A QUANTITATIVE EXAMINATION OF THE RELATIONSHIP BETWEEN LEADERSHIP

PRACTICES AND LEADERSHIP EFFECTIVENESS IN PERSONAL CARE AIDE JOB

SATISFACTION AND TURNOVER AND CUSTOMER SATISFACTION IN THE HOME

HEALTHCARE INDUSTRY

by

William Travis Hodge

Doctoral Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Liberty University

(December 16, 2016)

Abstract

This non-experimental quantitative correlational research examined the relationship between the leadership practices of workers in the home healthcare industry who manage Personal Care Aide (PCA) employees, and leadership performance effectiveness (metrics) of PCA job satisfaction, PCA employee turnover, as well as the customer satisfaction for home healthcare clients who received services delivered by PCA employees. The problem that is addressed by the research is the lack of home healthcare leaders who understand and adopt leadership practices for enhancing PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction, amid the expanding U.S. home healthcare industry. Leadership practices were based on the self-observed scores collected from home healthcare workers who lead PCA employees, via the Leadership Practices Inventory (LPI-Self) instrument. PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction, were based on archival data provided by a home healthcare organization and its leaders, collected as part of its ongoing quality assurance strategy. Correlational analyses resulted in statistically non-significant relationships between independent and dependent variables for the sample (N = 205). A supportive leadership style, as emphasized by The Five Practices of Exemplary Leadership® model, focuses on developing leader-follower relationships by demonstrating leadership practices in the best interests of individual employees, with the goal of maximizing organizational achievements. The principles of servant leadership emphasize the importance of supporting the performance of PCA employees, enabling their best efforts, and having a vision that brings all efforts together for a common purpose. Biblically, the life of Jesus Christ is depicted as the ultimate example of servant leadership. *Keywords*: LPI, leadership practices, effectiveness, satisfaction, turnover, home healthcare, personal care aide.

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_____ Date: _____

Dr. Eric Richardson, Chair

_____ Date: _____

Dr. Dave Duby, Committee Member

_____ Date: _____

Dr. Gene Sullivan, DBA Program Director

_____ Date: _____

Dr. Scott Hicks, Dean, School of Business

Dedication

This dissertation is dedicated to my Lord and Savior, Jesus Christ, for it is He who died on the cross that I might have *eternal life* (John 3:16 EXB). To my precious bride, Shannon Andrews Hodge, for it is she that I left my father and mother for to be *united* in one flesh (Genesis 2:24), and with whom I *love* as Christ loved the church (Ephesians 5:25-29). To my mother and father, Ted William Hodge and Carol Hash Hodge, for it is they that I *honor* through this academic achievement (Exodus 20:12).

Acknowledgments

I offer a sincere thank you and special blessing upon my brothers and sisters in Christ that supported me and made sacrifice throughout the rigor of this doctoral program, and to those that fostered my spiritual, academic, and professional growth. To each of the faculty at this anointed institution, Liberty University, for it is they that have chosen to live by a higher standard as teachers (James 3:1). To my wise counsel, Owen McKinley Foriest, for it is he who helped light my doctoral path with the Word (Psalm 119:105). To my doctoral chair, Dr. Eric L. Richardson, for it is he who aided my aimless trotting by training me toward goals, coaching me to run to win and fight like a boxer for this prize (1 Corinthians 9: 24-26). To my editor, Dr. Valerena U. Candy, for it is she that encouraged me during this foot race, that I one day might race with horses (Jeremiah 12:5).

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Section 1: Foundation of the Study

This research examined the relationship between the leadership practices of workers in the home healthcare industry who manage Personal Care Aide (PCA) employees, and leadership performance effectiveness (metrics) of PCA job satisfaction, and PCA employee turnover. The research also examined the relationship between leadership practices of workers in the home healthcare industry who manage PCA employees, and customer satisfaction for home healthcare clients who received services delivered by PCA employees (PCA services customer satisfaction). Leadership practices were based on the self observed scores collected from home healthcare workers who lead PCA employees, via Kouzes and Posner's (2001) Leadership Practices Inventory (LPI-Self) instrument, which is comprised of five subscales of leadership: Model the Way; Inspire a Shared Vision; Challenge the Process; Enable Others to Act; and Encourage the Heart. PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction, were based on archival data provided by a home healthcare company and its leaders, collected as part of its ongoing quality assurance strategy.

The research questions asked whether a statistically significant relationship exists between LPI-Self scores (the independent variable) of home healthcare workers who manage PCA employees, and the three dependent variables: PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. The corresponding null hypotheses were that no statistically significant relationship exists between the independent variable and each of the dependent variables. Leaders in the home healthcare industry are challenged to improve efficiencies while meeting an increasingly growing demand if they are to remain competitive. This research draws upon the existing body of management literature surrounding leadership and organizational performance and productivity. This research is relevant to the Doctor of Business

Administration program at Liberty University, as it contributes to the body of knowledge focused on the relationship between leadership and organizational performance. The results may contribute to knowledge and application within the scholarly-academic community focused on improving understanding and application of leadership practices, engagement, and commitment in contemporary business organizations.

Background of the Problem

In the United States, the population of individuals aged 65 years and older is projected to double over the next 15 years and is expected to exceed 70 million people (Ortman, Velkoff, & Hogan, 2014). The Baby Boomer generation has been defined as those born between 1946 and 1963 (Sand-Jecklin & Sherman, 2014). In conjunction with improved mortality rates, this generation is expected to generate an increased demand for healthcare services while simultaneously contributing to a shortage of supply workers, including nurses and PCAs, as they enter retirement (Ortman, Velkoff, & Hogan, 2014). The Baby Boomer will have largely retired by the year 2035, at which point there will be 25% fewer workers per retiree than there were in 2014 (Social Security Administration, 2015).

As the worker-to-retiree ratio decreases, effective leadership in healthcare organizations is all the more critical to enhance customer and job satisfaction levels, as well as to improve employee retention rates of committed, knowledgeable and experienced employees who are the foundation of a competitive edge. Research suggests that employees who consider a shortage of workers to be the norm, experience job dissatisfaction and make a decision to seek alternative employment (Ellenbecker, Samia, Byleckie, & Milburn, 2008). Further, demand for healthcare services is increasing exponentially as advances in technology and improvements in nutrition have extended life expectancy (Strulik & Vollmer, 2013). Hence, understanding the leadership

factors that improve job satisfaction and employee retention is critical for organizational survival.

Balogh-Robinson (2012) warns that the aging and related attrition and turnover of leadership positions in the home healthcare industry is projected to be upward of 70% during the next 5 years. This highlights the significance of studying and applying leadership practices that will attract and retain the skills needed to address the anticipated supply and demand challenge, within the healthcare industry. While leaders in the healthcare industry may choose to implement a variety of functional leadership strategies in pursuit of the growing market, it is evident that new levels of leadership effectiveness are inevitable given decreasing worker-to-retiree ratios and increasing demand for healthcare services.

From a home healthcare perspective, customers want to remain in their homes as they age and as disability requires them to seek assistance (The National Consumer Voice, 2012). According to the Bureau of Labor Statistics (2015b), Personal Care Aide (PCA) is a job classification for employees providing home healthcare services, which assist older adults with cognitive and other health related disabilities. The PCA job classification is projected to be the fastest growing occupation in the healthcare industry, increasing by 26% and adding the highest number of new jobs (458,100) of any occupation by the year 2024 (Bureau of Labor Statistics, 2015a). It is logical to assume that the demand for effective leadership practices, that can improve PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction, in home healthcare businesses, will also increase.

The federal government has recognized the pressing need for qualified PCAs by passing the Personal and Home Care Aide State Training (PHCAST) Program authorized under Section 5507(a) of the Affordable Care Act (ACA) (Department of Health and Human Services, 2016).

The purpose of the PHCAST grant program is to assist states in recruiting and training unemployed individuals as qualified PCAs in high demand areas. The Federal government also placed into effect the Companion Exemption Protection Act (CEPA) on September 18, 2015, granting overtime protections for all PCAs (Department of Labor, 2013). Though CEPA was overturned in 2016, its inception highlights the relevance of PCA leadership in the home healthcare industry. Further, healthcare insurance and overtime pay are financial benefits that impact how PCAs determine job satisfaction (Kalleberg, 1977).

Problem Statement

The home healthcare industry has experienced changes driven by government regulation while challenged to meet an expanding demand for services with a shortage of workers (Stone et al., 2006). The problem to be addressed is the lack of home healthcare leaders who understand and adopt leadership practices for enhancing PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction, amid the expanding home healthcare industry. Westerberg and Tafvelin (2014) claim that the lack of leadership engagement is common in home healthcare services, where solitary work restricts control and consequently mediates the quality of care provided. The connection between supportive leadership approaches and enhanced patient (customer) satisfaction justifies this research of the examination of leadership models and practices in the home healthcare industry (Wong, Cummings, & Ducharme, 2013). Understanding the factors that contribute to job retention of home healthcare workers is critical to addressing the forthcoming increased demand for related services (Butler, Brennan-Ing, Wardamasky, & Ashley, 2014).

