, 2001). The positive elements of the transactional style may be effective in for-profit organizations where there is a need for structure, predictability, and accountability. However, with its focus on transactions and rewards instead of intrinsic motivational elements, it may not be effective in the nonprofit hospital setting.

Transformational leaders motivate people through their values and beliefs, moving employees from a security and affiliation alignment to fulfilling the employees' needs for recognition, achievement, and self-actualization (Antonakis, 2001). Their focus is on ensuring the followers have a clear understanding of the "why" related to the tasks, using their charisma to encourage followers to commit to a vision that is larger than themselves. They have high expectations, which provides a sense of challenge and meaning to their followers' work (Khan et al., 2016). Transformational leadership has four components: idealized influence or charisma, inspirational motivation, individualized consideration, and intellectual stimulation. Idealized influence is demonstrated through confidence, competence and a commitment to achieving an important goal that aligns with their values and a strong purpose. A leader's charisma compels followers to join their mission and be proud of the leader and their purpose.

Charismatic leaders make followers feel good about their contributions and create a feeling of belonging to something special. Inspirational motivation is the ability to inspire others through the articulation of a future goal or vision that can be achieved. Individual consideration is a focus on providing development and encouraging creativity in followers, which can be done through effective delegation of important tasks while coaching and developing the followers. Intellectual stimulation comes from behaviors such as encouraging challenging the status quo, questioning assumptions, creating new ideas, and finding new ways to address problems and taking risks. In essence, the leader prepares their followers for future success by developing the followers' problem-solving skills (Boyett, 2006).

Previously it was noted that a leader's behavior is dependent on the leader's personality, the environment, and their followers. Transformational leaders often emerge during difficult times or times of significant change. The impact of transformational leaders is evident in their employees and the organization. Their behaviors are copied by their employees, which in turn become ingrained in the organizational culture (Antonakis, 2001). A benefit of transformational leadership is that it inspires people to do the right thing and encourages followers to create new ideas and apply them for the betterment of others while encouraging meaningful work, thus providing a good fit in the nonprofit hospital setting. However, transformational leadership may be too vague and provide too much decision-making authority for someone who needs strong direction and structure and may contribute to a lack of structure and consistency, which would not work as well in the for-profit hospital setting.

Previous research suggested that transformational leadership is most effective when transactional factors are included (Antonakis, 2001). Antonakis and House (2014) suggested the well-accepted transactional and transformational leadership styles were incomplete because they neglected the need for leaders to understand the external and internal markets as well as their competitors and market opportunities. As a result, they introduced instrumental leadership to expand on these styles. Activities such as formulating strategies, monitoring progress towards goals, and helping employees achieve their goals are not addressed in the transactional or transformational models; therefore, they were added to the instrumental leadership model. Instrumental leadership focused on strategic leadership and follower work facilitation (Antonakis & House, 2014).

Breaking it down further, strategic leadership includes environmental monitoring, strategy formulation, and strategy implementation. Environmental monitoring focuses on "scanning internal and external environments (e.g. markets, competitors) in order to (a) identify opportunities for growth and development and (b) provide adequate working conditions (e.g. resources) for their followers" (Rowold, 2014, p. 370). Strategy formulation and implementation include creating policies and sub-strategies (Rowold, 2014).

Follower work facilitation comprises path-goal facilitation and outcome monitoring. Path-goal facilitation focuses on providing the cognitive and practical support followers need to reach their goals. Leaders assist followers in understanding the path to their goals, however without including rewards or punishment. Outcome monitoring provides followers "with timely, instrumental feedback that is exclusively (a) relevant for the current task (e.g. 'How can mistakes be avoided?') and (b) constructive" (Rowold, 2014, p. 371). This method differs from contingent reward in that instead of the feedback being provided after the goal is complete, feedback is provided during the work process (Rowold, 2014).

Instrumental leadership is different from transactional and transformational in that the leader does not "engage follower's ideals, inspire, intellectually stimulate or pay attention to individual needs. Strategic leadership is not about having a transactional relation" (Antonakis & House, 2014, p. 750). Strategic leadership encompasses knowing the organization and its capabilities and designing strategies to meet those goals. Strategic leaders satisfy their team by using methods that provide satisfaction to them and are seen as effective in accomplishing organizational goals (Antonakis & House, 2014).

While this is an interesting theory, there is little research to validate its impact and there are no known instruments for assessment; therefore, it falls outside the parameters of this study.

With the current healthcare climate experiencing massive change and hospital systems experiencing growth through acquisitions and mergers, it is beneficial to determine which leadership style may be most prevalent. After examining multiple leadership styles, this study focused on transactional and transformational leadership. Transactional and transformational leadership has been found in nonprofit and for-profit organizations. During periods of growth, organizations often standardize procedures and enlist staff who will help with the adherence to processes, which may create an environment where transactional leadership, leadership that offers a benefit for meeting defined expectations, is often most effective. However, healthcare is experiencing rapid change with a focus on re-engineering and is navigating unchartered waters. Research suggests that during rapid change it is important to focus on individuals, groups, and organizations in which transformational leadership is most effective (Bass & Avolio, 2004).

With multiple leadership theories and a great variation in organizational cultures, business models, and industries, research on how leadership style impacts turnover would be beneficial. While there is a plethora of research on leadership styles, there is limited research on, which style may be most prevalent in different industries, including healthcare, and business models.

Size and Other Factors That Determine Leadership Style

Several factors influence the most appropriate leadership style in an organization. One consideration is the size of the organization, which may impact the relationship between the manager and their employees. Marx (2017) found a correlation between the size of the organization and the role of leadership. His study indicated larger companies place less emphasis on engaging and interacting with followers, were more risk-averse, and demonstrated more emphasis on leadership that was aligned with the organization's culture and strategy.

The degree of interaction and communication between employees and their managers also plays a role. Additional factors include the personality of the employees and other leaders in the organization, goal congruency, and the level of decision-making at the leadership level. For example, in organizations utilizing a more centralized decision-making model, there is less input from employees, which impacts the leadership style (Amanchukwu, Stanley, & Ololube, 2015).

Studies on Leadership Styles

Rowold et al. (2014) completed quantitative research to identify, which leadership theories are more important in for-profit and nonprofit organizations. Their research added to previous research that focused on only one business sector, either nonprofit or for-profit. They conducted their study in Germany with data collected from for-profit industries, including retail, insurance companies, and banks. The nonprofit entities included predominantly volunteer fire departments, church administrators, and unpaid musicians. Nine measurement instruments were utilized to determine the relative importance of six leadership theories to the effectiveness in for-profit and nonprofit

sectors: transformational, transactional, laissez-faire, consideration, initiating structure, and leader-member exchange (LMX). They compared the leadership theories to job satisfaction, affective commitment, and perceived job performance. The researchers posited that no single leadership theory could predict all the criteria of job satisfaction, affective commitment, and perceived job performance. LMX theory had the greatest impact on job satisfaction in both sectors. Transformational leadership influenced affective commitment; however, the effect differed between the for-profit and nonprofit sectors. In the for-profit sector, money was an important value; while in the nonprofit sector, the values were related to the organization's effectiveness. Consideration emerged as a predictor for job satisfaction in the for-profit sector, and transformational leadership was more important for job satisfaction in the nonprofit sector. Overall, Rowold et al. found transformational leadership to be the best predictor of leadership effectiveness in the nonprofit sector. Consideration was more important overall in the for-profit sector. However, the researchers believed no single leadership construct or theory could fully explain the variance in their results, and more research was needed in the nonprofit sector in the areas of LMX, transformational leadership and initiating structure.

Khan et al. (2016) evaluated the effects of leadership styles on performance in a tertiary care hospital in Pakistan. Their study included 30 leaders from three large healthcare organizations in Karachi. While 70% of the Pakistani population is cared for by the private sector, it is not clear if the healthcare organizations in the study were government, private, or nonprofit (Kumar & Bano, 2017). Data were collected using the MLQ containing nine leadership characteristics: idealized influence attributes, idealized influence behaviors, inspirational motivation, intellectual stimulation, individual

consideration, contingent reward, active management-by-exception, passive management-by-exception, and laissez-faire (Fiery, 2008). The dependent variables were outcomes, extra effort, effectiveness, and satisfaction, and the independent variables were transformational leadership style and transactional leadership style. The healthcare organizations were selected through stratified random sampling and participants were selected by random selection. The healthcare organizations were all tertiary care organizations. The results indicated the transactional leadership style had the greatest positive effect on the organizations and inspirational motivation had a negative impact on performance. The researchers suggested the composition of predominantly professional employees who may be motivated by reward, recognition, and management by exception, maybe a possible reason for the results.

Fiery (2008) conducted a quantitative study examining the link between culture and contexts, and transformational leadership in the healthcare industry. The MLQ 5x-short form, a Likert-style survey, was utilized to gather data from a sample of leaders in two multiple-hospital systems in northwest Virginia. Fiery concluded that the leaders in the two hospitals surveyed did not utilize transformational leadership. In a previous study, transformational behaviors were often utilized by nursing administrators and had a significant impact on lowering staff nurse turnover (Kleinman, 2004). “The results in this study countered the findings in previous studies where transformational leadership was found to be effective in hospitals” (Fiery, 2008, p. 116). With healthcare in a constant state of change and based on the research results, Fiery recommended expanding the research to additional healthcare organizations with consideration given to utilizing

quantitative and qualitative methods to determine, which style is most common and its impact on productivity.

Sow, Murphy, and Osuoha (2017) studied the relationship between leadership style, organizational culture, and job satisfaction in the US healthcare industry. This study sampled 111 individuals in 17 medical sites in the United States. Using the MLQ, the Work-Related Basic Need Satisfaction Scale, and Quinn and Rohrbaugh's competing values framework, they obtained employee perspectives on leadership style, job satisfaction, and organizational culture. The findings varied from previous studies in some areas. Transformational leadership appeared to increase employee satisfaction; however, it was most effective in organizations with an internally focused culture. They recommended additional research on how transformational leadership may impact different types of employees such as more experienced or resilient employees.

Another study in Saudi Arabia considered the relationship between leadership style, psychological empowerment, and organizational commitment. Asiri et al. (2016) collected 332 questionnaires from fulltime nursing staff at a government hospital. Their findings suggest nurse managers tend to focus more on transactional behaviors, such as "compliance and task completion, emphasize assignments, work standards, and task-oriented behaviors, and depend more on organizational punishments and rewards to influence nurses' performance" (pp. 6–7), which lays the foundation for evolving to transformational leadership. Overall, they found that transformational leadership led to high levels of trust due to empowerment and the tendency to delegate authority and autonomy, which led to increased employee commitment. The implications of the study included encouraging managers to focus on increasing participation in decision-making

and empowerment, to enhance the work environment, which should result in increased retention, job satisfaction, and work commitment.

Marx (2017) studied the impact of organizational size on leadership in for-profit manufacturing companies. In the study, sales were utilized to measure the organizational size and the majority of the participants worked in large organizations. Additionally, 85% of the participants had over 5 years of leadership experience. Marx found while leadership effectiveness did not necessarily vary with size, the leadership role did. Effectiveness was determined more by the leadership alignment with the "organization's strategy, policies, practices, procedures, and culture than on any particular leadership skill, trait, or style" (Marx, 2017, p. 87). Marx suggested that as an organization grows, the hierarchy becomes more rigid, and policies and procedures become more standardized, thus lessening the need for as much focus on employee engagement and interaction. With newer leadership styles, such as transformational leadership, being based on employee engagement, Marx suggested a further study on the impact of leadership styles at organizations of different sizes.

Chapter III

RESEARCH DESIGN AND METHODOLOGY

Overview

With inconclusive research to date regarding leadership styles in the healthcare industry, the purpose of this quantitative study was to analyze leadership styles in multiple for-profit and nonprofit acute care hospital organizations. Previous studies have rendered inconclusive or conflicting results regarding the most effective styles and several of the studies reviewed were conducted more than 10 years ago. The healthcare environment is changing rapidly, and these changes may well impact leadership styles. This study intended to determine if there was a difference in the predominant styles (transformational or transactional), based on the business model. Many elements may impact leadership style; however, this research collected self-reported demographics and turnover data to identify additional possible correlations to determine whether there is a relationship between business model, leadership style, size, and turnover.

Research Design

A mixed methods research design was utilized for this nonexperimental research study. The focus of the study was to combine statistical trends with information gathered through interviews to gain a better understanding of the research (Creswell 2015). Also, correlations were utilized for determining relationships between leadership style, turnover, and organizational size. Correlations are most appropriate when the researcher is attempting to assess if there is a relationship between variables and the variables cannot

be manipulated (Price, Jhangiani, & Chiang, 2015). This study assessed whether there is a statistical relationship between the leadership styles (using transactional and transformational leadership as the fundamental theories) in for-profit and nonprofit acute care centers and if there is a statistical relationship to turnover, based on the hospital business model. Also, the survey assessed whether the size of the organization impacted leadership styles.

To assess if there is a relationship between leadership style, business model, organization size, and turnover, hospital executives in for-profit and nonprofit acute care settings were surveyed utilizing the MLQ 5x to determine their leadership style tendencies. Demographic information such as organization size and turnover were self-reported along with the business model in which the leader functions. Data were utilized to answer the following research questions:

1. Is there a common leadership style of acute care hospital executives functioning in the nonprofit business model?
    - $H1_O$: In a comparison of hospital executives from nonprofit acute care centers, no common leadership style will emerge.
    - $H1_{A:}$ In a comparison of hospital executives from nonprofit acute care centers, transformational leadership is the common leadership style that will emerge.
2. What are the common leadership styles of acute care hospital executives functioning in the for-profit business model?
    - $H2_O$: In a comparison of hospital executives from for-profit acute care centers, no common leadership styles will emerge.

- $H2_{A:}$ In a comparison of hospital executives from for-profit acute care centers, transactional leadership styles will emerge.

3. Does leadership style impact staff turnover?
    - $H3_{O:}$ There is no statistically significant relationship difference between either the transformational leadership style and staff turnover and transactional leadership style and staff turnover.
    - $H3_{A}$: There is a statistically significant relationship difference between transformational leadership style and staff turnover and transactional leadership style and staff turnover.
4. Does the size of the hospital system impact leadership style?
    - H4o: In a comparison of hospital executives from small and large hospital systems, there is no statistically significant relationship between system size and transactional leadership style.
    - $H4_{A}$: In comparison to hospital executives from small and large hospital systems, there is a statistically significant positive relationship between system size and the transactional leadership style.

To obtain the most comprehensive data for analysis, a mixed-method approach was utilized. Creswell (2015) defined mixed method research as

> an approach to research in the social, behavioral, and health sciences in, which the investigator gathers both quantitative (closed-ended) and qualitative (open-ended) data, integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems. (p.2)

Creswell explained that there are three mixed methods designs: convergent design, explanatory sequential design, and exploratory sequential design. An explanatory sequential design, in which quantitative methods are utilized followed by qualitative methods to explain the data, was used in this study. Initially, a survey was sent to executives at the manager, director, vice president, and chief executive officer levels in small, medium, and large multisystem acute care settings. Once the surveys were received and trends were identified, open-ended interviews were conducted with executives to learn more about their personal experiences in each business model. Executives who have transitioned from nonprofit to for-profit business models were included in the open-ended survey discussions. The result was a more comprehensive understanding of the research problem. Although many elements may impact leadership style, this study was limited to analyzing transactional and transformational leadership behaviors in nonprofit and for-profit acute care centers and the relationship to staff turnover.

Design and Variables

The research questions were examined utilizing a nonexperimental mixed methods research study. In some areas, correlational research was conducted. Correlational research seeks to determine if there is a statistical relationship between variables without trying to control the variables (Price, et al., 2015). The dependent variables were the leadership style of the leader, characterized as transactional or transformational leadership and measured by the MLQ (5x) and turnover. The independent variables were the business model and size.

The business model independent variables were self-reported and were examined to determine if there is a relationship between leadership styles within nonprofit and for-profit business models. The turnover dependent variable was examined to determine if there is a correlation between actual turnover, the business model, and leadership style. To determine if size impacts the leadership style, the size was an independent variable.

Initial Data Source

Antonakis and House (2014) suggested most contemporary theories include transformational, transactional, and laissez-faire leadership styles. According to Day et al. (2014), transformational leadership has become the most recommended leadership approach. This research analyzed the prevalence of transformational, transactional, and laissez-faire leadership tendencies in the acute care hospital setting. Transformational leadership attempts to motivate followers by providing a greater understanding of what is right and important. Transactional leadership relies on contingent reinforcement whereas laissez-faire leadership is commonly described as non-leadership. Laissez-faire leaders are reluctant to provide direction, clarify expectations, or make decisions. The most widely utilized validated tool for research on transformational, transactional, and laissez-faire leadership is the MLQ using a Likert scale. A Likert scale is a method that can be utilized to rate people's attitudes and typically utilizes a 5- or 7-point scale. Likert scales imply a person's attitude is linear and assumes it can be measured. Strengths of a Likert scale include the ability to quantify responses and allow for several degrees of opinions that can be quantified. A limitation of a Likert scale is that people may respond more positively to put themselves in the best light (McLeod, 2019). The survey utilized a 5-point scale with the following response choices: (1) not at all, (2) once in a while, (3)

sometimes, (4) fairly often, and (5) frequently if not always. The MLQ (5x) has 45 items related to nine leadership factors.