As the healthcare market expands and the retiree-to-worker ratio increases, the demand for effective leadership practices will increase in tandem. According to Angood and Birk (2014),

constraints on revenue and heightened awareness by the market position healthcare leaders for making leadership decisions that ultimately affect the delivery of healthcare services. If leaders in the home healthcare industry are not executing exemplary leadership practices that lead to effective human resource decision-making, then the growing population of home healthcare workers and customers stand to bear the burden.

Purpose Statement

The purpose of this non-experimental quantitative correlational research was to examine the relationship between leadership practices (self observed LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry. The independent variable was exemplary leadership defined as home healthcare worker effectiveness (i.e., impacting commitment, engagement, and satisfaction) as leaders of PCA employees. The dependent variables were defined as home healthcare worker performance as leaders of PCA employees, and productivity effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction.

Nature of the Study

Method

This non-experimental quantitative correlational research examined whether there was a statistically significant relationship between home healthcare leadership practices and performance outcomes (job satisfaction, employee turnover, and customer satisfaction). Quantitative research approaches adopt objective reasoning based on the measurement of phenomena using closed end questions, numbers, and counts of observations (Creswell, 2011; Crotty, 1998; Monette, Sullivan, & DeJong, 2011). Quantitative research tests objective theories

by examining relationships between and among variables, and correlational research involves observing the world without direct interference (Creswell, 2014).

This particular research is justified in its use of quantitative research by its use of a survey in order to answer the research questions and to test the null hypotheses. This means that the quantitative nature of the research allows for numerical instances to be used as measurements for the events in question, allowing for further analysis of the research problem. Despite the rigid structure of the research design, it is believed that this is the most effective way to answer the research questions. Regardless of the specific research question that determines the statistical procedure, quantitative research is particularly strong at studying large groups of people and making generalizations from the sample being studied to the broader group or target population. This research employed a correlational research design to measure the association between the independent and dependent variables at a snapshot in time.

Comparatively, a qualitative research design was not appropriate for this research because the researcher was not exploring the qualitative consistencies of home healthcare leadership practices. Qualitative research employs direct contact with research participants and a focus on their individual experiences, as to explore the richness, depth, and complexity of phenomena (Creswell, 2014). This research was not attempting to explain leadership phenomena, rather, describe the correlation between descriptive variables. Further, mixed method research designs seek to generate conclusions from both quantitative and qualitative strands of research data (Crewsell & Plano Clark, 2011). Therefore, the researcher did not employ a mix method research design. Finally, a case study approach was not appropriate for this research, as the researcher was not conducting the research in an ordinary setting, following

issues or circumstances as they emerge, or within special scenarios structured by a causal theoretical model (Abma & Stake, 2014).

Design

The specific design for this research is non-experimental. In non-experimental research, it is not possible for the researcher to manipulate the predictor variable. Rather, the researcher must rely on observation, interpretation, or interactions to develop a conclusion (Gelo, Braakmann, & Benetka, 2008). Therefore, since this research was based on surveys, non-experimental research was beneficial in this particular study. This is because the research cannot demonstrate cause and effect.

Non-experimental research is high in external validity, allowing results to be generalized to a larger population (Gelo et al., 2008). Significantly, non-experimental research focuses on observations and interpretations. This means that non-experimental research cannot confirm that one variable causes another variable to occur. Non-experimental research is disadvantageous because it is not possible for the researcher to establish definitively cause and effect relationships or to manipulate variables, and the research method is mostly correlation or case study (Gelo et al., 2008). Yet, this type of research is advantageous because it meets needs that other studies cannot. This is important because some variables cannot be manipulated, such as age, gender, ethnicity, length of employment, or current opinion. Since these variables cannot be manipulated or controlled, it is possible for the non-experimental design to allow for the examination of these variables (Gelo et al, 2008). This method was deemed to be the most effective because the predictor variable could not be modified. The independent variable was exemplary leadership, which cannot be modified. As such, the research was most effectively completed as a non-experimental design.

A descriptive research design was not appropriate for this study because the researcher was not seeking to provide systematic information about the leadership phenomenon, rather, explain the relationship between leadership and performance outcomes. Further, a quasi-experimental research design was not appropriate for this study because the researcher was not seeking to establish a cause-effect relationship between the variables (Creswell, 2014). Finally, an experimental research design was not appropriate for this study because the researcher was not using the scientific method to test causality, or manipulate the independent variable to determine the effects on the dependent variable.

Research Questions

A number of factors may influence the degree to which a home healthcare leader produces effective leadership performance. This research focused on the relationship between the leader's self observed leadership practices and business performance outcomes pertaining to PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. The researcher investigated the following research questions (R):

R1. Is there a statistically significant relationship between home healthcare leadership practices and PCA job satisfaction?

R2. Is there a statistically significant relationship between home healthcare leadership practices and PCA employee turnover?

R3. Is there a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction?

The researcher proposed research question R1 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA job satisfaction. The researcher proposed research question R2 to

determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the PCA employee turnover metric calculated from the survey data. The researcher proposed research question R3 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA services customer satisfaction.

Hypotheses

The corresponding null hypotheses (H0) and alternative hypotheses (HA) for each research question are:

H01: There is no statistically significant relationship between home healthcare leadership practices and PCA job satisfaction.

HA1:   There is a statistically significant relationship between home healthcare leadership practices and PCA job satisfaction.

H02: There is no statistically significant relationship between home healthcare leadership practices and PCA employee turnover.

HA2:   There is a statistically significant relationship between home healthcare leadership practices and PCA employee turnover.

H03: There is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

HA3: There is a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

For the hypotheses and null hypotheses, the independent variable and dependent variables were the same as for the research questions. The hypotheses related to the research problem because they correspond by testing the null hypotheses concerning the statistically significant

relationships between the independent variable and the dependent variables. Chapter 3 provides

details on the data analysis used to test the null hypotheses and answer the research questions.

Theoretical Framework

The nature of the study was quantitative and non-experimental in design. The research

focused specifically on the home healthcare industry. The research examined the relationship

between Kouzes and Posner's (1987) Five Practices of Exemplary Leadership® model and

performance effectiveness (related to job satisfaction, employee turnover, and customer

satisfaction) in the home healthcare industry. The independent variable was exemplary

leadership defined as home healthcare worker effectiveness (i.e., impacting commitment,

engagement, and satisfaction) as leaders of PCA employees. The dependent variables were

defined as home healthcare worker performance as leaders of PCA employees, and productivity

effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services

customer satisfaction.

Kouzes and Posner (1987) developed the Five Practices of Exemplary Leadership®

model (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to

Act, Encourage the Heart) to measure transformational leadership characteristics. According to

Zagorsek, Stough, and Jaklic (2006), these five leadership dimensions accurately reflect the

common themes found within transformational leadership theory (e.g., empowerment,

recognition, values, vision). The Five Practices of Exemplary Leadership are supported by Ten

Commitments of Exemplary Leadership®. Within the Model the Way leadership practice,

exemplary leaders (a) clarify values by finding their voice and affirming shared values, and (b)

set the example by aligning actions with shared values. Within the Inspire a Shared Vision

leadership practice, exemplary leaders (a) envision the future by imagining exciting and

ennobling possibilities, and (b) enlist others in a common vision by appealing to shared aspirations. Within the Challenge the Process leadership practice, exemplary leaders (a) search for opportunities by seizing the initiative and looking outward for innovative ways to improve, and (b) experiment and take risks by constantly generating small wins and learning from experience. Within the Enable Others to Act leadership practice, exemplary leaders (a) foster collaboration by building trust and facilitating relationships, and (b) strengthen others by increasing self-determination and developing competence. Within the Encourage the Heart leadership practice, exemplary leaders (a) recognize contributions by showing appreciation for individual excellence, and (b) celebrate the values and victories by creating a spirit of community.

The concept of job satisfaction has been extensively researched across various organizational management topics, and reported in academic literature since the early part of the 19th century. The Hawthorn Studies were conducted between 1924 and 1932, with the host organization Western Electric, to determine the how the productivity of workers was being impacted by changing social, financial, and physical factors (Hassard, 2012). The value proposition presented highlights the influence of human relationships and social interactions on employee behavior and performance, which creates an awareness for the work values driving job satisfaction. According to Kalleberg (1977), work values (e.g., intrinsic, convenience, financial, career opportunities, relationships with coworkers, resource adequacy) have independent and significant effects on job satisfaction. According to Locke (1969), job satisfaction is a function of the perceived relationship between "what one wants from one's job and what one perceives it as offering or entailing" (p. 316). Edmans (2012) examined the link between job satisfaction and firm value, and found job satisfaction to have a positive relationship with firm value. Gibson and

Petrosko (2014) researched the effect of leadership practices pertaining to trust on employee job satisfaction and the intent to leave in a healthcare setting, and found that employees and customers in the healthcare industry face "immense challenges", which require a more "holistic view" of leadership effectiveness beyond the technical aspects of patient care (p. 16).

Employee turnover is a key issue facing the home healthcare industry, as turnover among frontline workers is a critical cost driver (Seavey, 2011). Reilly, Nyberg, Maltarich, and Weller (2014) found that rates of turnover in the nursing industry, in conjunction with job demands, "comprise a dynamic, evolving system that singularly and collectively influences patient satisfaction" (p. 787). Basford, Offerman, and Wirtz (2012) found supportive leadership practices to foster enhanced levels of job satisfaction and be negatively associated with employee turnover, intention to quit, and burnout. Abualrub and Alghamdi (2012) researched the impact of leadership styles on job satisfaction and turnover intention and found that nurses are more satisfied with leaders who demonstrated transformational leadership styles. Further, nurses who exhibited higher levels of job satisfaction intended to say with their employer longer. The results of the research emphasized the importance of transformational leadership as effective leadership practices in healthcare.

Churchill and Surprenant (1982) described customer satisfaction as being composed of four primary concepts: expectations, performance, disconfirmation, and satisfaction. According to Chuang et al. (2012), front-line employees play a critical role in the delivery of basic healthcare services, which directly influences customer satisfaction and other healthcare outcomes. While turnover of direct care workers may have negative organizational consequences in terms of recruitment and retention costs, the greater organizational risks appear to reside in decreased continuity, service quality, and productivity (Buffington, Zwink, Fink,

DeVine, & Sanders, 2012). Service quality has a direct influence on customer satisfaction

(Panchapakesan, Sai, & Rajendran, 2015). Further, direct care workers play an "indispensable

role" in providing results that foster customer satisfaction with healthcare services (p. 10).

According to Lopez-Perez et al. (2013), the empathic concern shown by direct care workers has

a direct influence on customer satisfaction, which benefits healthcare service providers and

recipients. The ability of direct care workers to manage emotions and interactions with

customers is an individual trait that can be assisted through leadership practices that foster

positive and authentic organizational climates (Grandey et al., 2012).

More detailed information regarding the survey design, sample size, methods, etc. will be

further described in Section 2.
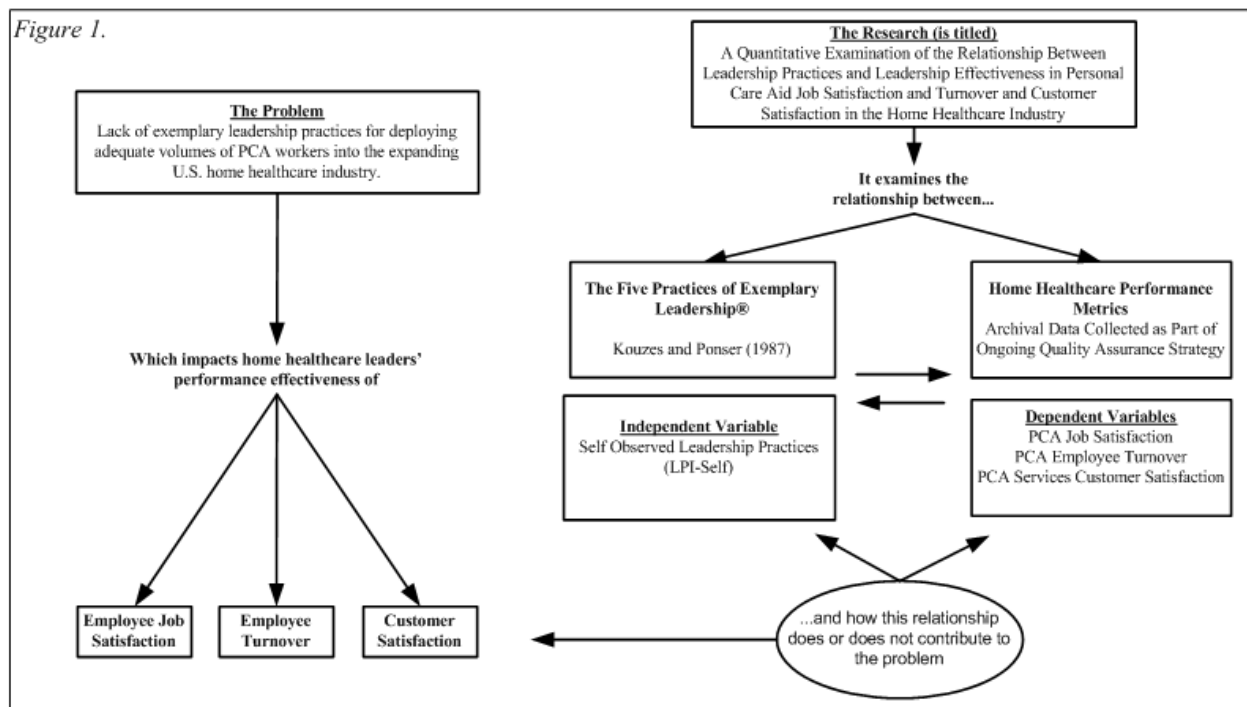
Figure 1. Theoretical framework

Definition of Terms

The following terms are defined relative to their use in this research:

Customer: The consumer or recipient of home healthcare services.

Customer Satisfaction: The cognitive state of being adequately or inadequately rewarded for the sacrifices a customer has undergone in a buying situation (Howard & Seth, 1969).

Job Satisfaction: The satisfaction with intrinsic and extrinsic factors affecting worker employment (Herzberg, 1987).

Leadership: The person to who has the right to conduct business for home healthcare services. According to Stogdill (1974), there are nearly as many definitions of leadership as there are authors who have sought to define the concept. Stogdill defined leadership as the "initiation and maintenance of structure in expectation and interaction" (p. 411).

Personal Care Aide (PCA): occupational designation for workers who assist clients with self-care and activities of daily living in a non-medical way (Bureau of Labor Statistics, 2015b).

Senior Citizen: Any U.S. citizen aged 65 or older residing in the U.S.

Assumptions, Limitations, and Delimitations

Assumptions

This research assumed that leadership was comprised of the five components of Kouzes and Posner's (1987) Leadership Practices Inventory® (LPI) instrument (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart). This assumption is supported by the validity and reliability of this survey instrument (Kouzes & Posner, 2016a; Posner & Kouzes, 1993). Therefore, it is appropriate to assume that leadership can be measured accurately according to these five components.

There are other survey instuments that measure leadership:

- Multifactor Leadership Questionnaire (MLQ) - by Bass and Avolio (1985)

- Transformational Leadership Behavior Inventory (TLI) - by Podsakoff, MacKenzie, Moorman, and Fetter (1990)

- Global Transformational Leadership Scale (GTL) - by Carless, Wearing, and Mann (2000)

- Student's Leadership Practices Inventory (LPI) - by Kouzes and Posner (1998)

- Leader Attributes Inventory (LAI) - by Burke (1994)

- CK Scale of Charismatic Leadership - by Conger, Kanungo, Menon, and Mathur (1997)

- Leadership Traits Questionnaire (LTQ) - by Northouse (2016)

- Path-Goal Leadership Questionnaire - by Indvik (1985, 1988)

but only the LPI sources leadership from these five factors combined. The LPI leadership factors are static and do not change over time. In comparison, leader member exchange (LMX) is based on relationships (i.e., a product of leaders and members' engagement with the realities of the environment), which are dynamic.

A fundamental assumption upon which the rationale of this research was based is that the dependent variables reflected leadership efficiencies with negligible influence exerted by unidentified mediating or moderating variables. For example, the underlying motivation for response bias may have been attributed to individual perceptions of satisfaction with other variables such as pay, disciplinary outcomes, or relations with peers. The accuracy and standardization of the existing data sampling and response techniques were accepted as meeting the robust standards required for doctoral primary research.

Critically, it was assumed that the research participants understood the survey questions and responded to each survey question honestly. This assumption is critical because the

researcher held no control over other mediating variables (e.g., participant fatigue or mood) or moderating variables (e.g., participant gender, age, tenure). Further, the research assumed that survey responses from research participants could be transformed from the ordinal to the interval level of measurement for purposes of conducting parametric statistics.

The research also assumed the archival data utilized to measure PCA job satisfaction and PCA services customer satisfaction metrics were gathered with minimal systematic error and bias. Further, it was assumed that customers of home healthcare services and employees of the home healthcare company rated various attributes of their experience honestly. Based on these responses, it was assumed that the importance of each of these areas and how much each one contributes to overall satisfaction (i.e., factors) were determined without bias. Further, respondent ratings in each of these areas as well as their relative importance were combined without statistical error to create an overall numerical index score reflective of customer and client satisfaction.