> Five scales were identified as characteristic of transformational leadership (idealized influence attributes and behavior, inspirational motivation, individual consideration, and intellectual stimulation). Three scales were defined as characteristic of transactional leadership (contingent reward, management-by exception-active, and management-by-exception-passive). One scale was described as non-leadership (laissez-faire). (Muenjohn & Armstrong, 2008, p. 5)

The MLQ includes 20 questions related to transformational leadership, eight questions related to transformational leadership and eight questions related to passive avoidance, which included laissez-faire. Nine additional questions were asked related to the participant's self-assessment of their extra effort, effectiveness, and satisfaction. The following are the three leadership styles (transformational, transactional, and passive avoidant) and the leadership characteristics related to each style that were assessed in the survey. Transformational leadership consisted of five subcategories to include idealized attributes (IA), idealized behaviors (IB), inspirational motivation (IM), intellectual stimulation (IS), and individual consideration (IC). IA behaviors build trust, inspire pride, and focuses the team on the overall interest of the group. IB assesses the leader’s behavior related to integrity and includes values, beliefs, overall vision, and the moral and ethical consequences of their behavior. IM behaviors provide meaning and challenge to their team’s work and focus on a better future. IS behaviors focus on stimulating innovation, encouraging new and creative ideas, and there is no ridicule for mistakes. IC behaviors focus on building the skills of the individuals on the team through new learning

environments and learning opportunities. Transactional behaviors included contingent reward (CR) and management-by-exception: active (MBEA). CR behaviors focus on setting clear expectations and rewarding achievement. MBEA behaviors include clear standards for performance and monitor performance closely to identify errors and take corrective action quickly. Passive avoidant characteristics include management-by-exception: passive (MBEP) and laissez-faire (LF). MBEP leadership behaviors include waiting on a problem to appear then taking punitive corrective action. LF behaviors can be described as non-leadership. They don't provide expectations, monitor performance, or accept leadership responsibilities (Bass & Avolio, 2004).

The survey was developed by Avolio and Bass (1995). Mind Garden Inc. has exclusive rights to the survey and approved sharing three sample survey questions. Below are a few sample items that were included in the survey:

"As a leader. . .

I talk optimistically about the future.

I spend time teaching and coaching.

I avoid making decisions." (Avolio & Bass, 1995)

The Full Range Leadership Model suggests every leader displays some level of behavior in each leadership style. The relationship of each style to the leader's effectiveness and activity level is shown in Figure 2. The optimal leadership behavioral profile shows a continuum of behavior beginning with infrequent use of the passive avoidant behaviors while increasing the use of transactional behaviors, and with the most frequently utilized behaviors being associated with the transformational style (Bass & Avolio, 2015).

Figure 2: Full Range Leadership Model: Effectiveness and Activity

The most valuable assessment would include feedback from peers and direct reports or subordinates. Due to the difficulty in gaining access to subordinates, peers, and others who may work with the healthcare leader, I utilized the self-rater portion of the MLQ 5x. The self-rater tool included asking for information only from the healthcare leader directly; therefore, the information analyzed for this research was based on the participant's self-perception.

Although some may question the validity of a self-assessment, validation research conducted by Muenjohn and Armstrong provides confidence that the MLQ 5x survey is effective in measuring transformation, transactional, and laissez-faire leadership (Muenjohn & Armstrong, 2008). The validation results are below. Mind Garden, the owner of the copyright to the MLQ surveys, suggests the survey is designed to provide insight into whether a leader or group of leaders are more or less transformational than the norm as opposed to determining and labeling a leader as transformational.

Table 3

MLQ-5x 2004 Reliability Score for "Self"

Scale	Reliability
Transformational Leadership	
Idealized Influence: Attributed	0.70
Idealized Influence: Behaviors	0.64
Inspirational Motivation	0.76
Intellectual Stimulation	0.64
Individualized Consideration	0.62
Transactional Leadership	
Contingent Reward	0.60
Management by Exception: Active	0.75
Passive/Avoidant	
Management by Exception: Passive	0.64
Laissez-Faire	0.60

Bass & Avolio (2004)

Mind Garden has proprietary rights to the MLQ survey. Multiple administration options are available through Mind Garden including paper administration, online administration by the researcher, and online administration by Mind Garden. For this research, permission was granted by Mind Garden, Inc. (Appendix A) for the survey to be administered by the researcher utilizing Qualtrix on the Valdosta State University website. A link was provided to be used anonymously by the participants with no registration or login information collected. This process led to the greatest potential for anonymity.

Although industry turnover rates are available, turnover rates for individual acute care centers are difficult to obtain by an independent source; therefore, I relied on turnover self-reported by the leader. Annual turnover rates for the total acute care center were requested. The size of the organization was collected through the demographic information provided by the survey participant.

Participant Selection and Sample Size

Although having subordinates provide feedback on their leader's style may be most enlightening, access to a broad range of potential participants is limited to the researcher; therefore, the research relied on self-reported data from healthcare executives. Identifying executive leaders in the healthcare setting proved to be a challenge. In some situations, the name of the CEO was available, and some contact information was available. No list of vice presidents or directors was easily available, and a listing may be impossible to create; therefore, I implemented snowball sampling. Snowball sampling is "based on a referral approach where a small number of individuals with specific characteristics recruit others with these characteristics from their networks or community" (Valerio et al. 2016, p. 3). I sent an invitation to participate (Appendix B) by email to CEOs, vice presidents, directors, and managers I knew in for-profit settings to include Hospital Corporation of America (HCA), which includes over 185 hospitals ("HCA at a Glance", n.d.), and Tenet Healthcare, which includes 65 hospitals (Our Story, n.d.), with a request to distribute the survey link to additional vice presidents and directors within their organizations. I sent emails to CEOs, vice presidents, directors, and managers in the nonprofit healthcare systems to include systems such as Novant Health, WellStar Health System, Greenville Health System, and Atrium Health, with a request to distribute the survey link to additional vice presidents and directors within their organization. I sent emails to CEOs, vice presidents, directors, and managers in smaller stand-alone acute care centers or small hospital organizations with fewer than six hospitals in the system, such as St. Josephs/Candler in Savannah, with a request to distribute the survey link to additional vice presidents and directors within their

organizations. Consent forms (Appendix C) were included in the first page of the survey. I sent an email requesting participation in the research study to all identified leaders in stand-alone, small, medium and large multisystem hospital organizations. Stand-alone hospitals were defined as one hospital. Small systems were made of two to five hospitals. Medium hospital organizations were defined as six to 10 hospitals and large multisystem hospitals were defined as more than 11 hospitals in the system.

Using the snowball sampling methodology, the targeted sample size of the survey was 66 completed surveys consisting of responses from a combination of for-profit executives, nonprofit executives, small acute care center executives, and executives who have operated in both nonprofit and for-profit acute care centers. The average response rate for an email survey is 24.8% (Response Rate Statistics, 2014). The researcher has 267 known contacts matching the target survey demographic. Using 24.8% as a guide, the survey response was estimated to result in 66 completed surveys. Ultimately, 146 leaders responded representing a 54% response rate; however, after deleting incomplete surveys, 111 surveys were completed, representing a 41.6% response rate.

The survey collected information including the business model, organizational size, management level, if their organization had experienced a merger, time in a leadership role within the current business model, number of employees supervised, and the voluntary turnover rate in the organization. Participants were asked if they previously worked in a different business model and if so, additional information was requested such as how long they worked in a nonprofit setting and how long they worked in a for-profit setting. After the surveys were completed, the results were analyzed using the SPSS data analysis program. The minimum, maximum, mean, and standard deviation were

calculated. A one-way ANOVA analysis was conducted to test the statistical relationship between the dependent and independent variables. Correlations were investigated using the Pearson product-moment correlation coefficient (r) and the Spearman Rank Order Correlation (rho).

Secondary Data Source

To clarify the research results, I sent an invitation to be interviewed (Appendix D) and conducted follow-up interviews with executives with experience in the for-profit, the nonprofit, and both types of acute care settings. The goal was to better understand leadership styles in both settings and the impact on staff turnover. I created the follow-up survey questions using the interview protocol refinement (IPR) framework to strengthen the reliability of the interview protocols. The IPR framework consists of four phases: "(1) ensuring interview questions align with research questions, (2) constructing an inquiry-based conversation, (3) receiving feedback on interview protocols, and (4) piloting the interview protocol" (Castillo-Montoya, 2016, p. 811).

At the beginning of each interview, participants confirmed they had read and agreed to the informed consent statement that was emailed to them in advance. A copy of the informed consent is included as Appendix E and the interview guide is included in Appendix F. The interviews were audio-recorded and transcribed for analysis. Once transcribed, the audio recordings were destroyed. Responses were coded using the elements that impacted leadership styles and leadership behaviors. Once coded, the data were analyzed to identify themes that provide additional insight into leadership styles and assist with the interpretation of the survey responses. Through analysis of the interview

data, the following categories emerged: organizational culture, decision-making, people management, accountability, leadership success, size, and advice to healthcare leaders.

For executives who voluntarily agreed to an interview, their responses and contact information were maintained as outlined below:

- Participants' contact information and any other identifiable information were maintained separately from the responses.
- Participants were coded using a unique identifier based on the time and date of the interview. Ex: if the interview was conducted on December 1 at 9:00 am, the identifier was 12.01.19.9.00am.
- Participants' names and contact information were not available to anyone other than the researcher.
- The participants' names and contact information will be held for three years after the successful defense and completion of the final dissertation.

The Institutional Review Board (IRB) for Valdosta State University determined this research protocol was exempt from IRB oversight under Exemption Category 2, which encompasses research that only includes interactions involving educational tests, survey procedures, interview procedures, or observation of public behavior (Appendix G). There were no known risks to the participants.

Limitations of the Research

This research will add to the body of knowledge and could lay a foundation for further research on leadership styles in acute care healthcare settings. However, there are limitations to this study related to access to leaders, survey size, and turnover data. According to the American Hospital Association, the 2019 updated total number of

hospitals in America is 6,210 (Fast Facts on US Hospitals, 2019). Due to limited access to executives and resource constraints, this research only assessed a small sampling of hospital leaders. The data is self-reported due to the difficulty of obtaining 360-degree feedback and regional data were not included in the study. Time demands on healthcare leaders limited access to many leaders for the interviews. Currently, there is no known method of obtaining turnover rates by hospital or department making it necessary to rely on self-reported data from survey participants. Using this method to obtain data provides a risk to validity.

Chapter IV

RESULTS

To gain a comprehensive look at the research questions, this study is composed of quantitative data gained through the MLQ 5x survey and qualitative data gained through individual interviews with healthcare leaders in manager, director, executive director, vice president, and CEO roles. This chapter provides the results from both methods of data gathering as well as the statistical testing that was conducted.

Summary of Respondent Demographics

Survey requests were sent to 269 CEOs, presidents, vice presidents, executive directors, directors, managers, compliance officers, ethics officers, safety officers, hospital or system based attorneys, and consultants in healthcare who are currently serving in a leadership capacity (or have peers who are that are eligible to participate in the survey) who were known to the researcher. The initial response was 146 representing a response rate of 54%. However, after removing the incomplete surveys, 111 responses were maintained for analysis, representing a 41% response rate for analysis. Respondents consisted of hospital leaders at various levels of the organization with years of healthcare experience spanning from 7 months to over 16 years. Respondents represented both the nonprofit and the for-profit business model and included stand-alone hospitals and systems of multiples sizes. As shown in Table 4, the largest response came from healthcare systems with more than 11 hospitals, which represented 43% of the responses, followed by small systems with 24.3%, and stand-alone hospitals with 23.4%. Over 60%

of the respondents worked in systems with over 10,000 employees (Appendix H). The prevalence of mergers and acquisitions in the healthcare industry was evident with 54% of the respondents, indicating they have been through a merger or acquisition, which included 33%, indicating the merger had occurred within the past 2 years.

Table 4

Hospital Responses

	Frequency	Percentage	Cumulative Percentage
Stand Alone 1 Hospital	26	23.4	23.4
Small 2–5	27	24.3	47.7
Medium 6–10	10	9.0	56.8
More than 11	48	43.2	100.0
Total	111	100.0	

Leadership demographics varied, with women representing 66% of the participants and men representing 34%. The largest categories of leadership roles were directors at 28.8% and managers at 22.5%, representing 51% of the respondents, as demonstrated in Table 5. Those with the title of president or CEO had the lowest participation with 6.3%. Over 80% of the respondents had 16 years or more of experience in healthcare, and 44% had more than 15 years of experience in leadership roles at a manager level or higher, as demonstrated by Table 6. Half of the respondents directly supervised 50 employees or fewer, and 29% directly supervised 51 to 200 employees; 79% of the participants supervised 200 or fewer employees (Appendix I).

Table 5

Current Position

	Frequency	Percentage
President or CEO	7	6.3
Vice President	19	17.1

Executive Director	15	13.5
Director	32	28.8
Manager	25	22.5
Other	13	11.7
Total	111	100.0

Table 6

Experience as a Leader in Healthcare

	Frequency	Percentage	Cumulative Percentage
0 – 5 years	19	17.1	17.1
6 - 10 years	23	20.7	37.8
11- 15 years	18	16.2	54.1
More than 15 years	49	44.1	98.2
I am not in a leadership role	2	1.8	100.0
Total	111	100.0	

Analyzing the experience in different business models, 43% had experience only in the nonprofit business model, 4% had experience only in the for-profit business model, and 53% had experience in both models. Of the respondents with experience in both business models, 58% currently work in the nonprofit model and 42% currently work in the for-profit model. Regarding the transitions, 56% started in the nonprofit model then moved to the for-profit model, 14% moved from the for-profit model to the nonprofit model, and 30% transitioned between both sectors more than once. Of the participants in the nonprofit sector who transitioned to the for-profit sector, 53% had an average of 15 years or more of experience in the nonprofit sector, whereas only 12% of those in the for-profit sector had more than 15 years of experience before transitioning. Regarding the number of employees supervised, 47% of the nonprofit leaders supervised fewer than 50 employees, 80% of the for-profit leaders supervised fewer than 50 employees, and 52% of those with experience in both sectors supervised less than 50 employees.

Leadership Survey Results

The respondents completed the MLQ (5x) survey designed to assess the self-reported tendencies in three of the leadership categories: transformational, transactional, and passive avoidance. In addition, the survey considered the respondents' perception of their desire to demonstrate extra effort, their personal effectiveness, and their personal satisfaction.

Business Model and Leadership Styles

Table 7 describes the overall self-reported leadership tendencies using means in each major leadership category and broken down by business model with a comparison to the overall survey mean. Regarding transformational leadership, the nonprofit leaders rated themselves as 4.22, which is lower than each of the other two groups and .04 lower than the survey mean of 4.26. Leaders in the for-profit sector rated themselves the highest with a mean of 4.43, which is .17 higher than the survey mean. Leaders with experience in both sectors scored 4.28, which is .02 higher than the survey mean. Similar trends were found in the transactional leadership tendencies, with the nonprofit leaders scoring themselves the lowest with a mean of 3.20 compared to the survey mean of 3.26, the for-profit leaders scored themselves at 3.60, which is .34 points higher than the survey mean. Leaders in both sectors scored right at the survey mean of 3.26. The trend continued in the passive avoidant tendencies with the nonprofit leaders scoring a 1.49, which is .08 lower than the survey mean of 1.57, those in the for-profit industry scored themselves at 2.05, which is .48 higher than the survey mean, and the leaders with experience in both sectors scored 1.59, which is .02 or only slightly higher than the mean.

To summarize, the nonprofit respondents scored themselves lower than the survey mean in every leadership style whereas the for-profit leaders who responded scored themselves higher than the survey mean. The leaders with experience in both sectors scored near or slightly above the survey mean in every category. A note of caution, the response of leaders with experience only in the for-profit sector was quite low with only five respondents out of 111 total respondents completing the survey. This representation makes sense due to the for-profit hospitals acquiring many of the nonprofit hospitals and the nonprofit leadership making a transition to the for-profit sector; however, it may skew the data.

A one-way between-groups analysis of variance was conducted to explore the impact of the business model on the leadership. For transformational leadership, the ANOVA test produced a significance score of .453, indicating the differences were not significant at the $p < .05$ level. The transactional leadership behavior score was .150, again, indicating the differences were not significant at the < .05 level. However, for passive avoidance behaviors, the score was .013, indicating the differences are significant at the $p < .05$. To summarize, the differences in the transformational leadership and transactional leadership scores were insignificant; however, the differences in the passive avoidance scores were significant.

Table 7

The Breakdown for the Nonprofit and For-Profit Leadership Tendencies

Do you have experience in nonprofit healthcare hospitals or for-profit healthcare hospitals?	*n*	Minimum	Maximum	Mean	*SD*
Totals Transformational	106	3.30	5.00	4.26	.395

Total Summary	Totals Transactional	110	1.40	4.00	3.26	.433
	Totals Passive Avoidance	110	1.00	2.88	1.57	.413
Nonprofit	Totals Transformational	45	3.30	4.95	4.22	.431
	Totals Transactional	47	1.40	4.00	3.20	.501
	Totals Passive Avoidance	47	1.00	2.38	1.49	.397
For-profit	Totals Transformational	5	3.65	5.00	4.43	.670
	Totals Transactional	5	3.00	4.00	3.60	.469
	Totals Passive Avoidance	5	1.75	2.63	2.05	.360
Both	Totals Transformational	55	3.55	5.00	4.28	.338
	Totals Transactional	57	2.40	4.00	3.26	.359
	Totals Passive Avoidance	57	1.00	2.88	1.59	.406

Table 8 presents a frequency distribution of current business models for the participants who have experience in both sectors. Analysis of the data reveals that the trends change. The nonprofit leaders' transformational score is 4.37, which is .11 above the survey mean, and the for-profit score of 4.20 is .06 below the survey mean. The transactional scores for nonprofit leaders is 3.28 which is slightly higher than the survey mean of 3.26, and the for-profit score is 3.25. Regarding passive avoidance, the nonprofit leaders scored 1.54, which is lower than the survey mean of 1.57, and the for-profit leaders' score of 1.64 is slightly higher than at the survey mean of 1.57.