Limitations

The research was limited to leaders operating within a single network of the U. S. home healthcare sector of the healthcare industry. The company selected for this research was well established, large in size, and representative of a significant population of home healthcare workers and customers. Understanding the leadership practices within this population of workers can be useful to the many other networks in this sector, as well as many other local-level agencies that serve the home healthcare industry.

Limitations of this research include those things that are not controllable, and/or cannot be explained by the research analysis. The research was limited by the research method selected by the researcher, and the amount of literature available on the subject matter. The research

project was also limited by its concentration on leadership roles that may, or may not, be in a position to directly influence the deployment of home healthcare workers for meeting the related demands for care services. Limitations influencing the dependent variable related to Baby Boomer retirement forecasts and the expansion of the senior care industry, increased competition for quality PCAs, and Federal regulations pertaining to PCA training, wages, and benefits.

This research focused on self observed perceptions of exemplary leadership practices as measured by the LPI-Self instrument and, and is limited by its constructs. Additional limitations pertaining to leadership practices include: self perception accuracy, emotional intelligence, inspirational motivation, and intellectual stimulation. Utilizing a different leadership practices instruments could provide a richer description of the unique aspects of home healthcare leadership (Tatlah, Iqbal, Amin, & Quraishi, 2014).

The data analysis technique for this research utilized the Pearson correlation coefficient (Pearson's *r*) statistic, as well as Spearman's correlation coefficient (Spearman's *rho*) where the assumptions of normality were violated, to examine whether a statistically significant relationship existed between the independent and dependent variables. The Pearson correlation coefficient (Pearson's *r*) is a robust statistic (Field, 2009) but does not infer any cause and effect relationship between the variables. The research interpreted the results and findings within that limitation while recommending future lines of inquiry.

Delimitations

The researcher sampled 389 leaders of PCA employees, in a leading home healthcare company with locations across the U.S. The support and participation extended by this home healthcare company and its leaders enabled the researcher to collect data using a convenience sample.

The researcher delimited this research in the following ways. First, the research of leadership practices in the home healthcare industry could be expanded to other home healthcare companies and other geographic locations, than only that which was selected for this study. In lieu of time constraints and financial restrictions, the sample for this research was limited to a leading home healthcare company. Limiting the sample size could decrease the representativeness of the population being examined and the ability to generalize the findings (Creswell, 2014). Therefore, the sample may not be representative of the entire population of PCA leaders across the home healthcare industry, the U.S., or globally.

The delimitations of this study include:

1. The participants were over 18 years of age.

2. The participants work for the targeted home healthcare company.

3. The participants work in one of the 389 offices identified.

4. The participants carry a title implying leadership over PCA employees (e.g., manager, director).

These constrictions limit the ability to generalize the study findings beyond the specific context.

Significance of the Study

Reduction of Gaps

The research presented holds significance for the various stakeholders in the home healthcare industry (e.g., owners, employees, customers, healthcare facilities, customer family members, and powers of attorney). The lack of home healthcare leaders who understand and adopt leadership practices for enhancing PCA job satisfaction and PCA employee turnover, as well as PCA services customer satisfaction, amid the expanding senior citizen population, is an important consideration for the home healthcare industry. Hiring, training, and developing

leadership that can address the significant challenges posed by market constraints and leverage internal resources is essential to maintaining a competitive edge. The apparent connection between supportive leadership approaches and higher customer satisfaction levels merits future examination of leadership models that test the mutlivariate influences on the relationship between leadership and customer outcomes (Wong, Cummings, & Ducharme, 2013).

Customers seeking home healthcare services face strikingly different value propositions from market providers, based on leadership effectiveness over PCA employees. This value is a composition of the leadership practices utilized in deploying PCAs into the home healthcare market, and the leader's effectiveness in generating high employee job satisfaction, low employee turnover, and high customer satisfaction levels for the home healthcare services rendered to the market. According to Westerberg and Tafvelin (2014), lack of leadership engagement is common in home healthcare services, where solitary of work limits the possibility of control, which mediates the quality (i.e., value) of care rendered. This research sought to demonstrate the importance of employing home healthcare leaders who practice leadership behaviors in a manner consistent with delivering high-value care services, via low-risk PCAs, in conjunction with the financial pressures of market expansion and increased competition.

The forthcoming constraints for the home healthcare industry will inevitably require more effective leadership practices for rendering adequate volumes of PCA's to the market, and promoting positive change in those who follow an established vision for high quality healthcare services. Understanding the factors that enhance the retention of home healthcare workers is critical to addressing the forthcoming demand direct care workers in the healthcare industry (Butler, Brennan-Ing, Wardamasky, & Ashley, 2014). For home healthcare businesses to remain competitive amid industry growth and increased federal regulations, the costs associated with

effective recruitment and retention of adequate volumes of low risk PCAs must be optimize.

Further, for businesses to remain profitable, increases to the cost of providing home healthcare

services are likely to be passed along to the consumer. Any lack of leadership effectiveness in

this regard may result in higher prices for the care services rendered by each PCA, which may

negatively impact customer satisfaction levels of the consumers. In contrast, home healthcare

leaders, who produce higher employee and customer satisfaction levels, may enjoy lower rates of

employee turnover which in turn serve to optimize the overall cost of deploying workers to the

home healthcare market.

Implications for Biblical Integration

According to the Genesis account, work is the designed avenue for human assets to

express their creativity and unique talents (Genesis 2:15). Business is a two-edge sword, that

provides quality products for the "needs of the body" (James 2:16 EXB), and meaningful work

for the laborers (Genesis 3:17-19). Biblically, the life of Jesus Christ is depicted as the ultimate

example of servant leadership. Robert Greenleaf, who coined the term servant-leadership in

1970, states that true servant-leadership begins with the "natural feeling that one wants to serve,

to serve first" (Greenleaf, 1977, p. 7).

It is the inherent ability to understand and share the feelings of others that enables a

servant leader to "do unto others" (Mathew 7:12 AMP) and "seek the welfare of his neighbor" (1

Corinthians 10:24). Jesus Christ described to his disciples an honor in caring for the thirsty, the

stranger, the poor, the sick, and the imprisoned (Mathew 25:35-36 NIV). Those in need of

healthcare can accurately be classified in any of the aforementioned categories.

In the Bible, the book of Ruth (NIV) tells the story of an elder mother, Naomi, with an

emotional sickness. Naomi, after losing her husband and two sons, asks to no longer be called

"Naomi" but instead be referred to as Mara as a reflection of her bitterness (Ruth 1:20).

Bitterness is a reflection of poorness in spirit. Jesus Christ described the poor in spirit as

"blessed…for theirs is the Kingdom of Heaven" (Matthew 5:3). The Amplified Bible expands

"blessed" in this verse to "spiritually prosperous with life-joy and satisfaction in God's favor and

salvation, regardless of outward conditions." In the case of Naomi, her outward condition

required care. Her daughter-in-law, Ruth, was called to bless Naomi's needs by providing the

appropriate level of care according to those needs. The PCA occupation can similarly be viewed

as a calling to serve the home healthcare needs of the market.

From a biblical worldview perspective, businesses should seek to maximize the unique

gifts of its employees and foster the potential to glorify God with their profession and calling.

Maximizing the unique gifts of employees requires business leaders to provide meaningful and

creative work, for which employees may utilize their God-given talents and gifts for the greater

good of humanity (Van Duzer, 2010). Although Ruth was from the wicked nation of Moab

(Numbers 25:1-5), she learned great spiritual values (i.e., Israelite biblical values) amid the

family of Naomi. Leaders of home healthcare businesses share a similar opportunity to

effectively lead PCAs in the deployment of high quality home healthcare services, with the

ultimate goal of providing care that is satisfying to both the customer and the worker, and

pleasing to God.

Further, leaders of home healthcare businesses are to reward workers with fair wages and

benefits for the home healthcare services they render. Continuing with the example of Ruth, the

Lord recompensed her for all she had done for Naomi. Ruth was given a "full reward" (Ruth

4:13). In this example, the Lord gave Ruth a husband, enabled her to conceive, and blessed her

with a son.

Relationship to Field of Study

The academic research of leadership practices, and its impact on business outcomes, is relevant to the Leadership Cognate of the Doctor of Business Administration at Liberty University. Leadership continues to be one of the most popular topics studied within the context of business, and the current study built upon previous research pertaining to leadership practices by focusing on the home healthcare industry. Further, utilizing the LPI-Self instrument to measure leadership practices provided a direct link for the study to transformational leadership theory.

This research added to the body of literature documenting the relationship that exists between leadership effectiveness and job satisfaction, employee turnover, and customer satisfaction. While research specific to the leadership practices of home healthcare workers who manage PCA employees, and their impact on organizational productivity measures, is scarce, research specific to leadership practices in the clinical setting of the healthcare industry (e.g., hospitals), and its related impact on nurse satisfaction/turnover and quality of care, is prevalent. For example, Martin, Mccormack, Fitzsimons, and Spirig's (2012) research of nurse administrators finds effective leadership practices to be essential for delivering high quality care within healthcare organizations, and best facilitated via formal leadership training and "purposeful facilitation" of leadership practices (p. 79).

Hunt (2014) utilized the LPI instrument to investigate job satisfaction and employee turnover among nurses and nurse supervisors. The findings revealed a positive correlation between leadership practices and job satisfaction but a negative correlation between leadership practices and turnover intent. Hunt interpreted the results to support a reciprocal relationship between patient (customer) satisfaction and nurse (employee) job satisfaction, and presented

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evidence to suggest that decreasing turnover rates in nursing roles contribute to improved patient outcomes.

A Review of the Professional and Academic Literature

The literature review section demonstrates how professional and academic research and literature clearly relate to the applied problem statement. The content of this literature review was drawn from acceptable seminal works, peer-reviewed journals, and other sound academic literature. The review of related theories compares and contrasts different points of view and the relationship of the study to previous research and findings, which provides depth to the study's problem and purpose. The literature review chapter begins with concise summaries of the leadership theories that have defined the most relevant aspects of leadership practices for improved business performance during the past century. This history of leadership theory is divided into six main categories: The Great Man Theory, Trait, Behavioral, Contingency, Transformational, and Servant Leadership. These leadership theories are the most commonly accepted categorizations of leadership in research literature and define the aspects of leadership practice most effectively (Leadership-central.com, 2016). The following section focuses on Kouzes and Posner (1987) Five Practices of Exemplary Leadership® (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart) and the Leadership Practices Inventory® (LPI) scale. The LPI was created to determine specific leadership characteristics that are present within individuals, and is a primary instrument used in this study. The Leadership and Motivation subsection discusses two theories of human motivation, and empirical studies within the body of management and business that focused on leadership practices and its relationship with organizational productivity measures, including: job

satisfaction, employee turnover, and customer satisfaction. The final subsection section summarizes Section 1 and provides a transition to Section 2.

Leadership Theory

The intent of the leadership theory section was to provide an overview of the seminal and contemporary leadership theories and concepts. The theoretical basis for leadership seemingly spans the length of time, from the beginning of mankind, through modern times, and into the future. Kehinde and Banjo (2014) reflect on the overwhelming academic and practitioner belief that organizational success depends upon leaders to facilitate changes and actions required to ensure and maintain organizational performance. A plethora of research focused on leadership styles has lent support to models linking leadership practices to positive organizational productivity (Kehinde & Banjo, 2014). Bass and Avolio (1990) claimed that leaders account for nearly two thirds of all positive outcomes, including enhanced levels of customer and job satisfaction.

Great Man Theory of Leadership

The concept of a leader-follower relationship appears to span the length of human existence. Egyptian hieroglyphics depicted concepts of leader, leadership, and follower, some 5,000 years ago (Stogdill, 1974). From a biblical perspective, the book of Genesis (1400 B.C.) serves as the theological foundation of Christian leadership in its description of God's creative work and the transfer of certain authorities to mankind. According to Genesis, God provided leadership to Adam (v. 2:16-17), Adam provided leadership to Eve (v. 3:16), and Adam and Eve provided leadership to their children (v. 4:1). According to Yammarino (2013), the design of this world results in a human desire and need for leadership, whereby humans idealize exemplary leaders.

Biblically, work is the most natural platform for leadership to function (Genesis 2:15). Humans are intended for work, and commanded to work "very hard" (Genesis 3:17 EXB). Working effectively requires a certain level of leadership for enabling a common purpose and goals for people to work toward. Effective working relationships enable the creation of value, and the multiplication of value for the greater good of humanity. Work matters and has eternal implications (Van Duzer, 2010), and its renderings will eventually be tested and rewarded (1 Corinthians 3:13-15). Therefore, understanding the constructs of leadership is paramount.

The Book of Exodus in the Old Testament, presents a historical rendering of the liberation of the people of Israel from slavery in Egypt in the 13th century B.C, under the leadership of Moses. It provides a clear example of how leadership influences work and the satisfaction levels of the stakeholders therein. Jethro, father-in-law of Moses, observed Moses' leadership practices for solving disagreements among the Israelite people, and the apparent dissatisfaction of the people for having to stand in line "from morning until night" waiting to bring their issue to Moses (Exodus 18:13-14 EXB). Jethro wisely instilled new leadership practices in Moses by helping Moses to develop a plan for leading the Israelites in new and better ways. Chapter 18 documents this intervention, whereby Jethro created a platform for the review of leadership practices by facilitating a "holy meal" in which all the elders came to eat, engaged in reflective inquiry with Moses about the current process for resolving disputes among the people, and established a systematic, reality based, and structured solution to "share the work" and make more effective use of Moses leadership position (v. 15-23).

The term "leader" appears in academic literature as early as the 13th century, and the theoretical concept of "leadership" appears as early as the 17th century (Stodgill, 1974). One of the earliest trait leadership theories to prevail in Western culture was The Great Man Theory,

popularized by Thomas Carlyle (1904) in his study of a diverse set of prominent and historical male persons. Through the illumination of heroic behaviors, Carlyle formalized the concept of a social hero and the identification of five characteristics of a great man: divinity, prophet, poet, priest, man of letters, and king. Carlyle held that all men who qualify as heroes are endowed with certain characteristics (e.g., bravery, steadfastness, sincerity, gentleness), which enable them to lead change and direct society. According to The Great Man Theory, in order to become a strong leader, a person must, in effect, copy the personality traits and characteristics exhibited by the heroic great.

The Great Man Theory fails to consider the constructs of leadership trait development or the influence of personality on one's ability to lead. Herbert Spencer (1873) argued against The Great Man Theory, stating that the genesis of a great man is a product of society's mental and material accumulations (e.g., intelligence, character, social arrangements), without which a great man is powerless and unable to function effectively. Bowerman and Van Wart (2011) supported the plausibility of The Great Man Theory, by postulating a certain influence that traits have on leadership behavior.

Trait Theories of Leadership

Formal scientific research of leadership theory began in the late 19th century (Bass, 1985). Origins of the trait paradigm in leadership theory began with Galton's (1869) theory of hereditary genius, which described a person's natural abilities as being endowed by inheritance, and operating within the same limitations as the physical features of the entire organic world (Derue, Nahrgang, Wellman, & Humphrey, 2011, p. 7). In an effort to further the systematic investigation of leadership traits, Allport and Odbert (1936) tabulated and categorized some 17,953 trait names in the English language, and reduced them to a "minimum listing" of 4,504

terms that symbolized the "most clearly real traits of personality" (p. 26). According to their research, depicting personality trait names as accurately and as faithfully as possible, in correspondence with authentic psychological dispositions, enhanced a person's ability to "understand and control one's fellow" (p. 1).

Allport (1937) went on to subdivide the trait name listing into a three-level hierarchy of traits (i.e., secondary, central, and cardinal). Secondary traits are described as the least influential to behavior, seen only in certain circumstances (i.e., situational), but must be considered in order to provide a complete picture of human complexity. Central traits represent a small number of defining traits that collectively shape individual behavior. Cardinal traits emerge occasionally as a single dominant force in personality that overshadows all others traits by ruling a person's passions and obsessions (e.g., need for money or fame).

According to the aforementioned theorists, leadership is multidimensional and influenced by social and psychological factors. Allport (1954) defined social psychology as "an attempt to explain and understand how the thoughts, feelings and behaviors of individuals are influenced by the actual, imagined or implied presence of others" (p. 5). Allport's research highlights how the presence of a leader can influence the behavior of individuals. Further, the psychological maturity of a leader, which stems from a well-developed sense of self and a richly adaptive set of attitudinal dispositions fostering mental health, influences leadership effectiveness. Allport (1954) also defined seven characteristics of mental health: specific and enduring extensions of self (i.e., involvement); dependable techniques for warm relating to others (e.g., trust, empathy, genuineness, tolerance); emotional security and self-acceptance; habits of realistic perception, versus defensiveness; problem-centeredness and the development of problem-solving skills; self-objectification pertaining to insight into one's own behavior (e.g., the ability to laugh at oneself);

a unifying philosophy of life, including a particular value orientation, differentiated religious sentiment, and personalized conscience.