A one-way between-groups analysis of variance was conducted to explore the impact of the business model on the leadership. The results of a one-way ANOVA test yielded the significance score for transformational of .077, the transactional significance score was .801, and the passive avoidance score was .337, indicating there is no significant difference at the $p < .05$ level.

Table 8

Participants with Experience in Both Sectors

If both, which model best describes your current hospital structure?		*n*	Minimum	Maximum	Mean	*SD*
Nonprofit	Totals Transformational	24	3.85	5.00	4.37	.318
	Totals Transactional	24	2.40	4.00	3.28	.390
	Totals Passive Avoidance	23	1.00	2.88	1.54	.489
For-profit	Totals Transformational	30	3.55	4.90	4.20	.341
	Totals Transactional	32	2.40	4.00	3.25	.345
	Totals Passive Avoidance	33	1.13	2.63	1.64	.329

Leadership Style Subcategories by Business Sector

Although the differences in leadership styles in the different sectors may appear to be slight or insignificant, further analysis of the subcategories for transformational, transactional, and passive avoidant provide insight into slight nuances in the data. The subcategories for transformational behaviors are measured by idealized attributes (IA), idealized behaviors (IB), inspirational motivation (IM), intellectual stimulation (IS), and individual consideration (IC). Analysis of the transformational subcategories based on the mean results displayed in Appendix J demonstrate that the nonprofit leaders scored below the survey mean in every transformational subcategory, for-profit leaders scored above the survey mean in four of the five categories except for IC and respondents with experience in both sectors were at or slightly above the mean in every category.

Transactional tendencies are measured by contingent reward (CR) and management by exception-active (MBEA). Based on the results provided in Appendix K, again in both subcategories the trends remained, the nonprofit leaders scored 4.06 for CR and 2.47 MBEA, which are lower than the survey mean of 4.14 for CR and 2.77 for

MBEA. The for-profit leaders scored 4.50 for CR and 3.80 MBEA, which is higher than the survey means, and the respondents with experience in both sectors scored at or slightly higher than the survey mean with 4.17 for CR and 2.93 for MBEA. Passive avoidant behaviors include management by exception-passive (MBEP) and laisse-faire (LF). Data provided in Appendix L show the nonprofit leaders scored 1.64 for MBEP and 1.34 LF, which is slightly lower than the survey mean of 1.72 for MBEP and 1.42 for LF. The for-profit leaders scored the highest with a 2.15 for MBEP and 1.95 for LF and the leaders with experience in both sectors scored at the survey norm, with a score of 1.72 MBEP and 1.44 for LF.

A one-way between-groups analysis of variance was conducted to explore the impact of the business model on the leadership subcategories. The results of ANOVA testing for the transformational subcategories were .150 for IA, .793 for IB, .857 for IM, .237 for IS, and .693 for IC, indicating there was no significant difference in the transformational behaviors at the $p < .05$ level. The ANOVA testing results for transactional behaviors included .235 for CR and .001 for MBEA, indicating there was no significant difference for CR at the $p < .05$ level. However, the score for MBEA was .001, indicating the difference demonstrates a relationship between the business model and MBEA. Post-hoc comparisons using the Tukey HSD test indicated the mean score for nonprofits ($M = 2.47$, $SD = .955$) was significantly different from the for-profit group ($M = 3.80$, SD = .908) and those with experience in both sectors ($M = 2.93$, $SD = .806$). ANOVA testing for the passive avoidant behaviors resulted in .115 for MBEP, indicating there is no significant difference for MBEP at the $p < .05$ level. The LF score of .018 indicates there is a relationship between the business model and LF; however, the test of

homogeneity for LF was violated. A review of the robust tests of equality of means produced a significance score of .246, indicating the variance was not significant.

The Impact of a Merger on Leadership Tendencies

According to the survey participants, 46% had not experienced a merger, 7% had been through a merger within the last year, 26% had been through a merger within the last 1 to 2 years, and 21% had been through a merger 3 or more years ago. The summary results of the respondents based on their merger experience are displayed in Table 9. Analysis of the impact of an organizational merger, the respondents who had not experienced a merger scored very close to the survey mean in transformational and transactional and equal to the survey mean for passive avoidant behaviors. However, those who experienced a merger within the last year scored higher than the survey means for transformational and transactional behaviors and lower in the passive avoidant behaviors. The respondents who had experienced a merger in the last 1 to 2 years scored close to transformational survey mean and above the transactional and passive avoidant survey mean. The respondents who had experienced a merger 3 or more years ago scored slightly higher than the survey mean for transformational behaviors and lower than the survey mean for transactional and passive avoidant.

A one-way between-groups analysis of variance was conducted to explore the impact of a merger on the leadership behaviors. Based on a one-way ANOVA test, the significance level for transformational was .354, transactional was .280, indicating the differences were not significant at the $p < .05$ level. The score for passive avoidant was .011 indicating there may be a significant difference based on experience with a merger.

Table 9

Participants Who Had Experienced a Merger

Has your hospital been through a merger or acquisition (your hospital was merged or acquired by another organization)?		*n*	Minimum	Maximum	Mean	*SD*
Survey Mean	Totals Transformational	106	3.30	5.00	4.26	.395
	Totals Transactional	110	1.40	4.00	3.26	.433
	Totals Passive Avoidance	110	1.00	2.88	1.57	.414
No	Totals Transformational	49	3.30	5.00	4.23	.436
	Totals Transactional	51	1.80	4.00	3.21	.423
	Totals Passive Avoidance	51	1.00	2.88	1.57	.404
Yes, recently, within the last year	Totals Transformational	7	3.85	4.90	4.51	.361
	Totals Transactional	8	3.00	4.00	3.48	.337
	Totals Passive Avoidance	7	1.00	1.63	1.32	.269
Yes, 1 - 2 years ago	Totals Transformational	26	3.65	4.90	4.23	.343
	Totals Transactional	27	2.40	4.00	3.33	.364
	Totals Passive Avoidance	28	1.13	2.63	1.74	.374
Yes, 3 or more years ago	Totals Transformational	23	3.55	5.00	4.28	.365
	Totals Transactional	23	1.40	4.00	3.19	.544
	Totals Passive Avoidance	23	1.00	2.38	1.41	.417

Impact of Hospital Mergers: Analysis by Sub-Categories

Data in Appendix M indicates respondents who had not experienced a merger scored slightly lower than the survey mean in four of the five transformational leadership subcategories, with the largest difference of .06 lower for IA and they scored equal to the survey mean of 4.41 for individual consideration IC. Respondents who had been through a merger within the last year scored higher than the survey mean in four of the five transformational leadership subcategories, with the largest difference of .38 for IS and they scored equal to the mean for IC. The respondents who had been through a merger in

the last 2 to 3 years scored slightly lower than the survey mean in four of the five transformational leadership subcategories, with the largest difference in the area of IB, which was .16 below the survey mean. However, respondents who had been through a merger in the last 2 to 3 years were .09 above the survey mean in IA. For respondents who had been through a merger more than 3 years ago, the results were mixed. They scored 3.99 for IA, which is .08 less than the survey mean of 4.07; 4.39 for the IB, which is .10 higher than the survey mean; 4.45 for IM, which is .07 higher than the survey mean; 4.15 for IS, which is equal to the survey mean; and 4.44 for IC, which is .03 higher than the survey mean. A one-way between-groups analysis of variance was conducted to explore the impact of a merger on the transformational leadership subcategory behaviors. The results of ANOVA tests were .280 for IA, .153 for IB, .421 for IM, .188 for IS, and .967 for IC, indicating there was no significant difference in the transformational behaviors at the $p < .05$ level.

Respondents who had not been through a merger scored slightly lower than the mean in both transactional leadership subcategories, individual consideration (CR) and management by exception-active (MBEA), with the greatest difference at .08 for MBEA as demonstrated in Appendix N. The respondents who had recently been through a merger scored significantly higher in both transactional leadership subcategories with a 4.54 in CR, which is .40 higher than the survey mean, and 3.13 for MBEA, which is .36 higher than the survey mean. Respondents who experienced a merger in the last 1 to 2 years scored .04 lower than the survey mean in CR and .15 higher than the survey mean for MBEA. The respondents who had been through a merger more than 3 years ago scored 4.16 for CR, which is .02 higher than the survey mean, and 2.59, which was .18

lower than the survey mean. A one-way between-groups analysis of variance was conducted to explore the impact of a merger on the transactional leadership subcategories. The ANOVA testing results included .373 for CR and .359 for MBEA, indicating there was no significant difference for CR or MBEA at the $p < .05$ level.

In the passive avoidant subcategories demonstrated in Appendix O, the respondents who had not experienced a merger scored 1.70 for management by exception-passive (MBEP) and 1.45 for laissez-faire (LF), which is within .02 of the survey mean of 1.72 and .03 of the survey mean of 1.42. Again, the respondents who went through a merger within the past year had the highest difference from the survey mean with 1.41 for MBEP, which is .31 lower than the survey mean and 1.18 for LF, which is .24 lower than the survey mean. The respondents who experienced a merger more than 1 to 2 years ago scored higher than the survey mean in both subcategories with a 1.92 for MBEP, which is .20 higher than the survey mean and 1.56 for LF, which is .14 higher than the survey mean. The respondents who experienced a merger more than 3 years ago scored lower than the survey mean in both categories with a 1.55 for MBEP, which is .17 lower than the survey mean and 1.27, which is .15 lower than the survey mean. A one-way between-groups analysis of variance was conducted to explore the impact of a merger on the passive avoidant leadership subcategory behaviors. ANOVA testing resulted in .017 for MBEP showing there is a significant difference at the $p < .05$ level for MBEP, indicating there is an impact due to a merger. Posthoc comparisons using the Tukey HSD test indicated the mean score for respondents who had experienced a merger in the last 1 to 2 years ($M = 1.92$, $SD = .509$) was significantly different from those who had been through a merger recently ($M = 1.41$, $SD = .462$) and those who had

been through a merger 3 or more years ago (M = 1.55, SD = .488). The ANOVA test result of .073 for LF indicates there is no significant difference between the variances as a result of a merger.

Impact of Organizational Size

The survey results in Table 10 show the size of the organization. Leaders in stand-alone organizations scored themselves at 4.21, which is close to the survey mean of 4.26 for transformational behaviors. Their score of 3.19 for transactional behaviors is slightly lower than the survey mean of 3.26. Their score of 1.52 for passive avoidant behaviors is slightly below the survey mean of 1.57. Further analysis reveals leaders in small organizations scored themselves at 4.27 for transformational characteristics compared to the survey mean of 4.26, 3.21 for transactional characteristics compared to a survey mean of 3.26, and 1.67 for passive avoidant compared to the survey mean of 1.57. Medium-sized organizations scored slightly higher than the survey mean in transformational (4.35) and transactional characteristics (3.38) and scored a 1.38 in passive avoidant characteristics, which is .19 lower than the survey mean of 1.57. Large organizations were close to the mean in every category. Based on the one-way ANOVA results, transformational received a significance score of .837, the transactional significance score was .579, and the passive avoidance significance score was .231, indicating the differences in means were not significant at the $p < .05$ level.

Table 10

Current Hospital Size

What is the current hospital size of your healthcare system? Number of Hospitals		*n*	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals Transformational	106	3.30	5.00	4.26	.395
	Totals Transactional	110	1.40	4.00	3.26	.433
	Totals Passive Avoidance	110	1.00	2.88	1.57	.414
Stand Alone 1 Hospital	Totals Transformational	25	3.40	4.95	4.21	.375
	Totals Transactional	26	2.40	4.00	3.19	.386
	Totals Passive Avoidance	26	1.00	2.13	1.52	.319
Small 2–5	Totals Transformational	27	3.30	4.90	4.27	.404
	Totals Transactional	27	1.40	4.00	3.21	.522
	Totals Passive Avoidance	26	1.00	2.38	1.67	.376
Medium 6–10	Totals Transformational	10	3.55	5.00	4.35	.495
	Totals Transactional	10	2.60	4.00	3.38	.426
	Totals Passive Avoidance	10	1.00	2.88	1.38	.610
More than 11	Totals Transformational	44	3.30	5.00	4.27	.387
	Totals Transactional	47	1.80	4.00	3.29	.408
	Totals Passive Avoidance	48	1.00	2.63	1.59	.425

Organizational Size Analysis by Subcategories

Separating the data in Appendix P into leadership subcategories, the first analysis is related to transformational leadership. Leaders in stand-alone organizations scored slightly lower on each of the five transformational leadership subcategories except for IM, which was .08 above the mean. Leaders in small organizations scored slightly higher in IB, inspirational motivation IM, intellectual stimulation IS, slightly lower than the survey mean in IA, and equal to the survey mean for IC. Leaders in medium-sized organizations scored higher than the survey mean in every subcategory except for IM, where their score of 4.30 was .08 lower than the survey mean. Leaders in large organizations scored almost equal to the survey mean in the transformational leadership

subcategories except for IA, where they scored .04 higher than the survey mean and IM where they scored .06 lower than the mean. Large organizations were the most represented in the survey, with 43% of all respondents working in large organizations. The results of ANOVA tests were .579 for IA, .778 for IB, .613 for IM, .817 for IS, and .545 for IC, indicating there was no significant difference in the transformational behaviors and organizational size at the $p < .05$ level.

Reviewing transactional characteristics in Appendix Q, stand-alone hospitals scored 4.19 for CR, which is slightly higher than the survey mean of 4.14 and their score of 2.56 for MBEA is lower than the survey mean of 2.77. The opposite was true for small hospital systems; the contingent reward CR score of 4.10 was slightly lower than the survey mean of 4.14 and their score of 2.90 for management by MBEA was .13 higher than the survey mean of 2.77. Medium hospital systems scored 4.43 for CR, which is .29 higher than the survey mean of 4.14 and 2.67 for MBEA, which is .10 lower than the survey mean of 2.77. Larger hospital systems scored 4.07 for CR, which is .07 lower than the survey mean and 2.84 for MBEA, which is .07 higher than the survey mean. The ANOVA testing results included .352 for CR and .528 for MBEA, indicating there was no significant difference due to organizational size for CR or MBEA at the $p < .05$ level.

An analysis of the data in Appendix R shows only slight differences in the results for passive avoidant characteristics based on hospital size. The stand-alone hospitals scored 1.69 for MBEP, which is close to the survey mean of 1.72 and 1.35 for LF, which is .07 lower than the survey mean of 1.42. Small hospital systems scored 1.79 for MBEP, which is .07 higher than the survey mean and 1.53 for LF, which is .11 higher than the survey mean of 1.42. Medium hospital systems had the most significant range in scores

rating themselves at 1.48 for MBEP, which is .24 lower than the survey mean and 1.28 for LF, which is .14 lower than the survey mean of 1.42. Large hospital systems were very close to the mean in both categories, with a score of 1.75 for MBEP, which is .03% higher than the survey mean and 1.43 for LF, which is .01 higher than the survey mean of 1.42. The ANOVA test result of .439 for MBEP and .386 for LF indicates there is no significant difference between the variances related organizational size.

Leadership Characteristics by Position

Survey results displayed in Table 11 were analyzed by the current position of the respondent. Executive directors and vice presidents had the highest transformational score, with a score of 4.39 for executive directors, which is .13 above the survey mean, and a score of 4.38 for vice presidents, which is .12 above the survey mean. Those identified as “others”, which includes leadership roles such as compliance officers and attorneys, scored the lowest in the transformational category, with a score of 4.04, which is .22 below the survey mean. This is followed by managers, with a score of 4.14, which is .12 below the survey mean. Executive directors and directors also had the highest transactional scores, with a 3.31 for executive directors and 3.33 for directors with both above the survey mean of 3.26. CEOs scored the lowest in transactional, with a score of 3.09 and .17 below the survey mean. Managers scored the highest in passive avoidance, with a score of 1.70, which is .14 above the survey mean, followed by others, with a score of 1.63, which is .06 above the survey mean, and CEOs scored the lowest, with a score of 1.41, which is .16 below the survey mean. Based on a one-way ANOVA test, the transformational score was .086, transactional was .786, and passive avoidance was .520, indicating there is no significant difference in the means at the $p < .05$.

Table 11

Current Position

		n	Minimum	Maximum	Mean	*SD*
President or CEO	Totals Transformational	6	3.55	5.00	4.28	.525
	Totals Transactional	7	1.40	4.00	3.09	.824
	Totals PA	7	1.00	1.75	1.41	.257
Vice President	Totals Transformational	18	3.55	5.00	4.38	.408
	Totals Transactional	19	1.80	4.00	3.23	.454
	Totals PA	19	1.00	2.13	1.57	.347
Executive Director	Totals Transformational	14	3.95	4.95	4.39	.339
	Totals Transactional	15	2.60	4.00	3.31	.406
	Totals PA	15	1.00	2.13	1.54	.330
Director	Totals Transformational	32	3.70	4.95	4.31	.314
	Totals Transactional	32	2.80	4.00	3.33	.336
	Totals PA	32	1.00	2.38	1.51	.374
Manager	Totals Transformational	24	3.30	4.90	4.14	.396
	Totals Transactional	24	2.40	4.00	3.21	.427
	Totals PA	24	1.00	2.88	1.70	.526
Others	Totals Transformational	12	3.30	4.90	4.04	.481
	Totals Transactional	13	2.40	4.00	3.23	.431
	Totals PA	13	1.00	2.63	1.63	.513

Leadership Analysis of Subcategories Based on Current Position

Separating the data into leadership subcategories, the first analysis is related to transformational leadership based on data found in Appendix S. For IA, presidents and CEOs had the lowest overall score of the respondents, with a score of 3.86, they scored above the mean for IB, IM, and IS, and .13 points below the survey mean for IC. Vice presidents scored 4.04 for IA, which is slightly lower than the survey mean of 4.07; however, they scored higher than the survey mean in the remaining four subcategories. Executive directors and directors scored higher than the survey mean in every

subcategory. Managers and others scored lower than the survey mean in every category. Based on a one-way ANOVA test, the significance scores were .786 for IA, .243 for IS, and .328 for IC, indicating there is no significant difference in the means at the $p < .05$. The significant score for IB was .004 and IM was .018, which is less than $p < .05$, indicating there is a significant difference in the means.