Stogdill (1974) furthered trait leadership research by conducting a comprehensive review of leadership literature, and outlining ten traits associated with proficient leadership: honest, intelligent, great sense of humor, initiative (e.g., persistence, ambition, desire to excel), competent, integrity and conviction, responsibility, insight (e.g., into self, others, and the wider environment), self-confidence, and inspiring. McCall and Lombardo (1983) expanded on Stogdill's work, arguing that leaders are made or broken based on emotional stability, the ability to admit faults and errors, intellectual strength, and having refined interpersonal skills and relations.

Behavioral Theories of Leadership

As leadership theory evolved, researchers began to look beyond trait theory and into leadership behaviors and its influence on leadership effectiveness. House and Adjta (1997) provided an extensive literature of leadership theory, and concluded that a significant amount of early research findings on trait theory was not replicable. Critics of the trait approach argued that traits must be persistent, predictable, sustained over significant periods of time, and observed under different circumstances and situations. House and Adjta (1997) also demonstrated how the development of knowledge concerning leadership phenomena had cumulated over time, suggesting that leadership may also be a subjective and a non static reflection of societal preferences.

A central theme in all definitions of leadership appears to be the notion of influence, whereby leadership effectiveness comes as a result of successfully creating and maintaining effective relationships with those influenced (Bhugra, Ruiz, & Gupta, 2013). Research into the

behavioral practices that leaders adopt, provided a basis for new leadership theories to form and take into account the reciprocal or exchange behaviors of followers. According to Yammarino (2013), leadership effectiveness research conducted prior to 1970 focused strictly on the leader as a person, the group being led, and the effectiveness of group performance based on how the leader interacts with the group overall.

Blake and Mouton (1964) proposed a two-dimensional combination of both relationship-oriented and task-oriented behaviors for maximizing organizational benefit. The researchers formulated a managerial grid, which includes key behaviors associated with good leadership: initiative (i.e., being at the forefront of action); inquiry (i.e., seeking and testing information to further understanding); advocacy (i.e., communicating opinions and ideas with convictions); decision-making (i.e., identifying possible options and consequences, and acting on one); conflict resolution (i.e., confronting disagreements and reaching a resolution); critique (i.e., using previous experience to anticipate how behaviors have an effect on actions); resilience (i.e., understanding how problems influence the ability to move forward). According to the researchers, this theory of managerial behavior attempts to overcome issues pertaining to uni-dimensionality in earlier leadership theory. The dual theory that emerged depicts conflict management as a function of a concern for self (high or low), combined with a concern for others (high or low).

Willcocks (2012) researched the history and background of leadership in the nursing industry, and found the position power of nursing roles to be unique, requiring specific leadership styles depending upon the context (e.g., intensive care versus a general medical ward). Such leaders require specific characteristics for enabling them to inspire, stimulate, and motivate their workforce. It can naturally be assumed that a similar logic applies to the context of leaders

of PCA employees, in that specific leadership practices are more conducive for the home healthcare industry than others. Therefore, further analysis and interpretation of specific leadership practices is necessary for optimizing leadership effectiveness for deploying PCA's into the home healthcare market.

Contingency Theories of Leadership

Contingency theories were developed to reconcile differences in the behavior of leaders. Robbins and Judge (2011) discuss five contingency theories: Fiedler's Contingency Theory of Leadership (Fielder, 1971); Leader Member Exchange Theory (Dansereau et al., 1975); the Path-Goal Theory (House, 1971); the Situational Leadership Theory (Hersey & Blanchard, 1982); and the Leader-Participation or Decision Process Theory (Vroom & Yetton, 1973).

Fred Fiedler (1958) proposed a contingency model of leadership, whereby leadership effectiveness is based upon position power, leader-member relations, and task structure (Landis, Hill, & Harvey, 2014). These three leadership variables determine the favorableness of each situation and assists leaders in determining the most effective leadership style (i.e., set of behaviors). Within this construct, the leader-member arrangement relies upon how the group receives the leader, work tasks, and the leader's ability to exert control over the group. The model promotes the proper matching of leaders with situations in which they will be most effective.

Fielder's contingency theory (1971) was the first to suggest that the most appropriate leadership style should be based on an interaction between leader, follower, and situation. The variables include: the leader-follower relationship; the leadership styles of task-orientation or relationship-orientation; and the situation defined by task, structure, or position power. Fielder claimed that the interaction of variables (behaviors) associated with task-motivation and

relationship-motivation, defined the degree of situational control (influence) the leader can exert on a follower or group. Fielder argued that leader-follower relationships are the most important aspect of any situation lending support for the LMX model. However, Fielder also emphasized how the leader's psychological disposition was the main determinant in ability to lead.

Dansereau et al.'s (1975) research used a longitudinal design to support the theory that leadership is the product of an exchange relationship that develops within a vertical dyad over time. The sample was comprised of 60 managers whose positions formed the administrative pyramid of the housing division within a large public university. The epistemology is constructivism since the authors take the view that leader member exchange (LMX) is the product of leaders and members' engagement with the realities of the environment. Adopting a mixed-methods design, the authors gathered survey data, through interpretative interview techniques and found that leaders did not treat all followers equally. The authors' approached questions that challenged the traditional trait school of thought. Further, they conceived a vertical dyad approach empathizing the critical contribution each member of the dyad, including what the superior's influence (with and without authority) brought to performance.

House and Adyta (1997) describe LMX as an alternative approach to leadership that no longer considered the character of the leader to be the sole focal point and determinant of organizational success. Building upon the work of Dansereau and colleagues (1975), Graen and Uhl-Bien (1995) conducted a review of the literature on LMX in an effort to bring together many differing levels and elements of leadership that contribute to job satisfaction, organizational commitment, and performance generally. They claimed that the Vertical Dyad Linkage (VDL) and Average Leadership Style (ALS) could be combined to develop a theory based on mature relationships as a predictor of performance in the workplace. The literature review used

statistical analysis to compare and evaluate findings of earlier research and proposed an alternative leadership theory comprised of three elements: the leader characteristics and behaviors, the follower's characteristics and behaviors, and the dyadic relationship between the leader and follower. Graen and Uhl-Bien (1995) claimed that differential relationships existed as an outcome of the perceptions of followers and that high quality LMX was positively correlated with enhanced performance and perceptions of job satisfaction and organizational commitment.

Hersey and Blanchard (1982) proposed a behavioral approach to leadership that took into account the situation or context within which a leader operates. This contingency or situational leadership theory supports a flexible style of leadership that adjusts in order to leverage external and internal resources with the goal of maximizing organizational achievements. The theory is built upon two pillars: leadership style and the level of maturity of those being lead. Leadership style stems from four basic leadership practices: telling, selling, participating, and delegating (Hersey & Blanchard, 1982).

According to Meirovich and Gu (2015), telling is a strictly authoritative style in which a leader dictates to followers the task behaviors to be performed. Selling solicits followers to buy in to the organizational vision, and takes into consideration follower input. The participating leadership style enables shared decision-making by the leader and follower, via building and maintaining functional relationships. Delegating passes the majority of process responsibility onto an individual or group, while maintaining leader involvement and influence. Within this construct, the four leadership styles vary in the level of task and relationship behavior exhibited for influencing followers. Optimal balance between task and relationship behavior is dependent upon employee confidence and skill in conjunction with the work task.

According to Hersey and Blanchard (1982), work performance is a function of maturity and a product of psychological willingness and job ability. Leadership effectiveness is contingent upon effectively matching the leadership style (i.e., task focuses or relationship oriented) to the maturity level of the follower in order to set high but attainable goals. Task oriented leaders define follower roles, establish formal communication and create organizational patterns, while relational oriented leaders practice concern for followers, foster harmonious relationships, and regulate equitable participation (McCleskey, 2014). According to Shin, Heath, and Lee (2011), effective leaders engage in a situationally determined mix of task and relation leadership behaviors. In this regard, knowledge assists leaders in identifying employee needs and potential development areas (Sethuraman & Suresh, 2014).

In an attempt to address critics of the contingency approach to leadership, and to justify variance in group-level performance, Fielder and Garcia (1987) developed the Cognitive Resource Theory. According to this theory, stress interferes with performance and, ultimately, will determine whether participative or directive leadership is more appropriate. However, as with Situational Leadership, unless a causal relationship is established, it is limited in its predictive ability within the workplace (Fielder & Garcia, 1987).

Robert House (1971) defined the path-goal theory for identifying the most effective approach to leadership based on the worker goals and other situational factors. Supporters of the Path-Goal Leadership model argue that leaders support and motivate others via goal identification, the removal of obstacles to achievement, and the establishment of a system of rewards. Accordingly, the primary task of an effective leader is to promote productive work behaviors by strategically matching employee and organizational goals. This perspective calls

for a deep understanding of the nature of subordinates, the factors that motivate them, and the nature of their work environment.

The Path-Goal model (House, 1971) defined four primary leadership styles: supportive, directive, participative, and achievement-oriented. Supportive leadership focuses on developing the leader-follower relationships by demonstrating sensitivity to individual needs and taking steps to make decision in the best interests of individual employees. House (1971) argued that this leadership style is more effective when work tasks are repetitive or stressful. Directive leadership communicates goals and expectations to workers while assigning clearly defined tasks to each individual employee. This leadership style is more effective when work tasks are complex or unstructured and work group members are inexperienced. Participative leadership focuses on mutual participation by the leader and followers through which the leader consults with individuals in the work group to incorporate in the decision-making process. Participative leadership is more effective when work tasks are complex and challenging, and where work group members are experienced and desire to provide input. Achievement-oriented leadership sets challenging goals for work groups and maintains high standards for each individual worker. This leadership style is most effective where leaders have confidence in worker abilities, and work group members lack motivation or challenge in their work tasks.

Vroom and Yetton (1973) defined a normative decision-making model of leadership, which describes how the nature of the group, leader, and situation, determine the degree to which the group is to be included in the decision-making process. Within this construct, the style of decision-making procedure defines a certain style of decision-making (i.e., autocratic, consultative, group). Accordingly, the choice of leadership style and leadership behavior is deeply influenced by organizational context, and determines follower involvement in the

decision-making process. Jago (1988) described five choices by which a leader ultimately

decides upon in consideration of the situation or context: sole decision-making, consult other

members individually, consult the group, facilitate, or delegate decision-making authority.

The phenomenon of leadership exists within the context of the leader-follower dyad

where leadership takes place. Accroding to Muna (2011), effective leaders are able to adapt

leadership styles and practices to unique contextual factors. Further, effective leaders learn

leadership skills through practice with "mastering the context" in order to achieve goals through

hard work, determination, and perseverance (p. 877). "Context matters a great deal when it is

given an importance equal to leadership" (Osborn & Marion, 2009, p. 205).

Transactional and Transformational Leadership

As noted above, the leadership style of home healthcare leaders may vary depending

upon the situation (Eagly, 2007; Lockwood-Rayerman, 2003). Transformational and

transactional are two main leadership styles used to supervise, guide, and motivate at the

individual and organizational levels (Vinkenburg, van Engen, Eagly, & Johannesen-Schmidt,

2011). Transactional leadership behaviors are "established through exchange, such as reward

systems for meeting particular objectives" (Lai, 2011, p. 1). Transformational leadership

behaviors inspire followers, resulting in both leader and follower raising each other up to higher

levels of morality, motivation, and performance.

Essentially the difference between the two styles may be attributable to the source and

nature of rewards associated with performing work tasks. Transformational leadership

approaches stimulates, empowers, and motivates individuals to enhance performance and

transcend above and beyond individual self-interest. On the other hand, transactional approaches

are contingent upon performance and external rewards and an employee is considered to be

motivated by the drive to achieve the reward or to avoid pecuniary penalty, including possible dismissal for poor performance or errors (Eagly, 2007; Lai, 2011).

Burns (1978) developed a taxonomy that distinguished transformational from transactional leadership (i.e., moral versus amoral), based on the behaviors a leader employs for influencing follower aspirations and modifying follower behavior. According to Burns' framework, transactional leaders employ exchange theory as their primary motivator for follower compliance. The transactional approach is base on mutually beneficial transactions between the leader and follower. In contrast, transformational leaders pursue the intrinsic values of followers as a primary motivator, and seek to capture follower respect, trust, admiration, and loyalty. Transformational leadership intrinsically motivates followers to become agents of collective achievement. According to Burns (1978), "Leadership over human beings is exercised when persons with certain motives and purposes mobilize…institutional, political, psychological, and other resources so as to arouse, engage, and satisfy the motives of followers" (p. 18). Many of the current theories of transformational leadership were derived from Burns' seminal work.

Servant Leadership

Robert Greenleaf coined the term "servant-leadership" in 1970, and stated that true servant-leadership begins with the "natural feeling that one wants to serve, to serve first" (Greenleaf, 1977, p. 7). Servant leadership as a leadership practice fosters balance between the spectrums of desired organizational outcomes, and the fulfillment of the personal needs. According to Reinke (2004), it is the best mindset for navigating the innate tension between organization and independence while holding the organization "in trust". Servant leadership demonstrates an "altruistic mind-state" motivated by an empathetic desire to benefit another person (Beck, 2014). Within the servant leader construct, there are four core principles essential

for moral authority: sacrifice, commitment to a worthy cause, belief that ends and means are inseparable, and relationships (Greenleaf, 1977).

Transformational and servant leadership styles are often observed and practiced in healthcare delivery organizations (Waterman, 2011). According to Waterman (2011), the principles of servant leadership emphasize the importance of providing quality care services, and assists healthcare leaders in supporting the performance of direct care workers, enabling their best efforts, and having a vision that brings all efforts together for a common purpose. This desire to serve tends to be relevant in all caring professions, where leadership effectiveness is dependent upon the congruency of worker actions with their values and beliefs (Willcocks, 2012). According to De Pree (1989), "The first responsibility of a leader is to define reality. The last is to say thank you. In between the two, the leader must become a servant and a debtor." (p. 11). Further, leadership effectiveness comes as a result of enabling others to reach their personal and institutional potential.

Bass (1985) developed a transformational approach to leadership by which leaders motivate followers to do more by recognizing and matching the needs and abilities of subordinates and of the organization as a whole. According to Bass, leaders (e.g., intellectuals, reformers, revolutionaries, heroes) directly influence the outcome of organizational success versus failure based on their leadership practices. According to Bass' research, superior leadership performance is exhibited when leaders heighten and expand follower interests by generating an awareness and acceptance of the organizational purpose and mission. Further, effective transformational leaders are able to motivate followers toward a vision beyond their own self-interest, and onto that of the greater organizational good.

Bass (1985) identified four principal behaviors associated with transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Idealize influence fosters a moral demand for followers to regard organizational interests as more important than their own personal interests. Inspirational motivation serves to align followers with a common vision and goal. Intellectual stimulation challenges followers and encourages their creativity and innovativeness. Individualized consideration nurtures follower talent and unfolds their potential through a full understanding of their personality, abilities, and goals. In contrast, transactional leadership uses contingent reward behavior to motivate employees, provide clarity in their job requirements, and enforce disciplinary actions (Bass, 1985).

Transformational leadership has been found to be strong predictor of leadership effectiveness in the healthcare industry (Stahl, Covrig, & Newman, 2014). Yee, Lee, Yeung, and Cheng (2013) examined the attitudinal and motivational factors of customer-contact employees, and the management style of managers as antecedents to service quality in high-contact service sectors researchers, and found transformational leadership to be more effective than transactional leadership for influencing employee attitude in high-contact service firms. Further, transformational leaders who practice idealized influence, inspirational motivation, and individual consideration, exhibit higher levels of leadership effectiveness than transactional leadership practices (e.g., contingent-rewards, management-by-exception).

According to Yee, Lee, Yeung, and Cheng (2013), transformational managers tend to be proactive in ensuring the delivery of superior service quality. Through idealized influence, transformational leaders serve as role models for their employees, which fosters improved proficiency in service delivery. Through inspirational motivation, transformational leaders

forster the employee's ability to learn new skill sets and master the various nuances of service encounters. Through intellectual stimulation, transformational managers encourage employees as they navigate unpredictable customer needs and service environments. Through individualized consideration, transformational leaders show concern for each employee and support their individual efforts in working through the challenges of service delivery.

Transformational leaders are able to inspire followers to exceptional levels of performance via a charismatic leadership process, by "connecting emotionally, and assisting them in engaging in new ways of thinking" (Vito, Higgins, & Denney, 2014, p. 810). Transformational leaders also utilize intellectual stimulation and inspirational motivation to influence a follower's attitudinal orientation toward change and to appeal to their core values. This can be tapped not only through values and aspirations, but also through leadership practices and corresponding behaviors (Oreg & Berson, 2011). According to Oreg and Berson (2011), the leadership practices displayed by leaders "of" organizations are very likely to resonate "in" the organization (p. 650).

The creation of a shared vision is essential for transformational leadership (Nickolic & Robinson, 2012). Further, the capability to facilitate emotions is a key factor for attaining a shared vision. Mason and Griffin (2014) concluded in a recent study that leaders who receive transformational leadership training exhibit positive psychological and behavioral changes. According to Yang (2014), transformational leadership sets a clear work-group vision that enables and motivates service personnel to realize the importance of delivering service quality and fulfilling customer needs.

The Five Practices of Exemplary Leadership

Kouzes and Posner (1987) developed The Five Practices of Exemplary Leadership®

model (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to

Act, Encourage the Heart). According to Zagorsek, Stough, and Jaklic (2006), these five

leadership dimensions accurately reflect the common themes found within transformational

leadership theory (e.g., empowerment, recognition, values, vision). Kouzes and Ponser's (1987)

Leadership Practices Inventory® (LPI) scale was created to determine specific leadership

characteristics that are present within individuals.