Reviewing transactional characteristics in Appendix T, presidents and CEOs scored 3.93 for CR, which is lower than the survey mean of 4.14 and their score of 2.07 for MBEA is lower than the survey mean of 2.77. Vice presidents and executive directors scored higher than the survey mean in both CR and MBEA. Directors scored 4.12 for CR, which is slightly below the survey mean of 4.14, and 2.83, which is above the survey mean of 2.77. Managers rated themselves lower in both categories, whereas others rated themselves lower than the survey mean for CR, with a score of 4.04 and higher than the survey mean for MBEA, with a score of 2.92. Based on a one-way ANOVA, the significance score for CR was .148 and MBEA was .440, indicating there is no significant difference at the $p = < .05$ level.

An analysis of the data in Appendix U shows differences in the results for passive avoidant characteristics based on position. Presidents and vice presidents scored lower than the survey mean in both subcategories. Executive directors scored 1.62 for MBEP, which is lower than the survey of 1.72 and 1.47 for LF, which is higher than the survey mean of 1.42. Directors scored themselves lower than the survey mean in both subcategories and managers scored themselves higher than the survey mean in both subcategories. Others scored 1.71 for MBEP, which is slightly lower than the survey mean of 1.72 and 1.54 for LF, which is higher than the survey mean of 1.42. Based on the

results of a one-way ANOVA, the score for MBEP was .868 and the score for LF was .344, indicating there is no significant difference at the $p < .05$ level.

Gender

Based on the results demonstrated in Table 12, the scores for females and males were similar. For transformational characteristics, women scored 4.25 and men scored 4.26. The transactional scores were 3.25 for women and 3.24 for men. Passive avoidant scores for women were 1.56 and 1.59 for men. Based on the one-way ANOVA test, the transformational leadership significance score was .885, the transactional leadership score was .914, and the passive avoidance leadership score was .765, indicating no significant difference at the $p < .05$ level.

Table 12

Gender

Gender		*n*	Minimum	Maximum	Mean	*SD*
Female	Totals Transformational	69	3.30	5.00	4.25	.369
	Totals Transactional	72	2.40	4.00	3.25	.377
	Totals Passive Avoidant	72	1.00	2.88	1.56	.433
Male	Totals Transformational	36	3.30	5.00	4.26	.438
	Totals Transactional	37	1.40	4.00	3.24	.529
	Totals Passive Avoidant	37	1.00	2.63	1.59	.384

Extra Effort, Effectiveness, and Satisfaction

In addition to leadership style, the MLQ 5x asked questions related to extra effort, effectiveness, and satisfaction. Analyzing extra effort, the survey mean was 4.14, with the mean of the nonprofit leaders at 4.19, which is .05 higher than the survey mean. The for-profit leaders rated themselves at 4.33, which is .19 higher than the survey mean. The respondents with experience in both sectors scored 4.09, which is .06 lower than the

survey mean. Analyzing effectiveness, the survey mean was 4.33. The nonprofit leaders rated themselves at 4.36, which was .03 higher than the survey mean, and the for-profit leaders and those with experience in both sectors rated themselves slightly lower at 4.30 and 4.31 respectively. Regarding satisfaction, the survey mean was 4.34. The nonprofit respondents rated themselves the lowest at 4.32, followed by those with experience in both sectors, which scored a 4.34, which is equal to the survey mean, and the nonprofits scoring slightly higher than the survey mean, with a score of 4.4. Based on a one-way ANOVA test, the significance scores were .487 for extra effort, .856 for effectiveness, and .928 for satisfaction, indicating there is no significant difference in the means at the $p < .05$ level.

Turnover Data

The survey respondents were asked to share voluntary turnover in their hospital as a percentage. This number does not include lay-offs or other forced terminations. Turnover data was provided by 79 respondents. The data were analyzed by sector to determine the average turnover rate for nonprofit acute care centers and for-profit acute care centers. For the respondents who have experience in both sectors, the data were separated by their current business model. If a range was provided, the highest number in the range was utilized in the calculation. One response of 0 was assumed to be unknown and deleted. The self-reported turnover rate for nonprofit hospitals was 14.28%, and the self-reported turnover rate in the for-profit sector was 16.98%. This number includes one response that was corrected to 20% due to the assumption the respondent was noting a retention rate of 80% instead of a turnover rate of 80%.

Turnover data were also analyzed by the size of the organization. Stand-alone acute care centers reported a 15.74% turnover rate, small acute care centers reported a 12.11% turnover rate, medium acute care centers reported a turnover rate of 13.56%, and large acute care centers reported a turnover rate of 17.02%. Considering these results, large systems and stand-alone acute care centers had the highest turnover rate whereas small acute care centers had the lowest turnover rate.

Additional analysis was completed to determine if there is a relationship between transformational leadership style and staff turnover and transactional leadership style and staff turnover. The relationship between staff turnover and transformational behavior was investigated using the Pearson product-moment correlation coefficient. The results revealed no correlation between the two variables, $r = -.052$, $n = 80$, $p < .001$; therefore, transformational behavior did not correlate with staff turnover. The significance level (two-tailed) was .659.

Table 13

Transformational Behavior and Turnover

Correlations			
		What is your organization's current average annual voluntary turnover rate?	Totals Transformational
What is your organization's current average annual voluntary turnover rate?	Pearson Correlation	1	-.052
	Sig. (2-tailed)		.659
	n	80	76
Totals Transformational	Pearson Correlation	-.052	1
	Sig. (2-tailed)	.659	
	n	76	106

The relationship between staff turnover and transactional behavior was investigated using the Pearson product-moment correlation coefficient. The results revealed a small correlation between the two variables, $r = .103$, $n = 80$, $p < .001$. The significance (two-tailed) was .362, indicating the correlation was not significant.

Table 14

Transactional Behavior and Turnover

Correlations			
		What is your organization's current average annual voluntary turnover rate?	Totals Transactional
What is your organization's current average annual voluntary turnover rate?	Pearson Correlation	1	.103
	Sig. (2-tailed)		.362
	n	80	80
Totals Transactional	Pearson Correlation	.103	1
	Sig. (2-tailed)	.362	
	n	80	110

Qualitative Data

After the online survey data were collected and analyzed, individual interviews were conducted with healthcare leaders to provide greater insight into leadership styles in the nonprofit and for-profit acute care sectors using the IPR. Three healthcare leaders, who sent an unsolicited email and shared they completed the survey and were very interested in the results, agreed to be interviewed as part of the pilot program. Two of the pilot participants held leadership roles in both sectors of healthcare and are currently pursuing their degrees at the doctoral level. They completed the interview as designed

then provided insight and feedback on the topic, the questions, and the process. The third participant in the pilot program had more than 30 years of healthcare experience in both the nonprofit and for-profit sectors. From the initial survey email list, 17 additional healthcare leaders were interviewed for a total of 20 interviews to include three CEOs, two vice presidents, seven directors, seven managers, and one who served in another leadership role equivalent to a vice president. There were 16 interviews with leaders that had experience in both the nonprofit and for-profit sectors, one interview with a leader who had experience only in the for-profit setting, and three leaders with experience only in the nonprofit setting. Of the 20 leaders interviewed, four worked in small organizations, two worked only in large healthcare systems, and 14 had experience in both small and large organizations.

After 20 interviews, saturation was reached. Creswell (2015) defines saturation as "the point in data collection when the researcher gathers data from several participants and the collection of data from new participants does not add substantially to the codes or theme being developed" (p. 77). The interviews were confidential; therefore, the transcripts were coded using the date and time of the interview; the names of the organizations and of the leaders who were interviewed were removed from the written transcripts. The audio information was destroyed once the interviews were transcribed. The transcripts were coded then analyzed for trends. The following topics and trends that impact leadership style were identified: culture, decision-making, people management, accountability, leadership success, size, and advice to healthcare leaders.

Organizational Culture

A major theme that developed throughout the interviews was the difference in the organizational culture between the nonprofit and for-profit acute care centers. Organizational culture was defined by Watkins (2013) as to how organizations do things. He suggests culture moves past simply behavior of the organization and demonstrates the jointly held beliefs that form a foundation for aligned purpose and action. The interviewees shared that both business models and the environment in which an organization operates impact the culture of the organization.

Theme analysis revealed commonalities in the healthcare industry, the expectations, and responsibilities within the for-profit and nonprofit healthcare sectors. All acute care centers exist to take care of the patient and the patient focus was prevalent and discussed in both sectors. The healthcare industry is highly regulated. Compensation for services entails a lot of factors out of the control of most healthcare leaders with insurance companies and the government deciding much of the reimbursement payments. Based on the healthcare industry and demands, all hospital leaders need to pay strong attention to detail, quality measures, and the community. Both sectors are heavily regulated creating challenges for leaders to know the regulations from various entities and ensure compliance. They both have productivity and financial goals to be accomplished. Both sectors are trying to be profitable for similar and for different reasons.

For-profit organizations not only need to provide needed services for the community, but they also need to ensure a return on their shareholder investment in the form of profits. Sometimes the community is not aware of for-profit healthcare centers'

contributions to the community because they look different than those in nonprofit hospitals. They pay taxes, which provides income to the local community to address wider needs and often they provide grants to the local community to address needs that impact the health of the community.

Nonprofits need to be profitable to ensure they can live out their mission and continue to provide services to the community. However, since they have stakeholders but not shareholders, their profits are reinvested into the organization and services to enhance their services to the community. The nonprofits have a stronger need than the for-profit hospitals to publicize and quantify their community contributions due to their tax-free status.

Although there are many similarities, how leaders address the healthcare challenges and daily operations vary based on the business model. Whereas nonprofits are obligated to stakeholders such as patients, residents, community leaders, local government officials, and funding agencies, for-profit acute care centers pay taxes and have an obligation to investors, which creates a culture that is focused on bottom-line performance and requires leaders to focus on internal operations and have the ability to change operational procedures quickly if needed. Accountability, organization, and processes are clear in for-profit organizations. For-profits have more process and organizational structure. From a leadership perspective, daily tasks are based on metrics and are more prescriptive in nature with competition between hospitals utilized as a way of increasing motivation and raising expectations organization-wide. For-profit acute care centers have vast resources available and access to others in their system to help address the challenges a leader may encounter. Unlike nonprofits, much of the community

involvement is determined by corporate goals. Comments related to the for-profit culture that surfaced during the interviews include:

> "Kind of a different focus on ensuring that the quality pieces are there, the patient experience pieces are there, and that they are reaching the financial goals."
>
> "I don't think they pull any punches and they make financial changes quickly, because they are for-profit, and they have stockholders. I think, not-for-profits, they have the same focus, the same financial concerns. It's just they don't turn the ship as fast because they have less reason to."
>
> "It's definitely not as a collaborative approach."
>
> "When I talk to the CFO in a for-profit hospital, their priorities are solid. Bottom line, you know, healthy labor numbers, profitability."
>
> "Everything became transactional instead of transformational."
>
> "A profit entity takes the financial perspective a lot more seriously than the nonprofit."
>
> "There are a lot of resources available from outside that hospital to come and perform a swarm activity where everyone comes from all over the division to look at it and figure out how to make this metric move."

Nonprofit acute care centers have a strong sense of mission and community with more of the interview conversations focused on quality and community engagement. Leaders in the senior ranks are more externally focused, analyzing methods of increasing connectivity with businesses and organizations in the community and with less structure than the for-profit systems. However, with the changing expectations in healthcare, the nonprofits are working on improving their focus on metrics and building systems to gain

access to data quicker. With the focus on mission, there is more collaboration across units and fewer silos. Nonprofit organizations tend to focus on a 3 to 5-year strategic plan whereas for-profits are keenly aware and their focus on strategy is on an annual basis. Comments related to the nonprofit culture that surfaced during the interviews include:

> "The quality and patient care are always spoken of first and foremost."
>
> "We do a lot of things in this organization that are based on our mission and our outreach to the community."
>
> "Their board is a decision-maker, but it's not all on finance and big community, you know, kind of pull on the heartstrings, and it, let's just say that profitability doesn't rank as high, like on that kind of scorecard with the board as it does in a for-profit."
>
> "Very family-driven, family-oriented, where there is a lot of team building, team support…. they do their work because of a higher calling."
>
> "They are motivated by the desire to do good, to bring about good positive things."
>
> "Always focused on quality, reimbursement comes later. They try to negotiate better payments through improving quality outcomes."

These are a few of the differences based on organizational culture; however, some of the differences lent themselves to further and more in-depth discussion. The following topics are explored further: decision-making, people management, accountability, leadership challenges and success, and advice for healthcare leaders.

People Management

People management was an area where there appeared to be many similar challenges and approaches to retention, motivation, and management. However, although some of the words utilized were similar, the organizational culture and size played a role in how the strategies were operationalized. Leaders in both sectors discussed recognition as a motivation strategy with resource availability being the difference. In large systems, both sectors discussed recognition and shared recognition programs, which were similar in nature. Stand-alone and smaller systems, which were typically nonprofit organizations discussed the lack of resources necessary to do the level of recognition desired.

Some of the differences in the retention strategies revolved around organizational culture. In large for-profit hospital systems, the ability to gain experience, education, and move throughout the U.S. served as a strong retention factor. They measured employee engagement regularly and had mandated systems in place for leaders to engage employees. To increase access to nursing graduates and to further organizational cultural goals, one system purchased a nursing school. This arrangement allows them to train the students on their methodology during the very early stages of their education and work experience. Several leaders also felt the work environment was important. The importance of the work environment was evident in nonprofit organizations as well. Comments regarding recognition and retention in the for-profit sector included:

> "More opportunity in the for-profit sector."
>
> "Validation. Feeling that you're happy with them or that they're doing what they're supposed to do."

"They are able to create these landscapes of retention that others can't possibly compete. . . . I can move virtually anywhere in the country, with all my benefits that in a way that if I'm in a single, not for profit, I have to start all over."

"I have created an environment where people want to come to work every day."

"They were similar, there was a lot more focus on it obviously in the for-profit. There was more latitude. You had more support and wanting to have an innovative, creative way to retain people, recruit people, whether it be through educational reimbursement, whether it be through performance bonuses, performance incentives, and other awards and recognition. Whereas the standalone, its often very, very challenging to have the additional funding or infrastructure to support as large-scale programs like education reimbursement, or incentives, based on your margin."

"You see more benefits for your labor than in the nonprofit."

"There is definitely a very strong focus again on analytics. They do employee surveys every 90 days and the expectation is that there is an action plan and that you continue to hit the mark with that. Daily employee rounding is expected. Asking the team members, what it is they need to do their jobs and working to get that stuff."

Similar to the for-profit leaders, nonprofit leaders' discussion of retention programs focused on organizational culture. Unlike their for-profit counterparts, nonprofit leaders focused on a deep commitment to the mission as a method of retention. Many interviewees discussed soft skills, transparency, and communication. There appeared to be more flexibility in working with employees on schedules and

demonstrating support for the individual. They included annual employee engagement surveys compared to the 90-day surveys at the for-profit centers. Some of the larger systems also provided performance bonuses, which were more common in the for-profit sector.

> "Not-for-profits perhaps have a deeper sense of loyalty and longevity because they're not moving people all the time because; it's not only people who want to move, but I think large for-profits move people purposefully."
>
> "You are going to check those surveys annually. But again, I have a little bit more ability to flex staffing, according to needs and probably utilize talents a little better."
>
> "Respect and support. Ensure people know where they stand, provide them with performance evaluation. Appreciate their differences and make sure they understand what each brings and that they are needed."
>
> "It's about the culture. Caring about people. Leadership visibility on the floors, town hall meetings, bi-weekly updates, communication, accessible leaders, open and transparent."
>
> "We are not the highest paid, but you know we have highly engaged team members."
>
> "We have a culture of fun. . . . We try to take time and opportunities to make the team and ourselves laugh when we're hunkered down, and things are really stressful."
>
> "By keeping them informed on what you are doing, allowing them to ask any question without concern, celebrating successes, we celebrate a lot!"

"It's really the soft skills that keep people."

Accountability

Although both sectors discussed accountability, this was a consistent area where interviewees shared a stark difference between their approach to accountability by the business model. According to the interview responses, the for-profit acute care centers have a strong focus on accountability with clear expectations and multiple systems in place to track goals, productivity, and outcomes, which are prescriptive in nature. These systems support the strong culture of accountability and provide the manager with the tools needed to manage to the targets. Data needed for daily decision-making are often available hourly. Therefore, missing a target becomes an issue and can put the leader at risk of disciplinary action. As a result, the leader's style often moves toward micromanagement by checking employee clock-in documentation and addressing any deviations immediately and checking charge reconciliations throughout the day. Meetings are structured with business goals as the focus to ensure everyone is working towards the goal. A focus on standardizing processes was evident by the interviewee's responses. Comments from the for-profit interviews include:

"There's clear achievable goals that they want you to obtain."

"They reinforce those goals daily".

"Accountability on steroids."

"The meeting culture is fearsome in a for-profit."

"You're spending a lot more time capturing these metrics and these numbers because that's what you're using to drive their decision."

"They micromanage everything to the minute basically for productivity. They're looking at 15-minute increments instead of like a whole day."

"In the for-profit, missing a target could become a death sentence. There is less leniency when you don't meet your targets. Nonprofits provide you with more time to take corrective action."

"They like it because they see the accountability. They see they get rewarded and recognized."

"Since I have had to be more detail-oriented and more strict on staffing and following exactly the protocols that rolls down to the staff, so I think they probably also feel, you know, a lot more accountability and a little, a little less span of control."

"People still get managed by their mistakes."

"Less fires, more firemen."

"Absolutely more data-driven."

"Much more prescriptive."

"Managing to process in a for-profit, verses managing to personality in a nonprofit."

"They're really using those metrics to identify opportunities to send in teams and help fix that but there are people that are just managing to the metrics."

Although nonprofit acute care centers also have productivity and outcome expectations, they are less inclined to have the prescriptive processes and systems in place to track metrics as effectively and timely as the for-profit centers. Interviewers suggest there is more leniency if a target is not met as long as the reasons are identified

and addressed promptly. In smaller nonprofit organizations, the inconsistency in processes, lack of systems, or the delay in providing leaders with timely metrics may lend itself to a more reactive leadership style. The lack of standardized processes for operations was also mentioned by interviewees as an area that varied from many of the nonprofit systems. However, to improve operations and remain competitive, larger nonprofits now have a stronger focus on financials and standardization than in previous years.

Comments from nonprofit interviews include:

"As for accountability, both systems expect you to meet your target and to be accountable; however, the nonprofit may provide you with more leniency in the timing."

"I think healthcare is a little late to the party on dashboards and key performance indicators and things like that. And I don't think we use them to make sure that we level expectations for leaders, so I think that's an area of opportunity for healthcare right now."

"In the nonprofit, it was much more that you participated in the database, but the results of a lot of those were running about six months behind."

"In reality, for the last year or so, it really started feeling that they were technically not a not-for-profit except on paper. Everything was tying back a lot to our outcomes. The majority of our outcomes and how we make decisions, which really tie back to the financial outcomes associated with it."

"We don't talk about finance, but our position is that if you have the right people doing the right thing, then all the finances will come because you will be spending

money on human capital because you will have enough people to do the work. And people will want to work there."

"Managers operate their unit as if they were, you know, mini hospitals. Daily, weekly, monthly, quarterly, there is no shortage of data."

Leadership Challenges and Success

Interview participants were asked about their challenges as well as what made leaders successful in their organization. In for-profit organizations, some of the challenges related to organizational size and system navigation. According to the interviewees, leaders are extremely busy ensuring the necessary data is entered into the system. This focus limited the time leaders had to spend on the unit with the team; however, rounding with the team was an expectation. With much of the decision-making done at the corporate level, there was a challenge related to maintaining relationships with the physicians and the community. With the vast amount of resources, the interviews revealed it was often difficult to know how to access the appropriate resources. This can be overwhelming for a new leader in the large for-profit sector. Comments related to the for-profit organization challenges include:

"It's being sort of a little fish in a big pond where there's a lot of communication that comes from corporate. And it takes a bit for that to assimilate into the organization."

"Time in the day and keeping up with all of the data. There's like 10 or 15 different things you're supposed to do every single day."

"In the for-profit environment, one of the biggest challenges is being able to maintain your own identity as a provider of care in the community and maintain

your relationship with physicians, and with other providers in your communities who you are reliant upon to deliver upon the promise of care because ultimately a lot of things are outside of your control in the for-profit."

Leaders who were successful in the for-profit systems demonstrated an understanding of metrics and how to utilize data for decision-making. They were competitive and enjoyed learning the system and were committed to the organization's culture and goals. Interview data reveals that these leaders can put the system goals ahead of the department or their facility and produce outcomes. Comments from the for-profit participants include:

"Be able to analyze and use the data to make more data-driven decisions."

"Those who can navigate the political structure. They are able to align with certain corporate partners and corporate entities to implement what has already been determined is the best course of action or plan for a facility regardless of what the story is, or needs may or may not be."

"Communicate is number one. I think having an ability to see the big picture, and not get caught up in all of the minutiae and being able to drive an agenda. I think number three is just being a people person. It's all the relationship-based stuff. Right. But you can be really nice and be a bad communicator, and you can be really nice and not drive an agenda. So, you would still not be good at driving your agenda."

"Recognize that this organization is owned by this company. They make the decision and regardless, you need to carry that out, you need to figure out how to make that work."

"I don't want to say its task-focused, it almost seems competitive in a way."

"You're motivated by the competition."

The challenges discussed in the nonprofit organizations involved dealing with growth in the demand for services. According to the interviewees, the growth created a need for more staff, capital, and resources. At times, the growth also meant acquisitions, which created the challenge of maintaining a local identity.

"Staying focused on capital deployment and addressing our explosive growth."

"Volume. And so, demand is a challenge. I would say human capital is a challenge."

"Sustainability. I think maintaining independence is always, from a community perspective and from a board perspective, is always important and maintaining that local autonomy and independence was one of the biggest challenges in the nonprofit world."

"How you prioritize what you're working on."

"Meeting the leaders and in really becoming kind of part of the leadership team at the other market was a big challenge because you were viewed as one of them."

A common theme for leaders who were successful in the nonprofit sector revolved around a sense of mission and their relationship with people. They had a good understanding of the business drivers while maintaining a balance in their relationships with the team. They are transparent in their communications and share with the team. They also have good relationships inside and outside of the organization. Comments related to leaders who were successful in the nonprofit acute care setting include:

"You need to understand the economics and need to understand how you make money in this business. And you also have to have mission."

"You have to have some sense of mission that you're fulfilled by things other than just financial compensation. You have to work well with people. And you have to understand the importance of serving your customers, your patients and making sure you're providing and doing all of this while you're providing a great patient experience."

"Dynamic. And when I say that it doesn't mean they're introverted or extroverted, it just simply means that they know how to get people excited and motivated to do what they're all about, you know, how the work is getting done."

"Work ethic, energy, integrity, good relationship skills."

"They mentor one up."

"Transparent."

"Involve the team, be more democratic in decision-making."

"Knowing your employees, time with the employees, collaborative relationships with employees and across the organization, and sharing the vision."

Organizational Size

Decision-making became a common theme with clear differences between the stand-alone and small acute care centers and large acute care centers. Interview responses revealed in stand-alone hospitals, decisions are made at the hospital level with more freedom to determine budgets and annual goals. Typically, the decision-making process includes the needs of the community. According to interview participants, leaders in smaller organizations need to be engaging with the community to share their story and to

engage their patient population. Decisions made at the local level are better understood and easier to share with the team. In larger systems, decisions that impact the local facility are often made at the corporate level with a consideration of the needs of other facilities and system goals.

Interviews revealed there is less autonomy in larger systems; therefore, leaders have less control over decisions that impact their hospital and daily operations. However, the nonprofit leaders shared that decision-making at the facility level was driven by the type of decision that needed to be made. The president has a significant amount of decision-making power and there is collaborative decision-making for the decisions that have transferability to other hospitals in the system. At the larger for-profit hospitals, it may be difficult to help the team understand the rationale for a decision; however, the leader is expected to support and implement corporate decisions. In larger organizations, it may also be difficult at times to know where to go to get input and resolution for problem-solving and who needs to be included in the problem-solving process, which extends the time it may take to resolve an issue. Comments regarding decision-making at the small nonprofit organizations include:

> "A greater span of control to the clinicians at the bedside."
>
> "We don't have a corporate office that dictates here's how this happens or here's our staffing model."
>
> "They are much more likely to look at impact indicators that are driven from the community needs and I guess that's why I would say from a community needs assessment that they can then be more impactful, or have a significant impact on the community."

Comments regarding decision-making at larger organizations include:

> "There is a level of hospital-specific decision-making that's driven by the President. And those things that have potential system transferability, then there is some collaboration in making the final decision."
>
> "We're just a part of this big organization where decisions are being made, you know, based on what some needs are for other facilities versus just thinking about our own facility."
>
> "I feel like I'm playing pinball. So I've taken the issue and I've rolled back and shoot the pinball to where I think it's supposed to go to get an answer and quick resolve, and then it pings off there, then suddenly it has to play off something else, and they ping it somewhere else."
>
> "The financial stability takes a huge amount of weight off of the staff and off of the leadership, but you have to temper that with the loss of control, and for leadership, I think the loss of control is a big thing."

The results reveal that the leadership experience is different in small hospitals compared to large systems. In small organizations, the scope of practice for a leader is greater and they need to understand multiple aspects of hospital operations. The wider span of control provides diverse experiences and is a great learning ground for leaders. According to the interviews, there are fewer guidelines and policies that mandate how the center is operated providing the leader with some freedom in how they operate. Leadership visibility tends to be greater in smaller organizations. In larger organizations, the span of control is more focused in an area of expertise and the leader gets direction often from corporate. Interview data reveal that the expectations of meeting metrics and

goals create a need to be in the office more, which makes rounding with the staff more difficult. However, there is a greater opportunity to move around and grow professionally in a large system. Comments regarding the leadership experience from small organizations include:

> "In smaller organizations, you need to be more operationally focused."
>
> "It's a good place to learn."
>
> "There was never really any specific guidance."
>
> "You've got a lot more visibility."

Comments regarding the leadership experience from larger organizations include:

> "You're going to have to go to some other hospital to move up."
>
> "Some of the leadership opportunities that are there to train in and some of the access they have to them…I do think the moving them around in a lot of different settings instead of just one, even though you don't have the bonding longevity, you have the experience in different size and complexity of organizations that make you very competent."
>
> "There was definitely more structure and policies from the system."
>
> "You may be providing excellent service but if you're not in the top for the system, then that is as if that is not the case."
>
> "You are drawn to your office to get things done; however, you actually need to get out more in the larger system."
>
> "It isn't personal, it's looking basically at numbers."
>
> "Larger systems invest more in data mining."
>
> "You know the standards that are set."

"I think the size has to do with it because they have to standardize operations across a major company."

Another prevailing theme was the greater resources available in the larger organizations. There are resources at the division level and corporate level to provide not only funding for priority projects but the expertise to deal with challenges as they arise. However, it may be difficult to figure out where or how to access the resource. Comments from large organizations include:

"There are a lot of resources available from outside the hospital to come and perform a swarm activity where everyone comes from all over the division to look at it and figure out how to make this metric move."

"You aren't reinventing the wheel, there's somebody else in the organizations that's done it before."

"You have more resources available in a larger place but sometimes getting to the right resource may be harder."

"Leadership being visible, of course, is easy to do the smaller you are. Because the larger you are the more layers you have and the harder it is to again, to stay connected with what I call people that are on the sharp edge."

"Benchmark themselves against their own hospitals, and know at the end of every month, how people are doing and are we heading towards the goal."

Advice to Healthcare Leaders

During the interview, leaders were asked to advise new leaders that are entering the healthcare field, which may provide greater insight into the current and future healthcare environment. The comments below are from people who have experience in

both sectors. Change management, analytics, mission, and culture were common themes as evidenced in the following comments:

> "Be ready for change."
>
> "Do data analytics."
>
> "Do some research on the culture especially if you're coming from an industry that's not necessarily used to having a lot of structure."
>
> "You have to be servant-minded."
>
> "You've got many forces that are looking at you and looking at labor and workforce, but you've also got many requirements that are governing your performance. You've got rules and regs that govern you from the joint commission and other outside organizations, so you have to be nimble and be open."
>
> "Let go of the old and embrace the new."
>
> "Start off in the for-profit so you get a sense of possibly where the industry is going and that you learn the skills immediately. I think they're very encouraging to new graduates and young professionals coming into the system. They have a good mentorship program; they have a good executive program. They have good options for people to grow within the for-profit systems pretty quickly."

To gain greater insight into challenges leaders encountered during a merger or acquisition and the behaviors that helped them be successful, participants were asked to provide advice for people going through a merger or transition to another business model. When referring to a transition in general, the following comments were shared:

"At a minimum, there's going to be restructuring so I think going into it open-minded I think and have realistic expectations. You know, asking reasonable questions. But I think you need to have a realistic expectation about the fact that you're going to change, you can't continue to operate like you always have, or you're not going to be successful."

"Figure out what the goals of the organization are and where do you fit in that picture."

"Remain positive. Don't change yourself. Stay with your core beliefs and change organizations if needed but don't change who you are at your core."

"You must let go of the wheel entirely to the acquiring organization."

"It needs to be just like you just got hired by this company."

For leaders transferring from for-profit to nonprofit, the theme was related to how to interact with the team. The following advice was given:

"The regiment of the business model is different…you have to be transformational and collaborative, and that the communication is different. It's often two-way, whereas in a for-profit, its one-way communication."

"Be patient. Listen carefully. Meet people where they are."

Advice for a leader transferring from the nonprofit sector to the for-profit sector included themes related to being positive, learning new tools, giving up control, and being willing to implement difficult decisions.

"Let go of the wheel. You want those that are acquiring to see your value so the temptation is to hang on to a big wheel, but the tighter you hang on to the wheel,

the harder, and this is the irony, the harder you make it for them to actually redirect this ship to save it."

"Know you will be asked to do some, make some hard decisions. Do what needs to be done to help support the mission and getting the facility where it needs to be. And that's not always easy. It's not always easy or popular."

"I think you have to be positive about the change. And if you can't be positive, then you need to make your own change. I think trying to hang on and think that you are changing the system is just a waste of your valuable energy and their valuable time."

"Get to know the tools quickly, how they reach the metrics that they reach."

Hypotheses Analyzed

This study intended to identify leadership styles in nonprofit and for-profit acute care centers to determine if there is a predominant style in each sector. Another focus of the study was to determine if the leadership style had an impact on staff turnover. A final element of the study was to determine if the hospital system size had an impact on leadership style. The study included four hypotheses, which were analyzed based on the survey results and the information gathered during the interviews.

Research Hypothesis 1

Hypothesis 1 posits that in comparison to acute care hospital executives, nonprofit executives use a predominant transformational leadership style. For this to be true, nonprofit leaders need to exhibit the transformational leadership behaviors, which challenge their team members to strive to meet their potential while maintaining high moral and ethical standards, go beyond self-interest for the good of the group, have a

collective sense of mission, seek differing opinions when solving problems, and help others develop their strengths.

The MLQ 5s survey results revealed nonprofit leaders who worked solely in the nonprofit sector scored themselves as demonstrating transformational behaviors slightly less than other respondents scored themselves. However, based on the ANOVA testing results, the significance score was .453, indicating the difference was not significant at the $p < .05$ level. The recipients who had experience in both sectors and are currently in the nonprofit sector scored themselves .12 above the survey mean. The ANOVA test results provided a significance score of .077, does not meet the $p < .05$ criteria.

Based on study information gained through interviews, trends demonstrate there is evidence of transformational behaviors. Statements such as "they mentor one up," "work ethic, integrity, good relationship skills," "always focused on quality, reimbursement comes later," and "the quality and patient care is always spoken of first and foremost" demonstrate the encouragement to their employees to strive to meet personal potential while maintaining high moral and ethical standards. Statements such as "they do their work because of a higher calling" and "they are motivated by the desire to do good, to bring about good positive things" demonstrate their willingness to go beyond self-interest. The collective sense of mission is evident in the statements "we do a lot of things in this organization that are based on our mission and our outreach to the community", "you have to have a sense of mission," and "you have to have some sense of mission that you're fulfilled by things other than just financial compensation." "Involve the team, be more democratic in decision-making" relates to seeking differing opinions when solving problems, and help others develop their strengths. Speaking about

leadership in the nonprofit sector from a CEO with experience in both sectors, “You have to be transformational and collaborative, and that the communication is different. It’s often two-way, whereas in the for-profit, its one-way communication.”

A further examination of the interview data reveals for-profit leaders also utilize transformational leadership. To determine if nonprofit leaders utilized transformational leadership more than the for-profit leaders, the transcripts were analyzed and examined based on the frequency of the reference or mention of the transformational behaviors in each sector throughout the interview.

Table 15

Transformational Behaviors

Transformational Behavior	Nonprofit	Profit
Mission-oriented	21	8
Challenge team members	7	4
High moral standard	2	0
Beyond self-interest, a higher calling	2	0
Differing opinions when problem-solving	6	8
Develop their strengths	10	12
Communication	7	2

Although there appears to be evidence that nonprofit acute care center leaders utilize transformational leadership, there is no significant evidence to indicate the leaders utilize transformational leadership more than for-profit leaders in the acute care setting. The significance score of .453 is greater than the *p*-value of < .05 and the interview data did not decisively refute the survey results; therefore, the hypothesis is rejected.

Research Hypothesis 2

Hypothesis 2 posits that for-profit acute care center leaders demonstrate a transactional leadership style. Transactional leaders focus on the management of the

organization as evidenced by constructive and corrective transactions. Behaviors include ensuring the goals are clear, rewards for meeting goals are clear, and a focus on irregularities, mistakes, exceptions, and deviations from standards.

An analysis of the MLQ 5s survey results indicated that the for-profit leaders scored themselves .34 points higher than the survey mean for transactional behaviors; however, there were only five respondents in this category. The low response rate may explain the significance score of .150, which indicates the difference was not significant at the $p < .05$ level. Participants who had experience in both sectors and currently working in the for-profit sector scored themselves 3.25, which is equal to the survey mean with a significance score of .801, indicating there is no significant difference at the $p < .05$ level. However, analysis of the subcategory ANOVA results for MBEA behaviors reveals a score of .001, indicating a significant difference in the MBEA behaviors between nonprofit and for-profit leaders, and between nonprofit leaders and leaders with experience in both sectors.

Based on information gathered from the interviews, there is some evidence indicating for-profit leaders utilize transactional behaviors more than their nonprofit counterparts. Their behavior is categorized as utilizing constructive and corrective transactions. The following statements show evidence of clear goals and tracking that is in place: “There’s clear achievable goals that they want you to obtain.” “They reinforce those goals daily”. Many interviewees referenced the rewards in place for meeting goals to include statements such as “You see more benefits for your labor than in the nonprofit.” “They really like being here, they like it because they see the accountability. They see they get rewarded and recognized.” A focus on metrics and attention to

irregularities, mistakes, exceptions, and deviations from standards is clear and was mentioned regularly when speaking of the for-profit model. Statements included "Accountability on steroids", "They micromanage everything to the minute basically for productivity. They're looking at 15-minute increments instead of like a whole day." "They're using those metrics to identify opportunities to send in teams and help fix that but there are people that are just managing to the metrics." "More of managing to process in a for-profit versus managing to personality in a nonprofit." "The corporate structure addresses the deviation in the for-profit world."

Although transactional behaviors were evident in the nonprofit leaders, an analysis of the frequency in which transactional behaviors were discussed in the interviews shows for-profit leaders discussed more transactional behaviors more than nonprofit leaders. One interviewee stated, "Everything became transactional instead of transformational."

Table 16

Transactional Behaviors

Transactional Behavior	Nonprofit	Profit
Clear goals	2	14
Rewards for meeting goals	8	13
Focus on accountability, metrics, irregularities, exceptions, deviations from standards	12	45

Whereas the for-profit leaders scored higher than the survey mean for transactional behaviors and the respondents with experience in both sectors scored higher than the mean, the significance score of .150 gained through ANOVA testing is greater than the *p*-value of < .05, indicating there is no significant difference. Further analysis of

the subcategory results indicated there was no significant difference in the CR behaviors between nonprofit and for-profit acute care leaders. However, there was a significant difference in the second subcategory of MBEA.

The interview data revealed a clear and stronger focus on transactional behaviors in for-profit leaders compared to their nonprofit counterparts. A challenge with using the Likert scale is that it assumes attitudes can be placed on a continuum, are linear, and people answered honestly. A potential weakness of a Likert scale includes the possibility of the validity being compromised by social desirability (McLeod, 2019). To address the possible validity challenge, the study included interviews with healthcare executives, which confirmed the stronger use of transactional behaviors in for-profit executives. Therefore, with the significant difference in the subcategory MBEA score, indicating for-profit leaders and those with experience in both sectors demonstrate more transactional behaviors, and with the data gathered in the interviews supporting the stronger focus on transactional behaviors in the for-profit sector, the hypothesis is partially confirmed.

Research Hypotheses 3

Hypothesis 3 posits that there is a statistically significant relationship between transformational leadership style and staff turnover and transactional leadership style and turnover. The relationship between staff turnover and transformational behavior was found to not correlate, $r = -.052$, $n = 80$, at $p < .001$; therefore, transformational behavior did not correlate with staff turnover. The significance level (two-tailed) was .659.

The relationship between staff turnover and transactional behavior was investigated and the results revealed a small correlation between the two variables, $r =$

.103, n = 80, $p < .001$. The significance (two-tailed) was .362, indicating the correlation was not significant. The hypothesis is rejected.

Research Hypothesis 4

Hypothesis 4 posits that as an organization grows, the leadership tends to become more transactional. An analysis of the MLQ 5s survey results in Table 17 indicates a progressive increase in transformational and transactional behavior as the organization grows with large organizations showing transactional behaviors level off. While the transactional scores for large organizations are still higher than the survey mean of 3.25, based on the Spearman's Rho testing, $r_s = .125$, $p < .05$, there is no statistical correlation in transactional leadership style based on the size of the organization.

Table 17

Organizational Size and Leadership Behaviors

Size	Transformational	Transactional
Survey Mean	4.26	3.25
Stand Alone	4.21	3.19
Small	4.27	3.21
Medium	4.35	3.38
Large	4.26	3.29

Interview responses indicate an increasing focus on transactional behaviors such as goals setting, managing to deviations, and standardization as the organization grows as evidenced in the following statements:

"It isn't personal, it's looking basically at numbers."

"Larger systems invest more in data mining."

"For a larger system, there is a lot more scrutiny in terms of your performance."

"You know the standards that are set."

"I think the size has to do with it because they have to standardize operations across a major company."

"Benchmark themselves against their own hospitals, and know at the end of every month, how people are doing and are we heading towards the goal."

While the survey data does not indicate a significant difference in leadership style based on organizational size, the interview data provides evidence to the contrary, therefore the hypothesis is partially confirmed.

Chapter Summary

This research was designed to determine the leadership styles most commonly utilized at the executive level in the acute care hospital nonprofit business model and the acute care hospital for-profit business model. The study assessed if there is a statistical relationship between leadership style, business model, and turnover.

This study generated extensive quantitative data from the MLQ 5s Survey and qualitative data through interviews with 20 healthcare leaders. The survey data were analyzed by the business model, impact of a merger, organizational size, leadership position, and gender. The respondents' perception of their extra effort, effectiveness, and satisfaction was included. The interview data were analyzed to ascertain what elements may impact leadership style resulting in the following trends: culture, people management, accountability, leadership challenges, leadership success, organizational size, and advice to leaders. Findings revealed that transformational behaviors were utilized equally in both sectors, for-profit leaders had a stronger propensity to utilize transactional behaviors related to the MBEA dimension, turnover was not related to

leadership style, and organizational size appeared to have some impact on the utilization of transactional behaviors.

Chapter V

CONCLUSIONS

Summary

In 2017, U.S. healthcare was a $3.5 trillion industry and accounted for 17.9% of the U.S. GDP (National Health Expenditure, 2018). With the size of the industry and its impact on our economy and the country's overall health, it is important to look at the behavior of the executives who lead organizations in this industry. The healthcare industry is experiencing significant change creating new challenges for healthcare leaders. Some of the challenges include new government mandates, financial stability, personnel shortages, and reorganizations. In response to shifts in the industry, U.S. hospitals are experiencing high numbers of mergers and acquisitions, with 102 acquisitions and mergers in 2016 alone (MacDonald, 2017). As a result, the number of nonprofit hospitals is declining due to the hospital being acquired by for-profit hospital systems and transitioned into for-profit entities. Leaders may be expected to change behavior based on their business model and their ability to make the transition may impact the organization overall. Ulrich and Small (2013) believed the leadership impact on organizations can be seen in the employee confidence, organization's identity, customer experience, investor value, and with their contributions to the community.

The purpose of this study was to ascertain the similarities and differences of leadership styles in the nonprofit and for-profit acute care setting and their impact on turnover. To determine if the similarities and differences were related to the size of the

organization, leadership style, and system size was analyzed. Additionally, an analysis of the impact on employee turnover, which ultimately impacts organizational productivity, was conducted. The survey tool, MLQ 5s, was developed by Bass and Avolio (2004) to assess the transformational, transactional, and passive avoidant behavior in leaders and was utilized to gather statistical data for this research study. Responses from 111 healthcare leaders were analyzed using SPSS software providing descriptive data including the frequency, mean, and standard deviation. ANOVA testing was completed to compare the mean scores of multiple groups and to determine the statistical significance. The correlation between leadership style and turnover was obtained using a Pearson product-moment correlation coefficient (r). Also, interviews with 20 leaders in the acute care healthcare setting were conducted to provide greater insight into the research questions. Data from the interview transcripts were coded and themes were identified.

Discussion of Results

The study results expected that nonprofit leaders would be more transformational, for-profit leaders would be more transactional, and as an organization increased in size, transactional behavior would be more prevalent. Turnover was expected to be similar in both sectors.

The findings related to transformational leadership in the nonprofit sector were surprising and produced conflicting results. The nonprofit leaders scored themselves slightly lower than the survey mean in the transformational category; however, based on statistical testing, the difference was not significant. Interviews with healthcare leaders provided support of the some of the survey results with a few areas, indicating there was a difference in behavior between the sectors such as nonprofit leaders mentioning a focus

on the mission more often than their for-profit peers. Other discussions demonstrated their behaviors were not significantly different than their for-profit counterparts as evidenced in the areas of development of employees and including different opinions in problem-solving. Rowald, Borgmann, and Bormann (2014), in a study of nonprofit leaders in a variety of industries, found transformational leadership in the nonprofit sector focused on utilizing values as a method of motivation. My study's results appear to support the previous study findings by the frequent mention of the mission in the nonprofit healthcare sector. However, although not as often, the mission was mentioned in the discussions with for-profit healthcare leaders suggesting due to the nature of healthcare, the mission may be important in both sectors. Sow et al. (2017) found transformational leadership had the most effect on employee satisfaction in organizations that were internally focused (such as for-profits). However, in this study, although the employees of the leaders who responded were not surveyed, scores of the leaders themselves showed no significant difference in their employee satisfaction. Also, this study confirmed Fiery's (2008) findings that leaders in the nonprofit healthcare environment did not utilize predominantly transformational leadership skills.

Based on the MLQ 5s survey data and the interview data, the transactional leadership dimension of MBEA was found to be more prevalent in the for-profit sector, which partially supported Khan et al.'s (2016) findings that transactional leadership has a positive impact on organizations and suggested an organization of predominantly professional employees are motivated by reward, recognition, and management by exception. In addition, that finding partially supported Asiri et al.'s (2016) findings that

found nurses focused on transactional behaviors. Transactional behaviors are believed to lay a foundation for an effective transformational style.

The study concluded that staff turnover was not related to either transformational leadership styles or transactional leadership style. This finding contradicts Kleinman's (2004) findings that suggested transformational leadership had a significant impact on lowering staff turnover in the healthcare setting. Perhaps one reason for this contradiction may be that Kleinman's study was published in 2004 and the healthcare environment has changed significantly since that time.

As an organization grows, this study partially confirmed that the leader's behavior may become more transactional. This finding supports Marx's (2017) study that found that as an organization grows, it becomes more rigid. With the growth in size, there becomes a greater need for standardized policies and procedures thus lessening the focus on employee interaction and engagement.

Interpretation

Healthcare is an interesting industry with unique nuances. Many similarities and differences in the leadership experience based on the business model were discovered in this study. Although at times the differences may appear minimal, they impact leadership behaviors in each sector.

A key element in retaining quality staff, including leaders, is finding a good match of skills and alignment to organizational culture. Gleeson (2017) asserted employees who are a good fit for the corporate culture are more likely to stay with the organization and have better performance. He posited that cultural fit is especially important in an environment like the current healthcare environment where there is

change, volatility, and ambiguity. The culture was a theme that emerged throughout the interviews; therefore, this study considered the impact of culture on leadership style. Although on the surface leaders in both healthcare sectors demonstrate similar behaviors, due to the culture, leadership behaviors are manifested in different ways and with different levels of intensity.

Nonprofit Culture and the Leadership Experience

Nonprofit leaders focus on mission and community needs as driving factors for decision-making. They are generally more externally focused than their for-profit counterparts; therefore, they may decide to offer services that address a need in the community even if the service may not be self-sustaining. They may spend more of their time making connections with businesses and the community. Local board members make decisions impacting the local hospital with a focus on meeting community needs. They focus on quality and patient care first, then look at how to finance the services. This does not mean they do not consider the business case; however, the business case comes after the service need has been identified. They understand the economics that drives the business and often work within tight budget constraints to provide services. There are less structure and standardized processes than their for-profit counterparts and they have more input into decision-making.

Retention strategies focus heavily on the deep commitment to the mission, which they expect will foster a deeper sense of loyalty. Leaders believe it is the soft skills of management and caring about the employees that will retain the staff; therefore, they focus on visibility on the units, leadership transparency, communication, and recognition. They celebrate milestones and successes whether they are small or large. The recognition

is often personal. Although nontangible recognition was evident in both small and large organizations, it was more evident in smaller nonprofits due to limited resources. Employee engagement surveys are often conducted annually to identify employees' overall thoughts on the work environment and their commitment. Leaders are typically identified from within the organization with an emphasis on internal promotions. The skills are gained through experience in their hospital and by expanding responsibilities augmented by leadership training at many of the larger organizations.

Accountability, although important in both sectors, is handled differently in each one. Nonprofits have metrics and data, which are analyzed; however, the frequency and access to data are often driven by the size of the organization. Many of the nonprofit leaders who had experience with standalone or small organizations shared access to data were lagging, which made accountability more difficult. They were responding to the data after the fact. They participated in gathering the data and then it was summarized and provided at the end of the month or at times, up to 6 months later. The respondents with experience in larger nonprofit systems indicated metrics have become a much greater focus and they utilized more sophisticated systems that were timely and more effective than the smaller hospitals. In both cases, whereas it was expected that deviations were addressed, they were provided some leniency than their for-profit peers in how long it may take to correct the situation.

Successful leaders in the nonprofit sector understand economics and how the organization makes money; however, there is also a deep commitment to the mission. They have a servant perspective, are fulfilled by mission more than money, and work well with people. They know how to get people excited about the mission and getting the

work done while displaying integrity in their everyday dealings. They recognize the team is integral to the success of the organization and build collaborative relationships and involve the team in decision-making. There is flexibility to meet personal employee needs while maintaining high standards of care. As one leader shared, they believe if you have the "right people doing the right thing, then all the finances will come."

For-profit Culture and the Leadership Experience

The culture at the for-profit hospitals differed from the nonprofits in that they are more internally focused on the bottom-line performance and internal operational procedures. They spend time inputting information into data systems, monitoring systems to identify deviations, and responding to deviations in real-time. Decision-making is mostly done at the corporate or division level leaving the leader with less input and flexibility to meet local needs related to physician requests, community needs, or staff flexibility. The decisions are based on data. Whereas the nonprofit organizations ask for input from the team and other leaders in the decision-making and problem-solving process, for-profit leaders have vast resources and draw from expertise throughout the system. If a leader is struggling with an issue, they bring in resources from throughout the system to help address it. Although the resources are vast, navigating systems and learning how to access the resources and get the work done can be more challenging. One leader summed up the leadership experience in the for-profit sector in that you need to be comfortable being a "little fish in a big pond" and another stated that you need to "stay within your lane."

For-profit organizations valued recognition and understood the need to retain staff. Some of the methods were similar to nonprofit organizations such as recognizing

anniversaries, rounding on the unit with a focus on finding staff to recognize, and celebrating successes. However, the recognition strategies were more structured, typically consistent throughout the system, included metrics, and they had more resources for recognition. For example, rounding with the team was expected daily to identify if staff had what they needed to do their job and to identify staff who excel. Leaders reported on their rounding activities daily. Regarding retention, education reimbursement programs were available, and employees could transfer anywhere in the system without losing benefits or accrued time with the company. Leadership recognition varied from the nonprofit sector in that leaders received bonuses for meeting targets. Expectations were clear and rewards for meeting expectations were clear, which makes it easier to see the benefit of your contributions. Employee engagement surveys were conducted every 90 days with an expectation that leaders respond to employee concerns and improvements are made between the surveys. Another variation from the nonprofit practices where leaders are groomed internally in the hospital, for-profit leaders typically are groomed from within the entire system. There are leadership development programs in place with the philosophy that leaders learn through experience. Therefore, leaders are moved to different locations throughout the system intentionally to gain experience that prepares them for a higher position.

Accountability is important in the for-profit system. The expectations are very clear and there is structure, multiple processes, and systems in place to correct deviations quickly. Expectations and leadership tasks can be prescriptive in nature with a clear understanding of what needs to be done and with direction on how to do it. Metrics in real-time provide leaders with data that identifies any deviations, which are expected to

be corrected quickly. With an abundance of data that can be analyzed at the unit level on an hourly basis, it is easier to understand what is happening in the organization in real-time and creates a strong foundation for accountability. The data are utilized to promote competition between leaders with the intent to raise the bar system-wide. This focus on accountability creates a strong transactional leadership style, which according to Avolio and Bass (1995), builds a foundation for transformational leadership.

Leaders who are successful in for-profit acute care centers analyze data and make decisions based on data. They are effective in navigating the large political structure and can communicate with multiple levels in the organization. Operational results are a focus; therefore, successful leaders can drive an agenda and get the expected results. They recognize the company makes the decisions and they need to carry it out regardless of their personal feelings or preferences. They learn how to make it work and they are motivated by competition. Several leaders mentioned it's not personal, it's about the numbers and meeting targets. If you can deliver results, you are fine. If you can't, due to the published metrics, it's known to all.

Community Commitment

Although the expectation of a nonprofit organization is to exist for the benefit of the community, some believe that would indicate that for-profits exist for investors alone. Tarsik et al. (2014) suggested for-profit entities have a stronger focus on the business indicators to include finance whereas nonprofits focus on service. Chaney (2016) interviewed Yvette Doran, who stated, "The culture of the for-profits is business-driven. The culture at nonprofits is service-driven" (para 4). However, Chaney (2016) went on to note that in healthcare this difference is more one of nuance in application due to the need

to demonstrate both service and business acumen. Government regulations require all hospitals to provide a certain level of service regardless of the business model. The interview discussions supported Chaney's (2016) assertations and questions some of the long-held beliefs of nonprofit and for-profit healthcare organizations. In speaking with healthcare leaders, there appears to a community component in each sector; however, how each entity contributes to the community may look different. For nonprofits consider local community needs and they play a key role in determining goals, services, and priorities. Nonprofits may be more apt to provide new or unique services that meet the needs of the community regardless of their return on investment. In contrast, for-profits contribute through paying taxes and in various other ways. A leader whose organization transitioned from nonprofit to for-profit shared that after 2 years, there had not been a decrease in charity care due to being acquired by a for-profit entity. In addition to the charity care that was previously provided, the organization provided grants to meet community needs and paid taxes. However, in comparison to nonprofits that provide community benefit reports where the contribution is clear, for-profit organizations do not have the same requirement; therefore, the contributions may not be recognized by the community.

Size

The study identified several differences in leadership style based on the size of the organization. The key differences were in the area of access to resources, the level of decision-making at the leadership level, career growth, and accountability.

A consistent theme in small organizations was a challenge with resources, which limited their ability to do some of the things they would like to do for their patients, their

staff, and the community. Recognition was important in both sectors with large organizations having greater resources for recognition; therefore, smaller organizations relied more on personal and nontangible recognition. The lack of resources in the smaller hospitals also could limit their ability to implement all the services they desired. Larger organizations had greater financial stability, which takes the weight off the staff; however, the tradeoff is the loss of control, which is important to many leaders.

Decision-making was an area impacted by size. Smaller hospitals made decisions at the local level and based the decisions on community needs. Leaders in smaller hospitals relied on their experience for decision-making and included the team or their peers in the process. Due to the lack of resources and limited access to others who may have experienced similar challenges, they are more likely to reinvent the wheel. In larger hospital systems, decisions were made at the division or corporate level based on system goals. Input on problem-solving in large systems involved seeking input from others in the corporate system and complying with the standards in place. Smaller hospitals have fewer policies and guidelines providing the leader with greater autonomy in decision-making while larger systems have less autonomy.

The leadership experience in small and large organizations differs in several ways. Leaders in small organizations have a greater span of control, the scope of practice is wider, and they need to understand multiple aspects of hospital operations. These experiences provide a good training ground and provide the leader with a broad perspective of the organization. There is more visibility; therefore, greater potential to influence direction and policy. In larger organizations, the leadership focus may be more specialized. They are provided greater opportunities to grow by moving throughout the

system as opposed to staying in one location and there are good training programs in place. There is more structure in place with goals and policies clearly defining the expectations, which research indicates leads to trust and consistency.

With the current national focus on healthcare, new regulations, government mandates, and the overall interest in improving quality, it is evident that accountability is essential in both sectors. Size impacts the ease of reporting and the level of accountability. In large organizations, there are systems in place to support strong accountability measures. Larger systems invest in data mining, provide data in real-time, can create internal benchmarks, and there are clear standards to meet creating an environment where leaders can proactively address deviations. Small hospitals, due to lack of resources, have more difficulty tracking metrics in real-time, which impedes the leader's ability to make decisions promptly and creates an environment where the managers are responding to information after the fact and therefore, they become more reactive.

Relevance to the Future of Healthcare

As stated previously, healthcare is experiencing rapid change that will impact the way organizations and those who lead them, behave. There is a move towards value-based reimbursements and consumerized care, which will require a focus on quality as well as a marketing mindset. Government mandates will foster more collaboration between providers to enhance outcomes and reduce costs. With the increase in information available online, the consumers of healthcare have become and will continue to be, more informed and change the relationship between providers, hospitals, and patients. Due to the tight financial conditions, government regulations, and new corporate

entrants into the market, mergers and acquisitions will continue. Moody's report suggests horizontal mergers will continue; however, there will also be an increase in vertical mergers and telemedicine will move the point of care from hospitals to homes or local clinics. As competitors such as Amazon and Walmart continue to expand their innovative services into the healthcare arena, hospitals will need to become more creative in their service delivery. To thrive, small community hospitals will need to find a way to build cooperatives that will assist with buying power as well as bargaining power (O'Brien, 2019).

Considering the prediction of continued mergers and acquisitions, leaders need to understand the culture and elements of leadership success during transitions as well as the leadership styles that will be successful based on the future challenges of healthcare. Avolio and Bass (1995) believed that to be effective in any environment leaders should increase transactional behaviors while increasing the utilization of transformational behaviors. As revealed by the survey, transactional behaviors of MBEA were utilized more frequently in the for-profit sector. Large nonprofits are increasing their data gathering and analytical capabilities and this trend should continue. Recognizing the financial constraints but to remain competitive long-term, smaller hospitals could benefit from increasing their data and analytical capabilities. Both the nonprofit and for-profit leaders utilized transformational behaviors to some extent; however, these styles will become even more essential in the future.

Innovations in technology will have a significant impact on how care is delivered. The increase in the ability to monitor health conditions via wearable devices opens new treatment avenues and can change the way care is provided. Data gathered through

smartphones, fitness devices, and other wearable technology can provide information on the health of an individual and open-up opportunities to intervene before catastrophic diseases develop. The data along with technology, such as telemedicine, can also provide opportunities for patients to be monitored and address health issues at home instead of in the acute care setting. Currently, approximately one-third of the healthcare expenses are related to hospital care, with 80% of the cost related to chronic illnesses. With a focus on consumer preferences and wellness, some chronic illnesses could be prevented or managed at home, leaving hospitals with predominantly critical care patients (Forces of Change. n.d.). This shift will fill hospitals with patients who have critical needs, increasing the reliance on good systems and processes for the best care. Artificial intelligence (AI) and robotics will play a stronger role in augmenting many of the back-office functions such as finance, human resources, supply chain and the revenue cycle (Forces of Change, n.d.). AI will provide leaders with more data and creative procedures requiring healthcare leaders to balance innovation and analytics.

Additional changes in care delivery will impact hospital leaders. The consumerized focus reinforces the need for leaders to keep the mission at the forefront, be servant leaders, and to be transformational with the team. As seen in the for-profit organizations, there is a strong emphasis on metrics and the need for metrics and data analytics will continue to grow. Government regulations will intensify and to meet the expectations, leaders will have to handle the operational, or what is often the transactional elements of the role, effectively.

To survive, small organizations will need to find a way to level the playing field in costs or be open to new partnerships or mergers. Large systems can negotiate deep

discounts for equipment and supplies due to their large buying power. The same is true for negotiating managed care contracts. If an organization represents over 100 hospitals, it has greater bargaining power than a stand-alone organization, which helps with their ability to provide high-quality care at a lower cost.

Leaders going through a merger or acquisition need to expect major changes and embrace them. Organizations merge for many reasons to include strategic presence and long-term stability; therefore, leaders should expect restructuring and not fight it. If their organization is acquired, they need to spend time learning the new culture and not be afraid to ask reasonable questions. They need to learn the goals of the new organization and how they can contribute. One of the toughest elements they may face is letting go of control to the acquiring organization; however, it will be one of the most beneficial to the leader and the transition. Leaders should act as if the merger represents a new job and they were just hired. Determining the business elements of the new organization, for example, how do they compete in the market, is important. They should consider the predominant behavior styles the leader observes and get to know the tools available. They should ask about the culture and observe behaviors that support the culture. For a nonprofit leader transitioning to the for-profit sector, one of the biggest changes will be the need for a stronger focus on transactional behaviors and metrics. For a for-profit leader moving to the nonprofit sector, understand there is a stronger focus on relationships and IC will be more important and there is more leadership latitude as well as patience demonstrated in reaching outcomes.

Although some healthcare professionals think transformational behaviors are the most important behaviors to display, it is vitally important for all leaders to heed the

advice of Bass and Avolio (2004) and display less reliance on passive avoidant behaviors, grow in competence in the transactional behaviors, and rely heavily on transformational behaviors. Leaders have drawn heightened awareness, and the skills they demonstrate during times of change and mastering these styles will help them be more effective in their current roles and the changing healthcare environment.

Limitations of the Research

This study added to the body of knowledge and laid a foundation for further research on leadership styles in the acute care healthcare setting. However, there are limitations to this study related to access to leaders, survey size and turnover data. According to the American Hospital Association, the 2019 updated total number of hospitals in America is 6,210 (Fast Facts on US Hospitals, 2019). Due to limited access to executives and resource constraints, this research only assessed a small sampling of hospital leaders. The data is self-reported due to the difficulty of obtaining comprehensive feedback from those with whom they lead. Regional data were not included in the study. Time demands on healthcare leaders limited access to many leaders for the interviews. Currently, there is no known method of obtaining turnover rates by hospital or department making it necessary to rely on self-reported data from survey participants. Using this method to obtain data provides a risk to validity.

Recommendations for Future Research

It appears mergers and acquisitions in the healthcare environment will continue in the future with the potential to have a great impact on leaders. The outcome of this study demonstrates there are distinct differences in the nonprofit and for-profit healthcare leadership experience. Leaders who understand themselves, their organizations, and how

to respond to changes in their environment can be more effective and help decrease healthcare costs while improving the patient experience.

This study included leaders from organizations of all sizes, including stand-alone organizations, as well as large systems and leaders who had experience in single sectors and those with experience in both sectors. Although the findings were clear in some areas based on the data gathered, the question remains to the extent the effect of organizational size has on leadership style. The for-profit entities represented were mainly large systems. Additional research is needed comparing leaders in large nonprofit systems with leaders in large for-profit systems to determine the extent to which business model versus size impacts behavior.

A review of leadership scores for the participants who had experience in both sectors was interesting. While the scores were not shown to be significant, there is a hint that nonprofit leaders who worked in both sectors may increase their transformational tendencies and is an area where future research would be valuable. There were also shifts in scores for leaders who experienced a merger in the past year which is another area that would benefit from additional study.

With the nature of healthcare focused on people, it is possible that the people drawn to healthcare come with a focus on a higher calling. It would be interesting to determine how these results were similar or different from those in other industries. Did the nature of healthcare attract leaders who naturally utilize the transformational leadership style?

Leaders may find the nonprofit business model more attractive due to its focus on community service. This study revealed a question of how the for-profit entities

contribute to the community. Further research is needed to examine the contributions to the community by nonprofit and for-profit organizations to determine the differences and similarities.

Conclusion

This study sought to determine the similarities and differences in leadership styles in the nonprofit and for-profit acute care environment. Secondarily, this study sought to determine the impact of organizational size on leadership styles. Also, the study sought to determine if there was a relationship between leadership model and staff turnover. The study found nonprofit and for-profit leaders display transformational leadership; however, it is manifested in different ways. For-profit leaders had a stronger propensity to utilize transactional behaviors related to the MBEA dimension. The statistical analysis of organizational size did not indicate a statistical difference in leadership style however the data gathered in the interviews appeared to contradict the survey. Turnover was found to be a concern in both sectors without a correlation to transformational or transactional leadership. More study is recommended evaluating large hospital organizations to determine the extent to which business model and size dictate leadership style.

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APPENDIX A:

Mind Garden Permission to Reproduce

Approval for Remote Online Use of a Mind Garden Instrument

Effective date is November 18, 2019 for:

JULIE OLSEN

You submitted your Application for Remote Online Use at 10:42 am EDT on October 09, 2019.

mind garden [v2]

Remote online use of the Mind Garden instrument stated below is approved for the person on the title page of this document.

Your name:

JULIE OLSEN

Email address:

julieo@comcast.net

Company/institution:

Valdosta State University

Mind Garden Sales Order or Invoice number for your license purchase:

HKGXJJGUX

The name of the Mind Garden instrument you will be using:

MLQ

Please specify the name of and web address for the remote online survey website you will be using and describe how you will be putting this instrument online:

https://valdosta.co1.qualtrics.com/jfe/form/SV_74foJOFC8oyAZs9 The survey was created in Qualtrics using the Valdosta State University access. Participants known to the researcher will receive an email requesting participation, a link to the survey will be included in the email.

Please include any other comments or explanations you would like to provide about your remote online use of a Mind Garden instrument:

I want to include the necessary copyright information and I'm assuming the verbiage will be sent to me or available online. I'll look for it. Thanks!

APPENDIX B

Invitation to Participate in the Survey

Invitation to Participate in the Study

As a doctoral candidate at Valdosta State University, I am conducting research on healthcare leadership styles in the for-profit and nonprofit acute care setting. With the current challenging healthcare environment, I am curious as to how it may be impacting leadership styles. Please consider providing your input by taking a short anonymous survey (10 minutes) and sharing the survey link with additional healthcare leaders.

https://valdosta.co1.qualtrics.com/jfe/form/SV_74foJOFC8oyAZs9

If you are interested in receiving a summary of the survey results, send me a quick email request at jaolsen@valdosta.edu.

Thanks in advance for your participation!

Julie Olsen

VSU Doctoral Candidate

APPENDIX C

Survey Consent Form

Survey Consent Form

You are being asked to participate in a survey research project entitled "Exploring Leadership Styles in Nonprofit and For-Profit Acute Care Hospitals,", which is being conducted by Julie Olsen, a student at Valdosta State University. The purpose of the study is to identify any similarities and differences in leadership styles between for-profit and nonprofit hospital leaders. You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about successful leadership styles in healthcare**.** There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participation should take approximately 15 minutes to complete. This survey is anonymous**.** No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to take the survey, to stop responding at any time, or to skip any questions that you do not want to answer. Participants must be at least 18 years of age to participate in this study. Your completion of the survey serves as your voluntary agreement to participate in this research project and your certification that you are 18 or older. You may print a copy of this statement for your records.

Questions regarding the purpose or procedures of the research should be directed to Julie Olsen at jaolsen@valdosta.edu. This study has been exempted from the Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

APPENDIX D

Invitation to Participate in the Interview

Invitation to Participate in the Interview

The leadership survey is closed and I had 111 valid responses! To dig deeper, I am interviewing a few people on their thoughts on leadership. Would you be willing to speak with me for about 30 minutes in the next couple of weeks and share your thoughts? We can do it over the phone, through a Zoom interactive session (it's like Skype), or I am happy to meet you at your office.

Thanks for your consideration!

APPENDIX E

Interview Consent Form

Interview Consent Form

You are being asked to participate in an interview as part of a research study entitled *"Exploring Leadership Styles in Nonprofit and For-Profit Acute Care Hospitals*", *which* is being conducted by Julie Olsen, a student at Valdosta State University. The purpose of the study is to identify any similarities and differences in leadership styles between for-profit and nonprofit hospital leaders. You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about successful leadership styles in healthcare**.** There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participation should take approximately 30 minutes**.** The interviews will be audiotaped to accurately capture your concerns, opinions, and ideas. Once the recordings have been transcribed, the tapes will be destroyed. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to participate, to stop responding at any time, or to skip any questions that you do not want to answer. You must be at least 18 years of age to participate in this study. Your participation in the interview will serve as your voluntary agreement to participate in this research project and your certification that you are 18 years of age or older.

Questions regarding the purpose or procedures of the research should be directed to Julie Olsen at jaolsen@valdosta.edu. This study has been exempted from the Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

APPENDIX F

Interview Guide

Survey Follow-up Interview Guide

You are being asked to participate in an interview as part of a research study entitled *"Exploring Leadership Styles in Nonprofit and For-Profit Acute Care Hospitals", which* is being conducted by Julie Olsen, a student at Valdosta State University. The purpose of the study is to identify any similarities and differences in leadership styles between for-profit and nonprofit hospital leaders. You will receive no direct benefits from participating in this research study. However, your responses may help us learn more about successful leadership styles in healthcare**.** There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participation should take approximately 30 minutes**.** The interviews will be audiotaped to accurately capture your concerns, opinions, and ideas. Once the recordings have been transcribed, the tapes will be destroyed. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to participate, to stop responding at any time, or to skip any questions that you do not want to answer. You must be at least 18 years of age to participate in this study. Your participation in the interview will serve as your voluntary agreement to participate in this research project and your certification that you are 18 years of age or older.
Questions regarding the purpose or procedures of the research should be directed to Julie Olsen at jaolsen@valdosta.edu. This study has been exempted from the Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

Introductory Questions				
How long have you been in healthcare? How long have you been in leadership at any level? What is your current position? Have you worked in nonprofit and for-profit hospital systems? What is the size of your current hospital system? (bed size)				
Transition Questions				
Initially, what got you interested in healthcare?				
Key Questions				
Why did you select a nonprofit hospital? For-profit?				

Briefly share what you believe to be the major similarities and differences in the nonprofit and for-profit leadership behaviors? OR You worked in both nonprofit and for-profit hospitals, in your opinion, what are the major similarities and differences between the two? What did you learn about yourself or your leadership style as you shifted between sectors?	
Has your organization been through a merger? If so, how long ago? What did you learn about leadership during the transition?	
Have you worked in smaller and larger organizations? If so, what do you see as the major differences?	
What is the key to retaining staff?	
Reflecting on how you spend your time each week, where would you say you focus the most?	
What has been the greatest challenge in your leadership role?	
What are your key expectations of a leader?	
What is the most important skill a healthcare leader needs to be successful now? In the future?	
What is the key to retaining your staff?	
How do you motivate the staff?	

If you could advise a new leader entering the healthcare field, what would it be?				
Closing Question				
Before we close the conversation, is there something about your experience that you believe is important to discuss or include as we look at leadership styles in healthcare?				

APPENDIX G

IRB Exemption

Institutional Review Board (IRB)
For the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

Protocol Number: 03925-2019 **Responsible Researcher:** Julie Olsen

Supervising Faculty: Dr. Victor Burke

Project Title: *Exploring Leadership Styles in Nonprofit and For-Profit Acute Care Hospitals.*

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is **Exempt** from Institutional Review Board (IRB) oversight under Exemption **Category 2**. Your research study may begin immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

ADDITIONAL COMMENTS:

- *Upon completion of this research study all data (data list, email correspondence, etc.) must be securely maintained (locked file cabinet, password protected computer, etc.) and accessible only by the researcher for a minimum of 3 years.*
- *Exempt protocol guidelines prohibit the collection and/or storage of audio/video recordings. Each interview recording must be deleted immediately upon creating the interview transcript.*

☒ ***If this box is checked, please submit any documents you revise to the IRB Administrator at irb@valdosta.edu to ensure an updated record of your exemption.***

Elizabeth Ann Olphie *10.07.2019*
Elizabeth Ann Olphie, IRB Administrator

Thank you for submitting an IRB application.
Please direct questions to irb@valdosta.edu or 229-253-2947.

Revised: 06.02.16

APPENDIX H

Number of Employees in the System

Number of Employees in the System

Approximately how many employees work in your system (the system is defined as your entire organization, not just the location in, which you work)? - Employees

		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	Small: Fewer than 5,000	27	24.3	24.3	24.3
	Medium: 5,000–10,000	17	15.3	15.3	39.6
	Large: More than 10,001	67	60.4	60.4	100.0
	Total	111	100.0	100.0	

APPENDIX I

Number of Employees Supervised

Number of Employees Supervised

What is the total number of employees you supervise (directly and indirectly)? - Number of employees

		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	Fewer than 50	56	50.5	51.4	51.4
	51 - 200	32	28.8	29.4	80.7
	201 -500	8	7.2	7.3	88.1
	More than 500	13	11.7	11.9	100.0
	Total	109	98.2	100.0	
Missing	System	2	1.8		
Total		111	100.0		

APPENDIX J

Transformational Subcategories Divided into Sector Experience

Transformational Leadership Subcategories Divided into Sector Experience

Do you have experience in nonprofit healthcare hospitals or for-profit healthcare hospitals?		N	Minimum	Maximum	Mean	Std. Deviation
Total Summary	Totals IA	110	1.75	5.00	4.07	.542
	Totals IB	108	3.00	5.00	4.29	.532
	Totals IM	111	2.50	5.00	4.38	.524
	Totals IS	109	2.75	5.00	4.15	.525
	Totals IC	111	3.00	5.00	4.41	.483
	Valid N (listwise)	106				
Nonprofit	Totals IA	47	1.75	5.00	4.01	.627
	Totals IB	46	3.00	5.00	4.26	.595
	Totals IM	47	2.50	5.00	4.36	.568
	Totals IS	46	2.75	5.00	4.07	.494
	Totals IC	47	3.25	5.00	4.37	.463
	Valid N (listwise)	45				
For-profit	Totals IA	5	3.75	5.00	4.50	.586
	Totals IB	5	3.25	5.00	4.40	.840
	Totals IM	5	3.50	5.00	4.50	.707
	Totals IS	5	3.75	5.00	4.45	.570
	Totals IC	5	3.00	5.00	4.30	.818
	Valid N (listwise)	5				
Both	Totals IA	57	3.00	5.00	4.08	.448
	Totals IB	56	3.25	5.00	4.31	.450
	Totals IM	58	3.25	5.00	4.38	.483
	Totals IS	57	2.75	5.00	4.18	.546
	Totals IC	58	3.00	5.00	4.44	.476
	Valid N (listwise)	55				

APPENDIX K

Transactional Subcategories Separated into Sectors

Transactional Subcategories Separated into Sectors

Do you have experience in nonprofit healthcare hospitals or for-profit healthcare hospitals?		N	Minimum	Maximum	Mean	Std. Deviation
Total Summary	Totals CR	107	2.00	5.00	4.14	.588
	Totals MBEA	109	1.00	5.00	2.77	.922
	Valid N (listwise)	105				
Nonprofit	Totals CR	47	2.00	5.00	4.06	.622
	Totals MBEA	46	1.00	4.50	2.47	.955
	Valid N (listwise)	46				
For-profit	Totals CR	5	3.75	5.00	4.50	.500
	Totals MBEA	5	2.25	4.50	3.80	.908
	Valid N (listwise)	5				
Both	Totals CR	54	2.75	5.00	4.17	.562
	Totals MBEA	57	1.00	5.00	2.93	.806
	Valid N (listwise)	53				

APPENDIX L

Passive Avoidant Subcategories

Passive Avoidant Subcategories

Do you have experience in nonprofit healthcare hospitals or for-profit healthcare hospitals?		N	Minimum	Maximum	Mean	Std. Deviation
Total Summary	Totals MBEP	111	1.00	3.50	1.72	.531
	Totals LF	110	1.00	3.00	1.42	.467
	Valid N (listwise)	110				
Nonprofit	Totals MBEP	47	1.00	3.50	1.64	.568
	Totals LF	47	1.00	2.75	1.34	.399
	Valid N (listwise)	47				
For-profit	Totals MBEP	5	1.75	2.50	2.15	.379
	Totals LF	5	1.00	3.00	1.95	.908
	Valid N (listwise)	5				
Both	Totals MBEP	58	1.00	3.00	1.72	.484
	Totals LF	57	1.00	2.75	1.44	.451
	Valid N (listwise)	57				

APPENDIX M

Impact of Hospital Mergers: Transformational Subcategories

Impact of Hospital Mergers: Transformational Subcategories

Has your hospital been through a merger or acquisition?		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals IA	110	1.75	5.00	4.07	.542
	Totals IB	108	3.00	5.00	4.29	.532
	Totals IM	111	2.50	5.00	4.38	.524
	Totals IS	109	2.75	5.00	4.15	.525
	Totals IC	111	3.00	5.00	4.41	.483
	Valid N (listwise)	106				
No	Totals IA	51	2.25	5.00	4.01	.529
	Totals IB	50	3.00	5.00	4.27	.562
	Totals IM	51	2.50	5.00	4.32	.592
	Totals IS	50	2.75	5.00	4.10	.576
	Totals IC	51	3.00	5.00	4.41	.480
	Valid N (listwise)	49				
Yes, recently, within the last year	Totals IA	8	3.75	5.00	4.34	.421
	Totals IB	7	4.00	5.00	4.57	.401
	Totals IM	8	4.00	5.00	4.63	.354
	Totals IS	8	3.50	5.00	4.53	.452
	Totals IC	8	3.50	5.00	4.41	.654
	Valid N (listwise)	7				
Yes, 1 - 2 years ago	Totals IA	27	3.00	5.00	4.16	.456
	Totals IB	27	3.25	5.00	4.13	.516
	Totals IM	28	3.25	5.00	4.34	.510
	Totals IS	27	3.00	4.75	4.11	.497
	Totals IC	28	3.00	5.00	4.37	.464
	Valid N (listwise)	26				
Yes, 3 or more years ago	Totals IA	23	1.75	5.00	3.99	.680
	Totals IB	23	3.00	5.00	4.39	.488
	Totals IM	23	3.75	5.00	4.45	.419
	Totals IS	23	3.50	5.00	4.15	.438
	Totals IC	23	3.50	5.00	4.44	.484
	Valid N (listwise)	23				

APPENDIX N

Impact of Hospital Mergers: Transactional Subcategories

Impact of Hospital Mergers: Transactional Subcategories

Has your hospital been through a merger or acquisition (your hospital was merged or acquired by another organization)?		N	Minimum	Maximum	Mean	Std. Deviation
.	Totals CR	107	2.00	5.00	4.14	.588
	Totals MBEA	109	1.00	5.00	2.77	.922
	Valid N (listwise)	105				
No	Totals CR	50	2.50	5.00	4.10	.565
	Totals MBEA	50	1.00	4.50	2.69	.905
	Valid N (listwise)	49				
Yes, recently, within the last year	Totals CR	6	3.50	5.00	4.54	.557
	Totals MBEA	8	1.50	4.25	3.13	1.043
	Valid N (listwise)	6				
Yes, 1 - 2 years ago	Totals CR	27	2.75	5.00	4.10	.569
	Totals MBEA	27	1.75	4.25	2.92	.750
	Valid N (listwise)	26				
Yes, 3 or more years ago	Totals CR	23	2.00	5.00	4.16	.673
	Totals MBEA	23	1.00	5.00	2.59	1.038
	Valid N (listwise)	23				

APPENDIX O

Impact of a Merger: Passive Avoidant Subcategories

Impact of a Merger: Passive Avoidant Subcategories

Has your hospital been through a merger or acquisition?		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals MBEP	111	1.00	3.50	1.72	.531
	Totals LF	110	1.00	3.00	1.42	.467
	Valid N (listwise)	110				
No	Totals MBEP	51	1.00	3.00	1.70	.480
	Totals LF	51	1.00	2.75	1.45	.467
	Valid N (listwise)	51				
Yes, recently, within the last year	Totals MBEP	8	1.00	2.25	1.41	.462
	Totals LF	7	1.00	1.75	1.18	.278
	Valid N (listwise)	7				
Yes, 1 - 2 years ago	Totals MBEP	28	1.25	2.75	1.92	.509
	Totals LF	28	1.00	3.00	1.56	.503
	Valid N (listwise)	28				
Yes, 3 or more years ago	Totals MBEP	23	1.00	2.50	1.55	.488
	Totals LF	23	1.00	2.50	1.27	.426
	Valid N (listwise)	23				

APPENDIX P

Current Hospital Size: Transformational Subcategories

Current Hospital Size: Transformational Subcategories

Number of Hospitals		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals IA	110	1.75	5.00	4.07	.542
	Totals IB	108	3.00	5.00	4.29	.532
	Totals IM	111	2.50	5.00	4.38	.524
	Totals IS	109	2.75	5.00	4.15	.525
	Totals IC	111	3.00	5.00	4.41	.483
	Valid N (listwise)	106				
Stand Alone 1 Hospital	Totals IA	26	3.00	5.00	3.99	.482
	Totals IB	26	3.00	5.00	4.21	.518
	Totals IM	26	3.50	5.00	4.46	.483
	Totals IS	25	3.25	5.00	4.08	.443
	Totals IC	26	3.00	5.00	4.32	.493
	Valid N (listwise)	25				
Small 2 - 5	Totals IA	27	1.75	5.00	4.01	.652
	Totals IB	27	3.00	5.00	4.32	.554
	Totals IM	27	3.50	5.00	4.44	.447
	Totals IS	27	3.50	5.00	4.20	.410
	Totals IC	27	3.25	5.00	4.40	.547
	Valid N (listwise)	27				
Medium 6 - 10	Totals IA	10	3.25	5.00	4.23	.533
	Totals IB	10	3.50	5.00	4.40	.530
	Totals IM	10	3.25	5.00	4.30	.744
	Totals IS	10	2.75	5.00	4.23	.731
	Totals IC	10	3.75	5.00	4.58	.457
	Valid N (listwise)	10				
More than 11	Totals IA	47	2.25	5.00	4.11	.510
	Totals IB	45	3.00	5.00	4.28	.539
	Totals IM	48	2.50	5.00	4.32	.540
	Totals IS	47	2.75	5.00	4.14	.582
	Totals IC	48	3.00	5.00	4.42	.447
	Valid N (listwise)	44				

APPENDIX Q

Current Hospital Size: Transactional Subcategories

Current Hospital Size: Transactional Subcategories

What is the current hospital size of your healthcare system? Number of Hospitals		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals CR	107	2.00	5.00	4.14	.588
	Totals MBEA	109	1.00	5.00	2.77	.922
	Valid N (listwise)	105				
Stand Alone 1 Hospital	Totals CR	26	3.00	5.00	4.19	.486
	Totals MBEA	26	1.00	4.25	2.56	.861
	Valid N (listwise)	26				
Small 2 - 5	Totals CR	26	2.00	5.00	4.10	.652
	Totals MBEA	27	1.00	4.25	2.90	.936
	Valid N (listwise)	26				
Medium 6 - 10	Totals CR	10	3.75	5.00	4.43	.409
	Totals MBEA	9	1.50	4.25	2.67	.952
	Valid N (listwise)	9				
More than 11	Totals CR	45	2.50	5.00	4.07	.630
	Totals MBEA	47	1.00	5.00	2.84	.947
	Valid N (listwise)	44				

APPENDIX R

Current Hospital Size: Passive Avoidant Subcategories

Current Hospital Size: Passive Avoidant Subcategories

What is the current hospital size of your healthcare system? Number of Hospitals		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals MBEP	111	1.00	3.50	1.72	.531
	Totals LF	110	1.00	3.00	1.42	.467
	Valid N (listwise)	110				
Stand Alone 1 Hospital	Totals MBEP	26	1.00	2.75	1.69	.497
	Totals LF	26	1.00	2.25	1.35	.340
	Valid N (listwise)	26				
Small 2 - 5	Totals MBEP	27	1.00	2.50	1.79	.458
	Totals LF	26	1.00	2.75	1.53	.492
	Valid N (listwise)	26				
Medium 6 - 10	Totals MBEP	10	1.00	3.00	1.48	.682
	Totals LF	10	1.00	2.75	1.28	.571
	Valid N (listwise)	10				
More than 11	Totals MBEP	48	1.00	3.50	1.75	.554
	Totals LF	48	1.00	3.00	1.43	.489
	Valid N (listwise)	48				

APPENDIX S

Current Position: Transformational Subcategories

Current Position: Transformational Subcategories

		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals IA	110	1.75	5.00	4.07	.542
	Totals IB	108	3.00	5.00	4.29	.532
	Totals IM	111	2.50	5.00	4.38	.524
	Totals IS	109	2.75	5.00	4.15	.525
	Totals IC	111	3.00	5.00	4.41	.483
President or CEO	Totals IA	7	1.75	5.00	3.86	1.029
	Totals IB	7	3.00	5.00	4.39	.720
	Totals IM	7	4.25	5.00	4.57	.238
	Totals IS	6	3.75	5.00	4.25	.418
	Totals IC	7	3.50	5.00	4.29	.548
	Valid N	6				
Vice President	Totals IA	19	2.25	5.00	4.04	.567
	Totals IB	18	3.00	5.00	4.51	.539
	Totals IM	19	3.25	5.00	4.58	.507
	Totals IS	19	2.75	5.00	4.22	.629
	Totals IC	19	3.75	5.00	4.53	.407
	Valid N	18				
Executive Director	Totals IA	15	3.25	5.00	4.13	.508
	Totals IB	14	4.00	5.00	4.52	.332
	Totals IM	15	3.75	5.00	4.58	.440
	Totals IS	14	3.25	5.00	4.23	.485
	Totals IC	15	4.00	5.00	4.53	.399
	Valid N	14				
Director	Totals IA	32	3.50	5.00	4.16	.420
	Totals IB	32	3.25	5.00	4.34	.434
	Totals IM	32	3.75	5.00	4.39	.435
	Totals IS	32	3.50	5.00	4.25	.435
	Totals IC	32	3.50	5.00	4.44	.421
	Valid N	32				
Manager	Totals IA	24	3.00	5.00	4.01	.534
	Totals IB	25	3.00	5.00	4.08	.477
	Totals IM	25	3.25	5.00	4.16	.549
	Totals IS	25	3.00	5.00	4.03	.579
	Totals IC	25	3.00	5.00	4.34	.577
	Valid N	24				
Other	Totals IA	13	3.00	5.00	4.04	.539
	Totals IB	12	3.00	5.00	3.90	.661
	Totals IM	13	2.50	5.00	4.14	.697
	Totals IS	13	3.25	4.75	3.89	.496
	Totals IC	13	3.00	4.75	4.19	.561
	Valid N	12				

APPENDIX T

Current Position: Transactional Subcategories

Current Position: Transactional Subcategories

What is your current position?		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals CR	107	2.00	5.00	4.14	.588
	Totals MBEA	109	1.00	5.00	2.77	.922
	Valid N	105				
President or CEO	Totals CR	7	2.00	5.00	3.93	1.068
	Totals MBEA	7	1.00	3.50	2.07	.850
	Valid N	7				
Vice President	Totals CR	17	2.75	5.00	4.41	.586
	Totals MBEA	18	1.25	4.50	2.81	.856
	Valid N	16				
Executive Director	Totals CR	15	3.25	5.00	4.32	.477
	Totals MBEA	14	1.00	4.25	2.89	.918
	Valid N	14				
Director	Totals CR	31	3.25	5.00	4.12	.508
	Totals MBEA	32	1.00	5.00	2.83	.993
	Valid N	31				
Manager	Totals CR	24	2.75	5.00	3.98	.489
	Totals MBEA	25	1.50	4.25	2.72	.846
	Valid N	24				
Other	Totals CR	13	2.50	5.00	4.04	.652
	Totals MBEA	13	1.50	4.50	2.92	1.007
	Valid N	13				

APPENDIX U

Current Position: Passive Avoidant Subcategories

Current Position: Passive Avoidant Subcategories

What is your current position?		N	Minimum	Maximum	Mean	Std. Deviation
Survey Mean	Totals MBEP	111	1.00	3.50	1.72	.531
	Totals LF	110	1.00	3.00	1.42	.467
	Valid N (listwise)	110				
President or CEO	Totals MBEP	7	1.00	2.25	1.57	.426
	Totals LF	7	1.00	1.75	1.25	.289
	Valid N (listwise)	7				
Vice President	Totals MBEP	19	1.00	2.50	1.75	.456
	Totals LF	19	1.00	2.75	1.38	.536
	Valid N (listwise)	19				
Executive Director	Totals MBEP	15	1.00	2.25	1.62	.399
	Totals LF	15	1.00	2.00	1.47	.410
	Valid N (listwise)	15				
Director	Totals MBEP	32	1.00	2.75	1.71	.532
	Totals LF	32	1.00	2.25	1.31	.354
	Valid N (listwise)	32				
Manager	Totals MBEP	25	1.00	3.00	1.81	.601
	Totals LF	24	1.00	2.75	1.55	.537
	Valid N (listwise)	24				
Other	Totals MBEP	13	1.00	3.50	1.71	.706
	Totals LF	13	1.00	3.00	1.54	.576
	Valid N (listwise)	13				