The LPI tool measures leadership competencies and behavior frequencies for The Five

Practices of Exemplary Leadership®: Model the Way, Inspire a Shared Vision, Challenge the

Process, Enable Others to Act, and Encourage the Heart. Kouzes & Posner (2012) describe the

five practices as: leaders modeling the way by finding their voice and setting the example,

inspiring a shared vision by envisioning the future and enlisting others in a common vision,

challenging the process by searching for opportunities, taking risks, and learning from mistakes,

enabling others to act by fostering collaboration and strengthening others, and encouraging the

heart by recognizing contributions and celebrating values and victories.

The Five Practices of Exemplary Leadership® are supported by Ten Commitments of

Exemplary Leadership®. Within the Model the Way leadership practice, exemplary leaders (a)

clarify values by finding their voice and affirming shared values, and (b) set the example by

aligning actions with shared values. Within the Inspire a Shared Vision leadership practice,

exemplary leaders (a) envision the future by imagining exciting and ennobling possibilities, and

(b) enlist others in a common vision by appealing to shared aspirations. Within the Challenge

the Process leadership practice, exemplary leaders (a) search for opportunities by seizing the

initiative and looking outward for innovative ways to improve, and (b) experiment and take risks

by constantly generating small wins and learning from experience. Within the Enable Others to

Act leadership practice, exemplary leaders (a) foster collaboration by building trust and

facilitating relationships, and (b) strengthen others by increasing self-determination and

developing competence. Withing the Encourage the Heart leadership practice, exemplary leaders

(a) recognize contributions by showing appreciation for individual excellence, and (b) celebrate

the values and victories by creating a spirit of community.

Accepting the leadership challenge requires "practice, reflection, humility, and

commitment to making a difference" (Kouzes & Posner, 2012, p. 6). According to Kouzes and

Posner (2012), of the top four characteristics that people most look for in a leader (i.e., honest,

forward-looking, competent, inspiring), three of these related to source credibility (p. 35).

Building credibility through trust requires a perception of trustworthiness. Building trust

typically requires evidence of trust, which is produced by consistently doing what you say you

will do (DWYSYWD). Kouzes and Posner (2012) describes DWYSYWD as the "second law of

leadership" (p. 40). Kouzes & Posner (2012) also describes leadership an "affair of the heart" (p.

345). According to Van Duzer (2010), building "long-term habits of the heart" is critical to

business leadership (p. 189).

Carless (2001) assessed the discriminant validity of the LPI using confirmatory factor

analysis, and concluded that the LPI assesses an over-arching construct of transformational

leadership. Chen and Baron (2007) researched the psychometric properties of LPI in conjunction

with nurses, and found the LPI instrument to be culturally appropriate for accessing leadership

behaviors in the healthcare industry. Lingam and Lingam (2015), who studied the leadership

practices of school principals using the LPI instrument, state that further research in leadership

practices is essential for determining gaps in the research and addressing them, and must be conducted in a broader set of specific contexts.

According to Lawrence and Pirson (2015), responsible leadership practices require an understanding of leadership theory beyond the economist paradigm (e.g., transactional leadership), and the development of skills to manage drivers of employee motivation. According to Bowles and Bowles (2000), who studied transformational leadership in nursing development units in England, leadership practices in healthcare are an influence based on interpersonal relationships and personal characteristics, which serves to attract and motivate followers toward organizational goals, as to improve healthcare services via a cohesive workforce. Further, the researchers find the LPI instrument and five practices to be relevant and cogent in the healthcare industry, and representative of the values that are attractive in healthcare leadership.

Fleming-Castaldy and Patro (2012) researched leadership in occupational therapy in healthcare utilizing the LPI instrument, and stated that the "conscious application" of leadership practices assists healthcare leaders in honing leadership skills, meeting the challenges set forth by an "everchanging" healthcare system, and answering the profession's "call for leaders with the power to influence (p. 200). Patrick, Laschinger, Wong, and Finegan (2011) researched staff nurse clinical leadership via a non-experimental survey design among 480 registered nurses providing direct patient care utilizing the LPI instrument, and found Encouraging the Heart leadership practice to be the strongest relationship for staff nurse perceptions of leadership support in their work environment. Further, nursing leaders who create structurally empowering work environments achieve more effective results in providing high-quality direct patient care. Jackowski and Burroughs (2015) researched the leadership practices and job satisfaction of

radiology administrators utilizing the LPI instrument, in which research participants scored lowest on the Challenge the Process and Inspire a Shared Vision leadership practices.

Burbank, Odom, and Sandlin (2015), who studied the personal leadership behaviors of undergraduate students by utilizing Student LPI within course curriculum, found that leaders experience growth and development via opportunities to apply leadership behaviors, dictated by their engagement in opportunities to practice leadership behaviors. According to Posner, Crawford, and Denniston-Stewart (2015), who conducted a longitudinal study of Canadian student leadership practices utilizing the LPI instrument, leadership behaviors are contingent upon the sociological manner in which behaviors are developed within the context of working together with others. In Bowers and Hamby (2013) research of leadership practices pertaining to volunteer workers, certain leadership practices were found to be more effective than others, depending upon the leadership context.

Leech and Fulton (2008) also researched the leadership practices of secondary school principals utilizing the LPI instrument, and found that individual leadership behaviors may have less of an influence on the decision-making culture of an organization due to prevailing factors (e.g., norms, values, and policies) stemming from the parent organization. McKinney, Labat, and Labat (2015) studied the leadership practices of principles who transformed school culture in blue ribbon schools, and found that leaders who find ways to motivate their teachers (i.e., employees) in a positive manner, positively impact student (i.e., customer) outcomes. The research results also suggested that leaders should invest time facilitating the growth of rapport among employees (e.g., reinforce common goals, promote workplace cooperation, share best practices).

Garrett-Staib and Burkman (2015) researched the leadership practices of Texas superintendents by statistically comparing the gender of LPI participants to each construct of the LPI, and found female superintendents to have stronger self-concepts pertaining to Encourage the Heart and Inspire a Shared Vision leadership practices. The researchers also state that these two leadership areas have the "highest effect on positive institutional leadership outcomes" (p. 164). Bento (2013) researched the leadership practices of Portuguese schools on the East Coast of the United States, and found that a proactive and serving style of leadership in performing management duties to be a precursor to exhibiting high LPI scores. Smith (2011) researched the transformational leadership behaviors of school librarians utilizing the LPI, and concluded that leadership skills can indeed be taught. Librarians who received transformational leadership skill training made substantial performance improvements compared to those who received no training.

Johns and Watson (2006) researched the leadership practices of women preparing for ministry, and found that participants exhibited higher LPI scores pertaining to competencies for utilizing people skills, and lower scores in the areas reflecting competence in cognitive or strategic skills. Hillman Jr. (2008), researched the leadership practices of non-seminary students and found that students over the age of 40 score significantly higher on Model the Way, Challenge the Process, Enable Others to Act, and Encourage the Heart leadership practices, compared to students under the age of 40. Gomez (2013) researched leadership behaviors of online graduate students and its impact on student success and retention, and found the Model the Way leadership practice to be a significant prediction of graduation. The researchers claim that leaders who "model the way" for others regarding how goals should be pursued, concentrate better on their own behaviors and self-discipline. Kelley (2008) researched the leadership

practices of undergraduate students with fraternity experience and the relationship to career

success after graduation, and found the length of job service to be positively correlated with the

Inspire a Shared Vision leadership practice.

Research by Mancheno-Smoak, Endres, Polak, and Athanasaw (2009) offers support for

cultural values as an indicator of a leader's propensity for exhibiting transformational leadership

behaviors. According to their research, LPI participants appear to self-report higher scores when

uncertainty avoidance (i.e., rules and protocols) and collectivism (i.e., favoring the needs of

society) are viewed as important work related values. Aimar and Stough (2007) who researched

the impact of culture on leadership practices in culturally and economically different regions of

the United States and Agentina, state that developing an awareness of leadership differences can

foster the analysis of leadership strengths and weaknesses within organizations and across the

organizations cultural differences. Rašković (2014) researched leadership practices in a small,

East-West European country context, and found that, on average, participants scored lowest on

the Inspire a Shared Vision leadership practice.

Williams, McDowell, and Kautz (2011) proposed a caring leadership model for the

healthcare industry, which builds upon Kouzes and Posner's (1987) Theory of Exemplary

Leadership (specifically, The Five Practices of Exemplary Leadership® model). The researchers

suggest that caring leaders embrace five core values: always lead with kindness, compassion,

and equality (conceptually similar to the Model the Way leadership practice); generate hope and

faith through co-creation (conceptually similar to the Inspire a Shared Vision leadership

practice); actively innovate with insight, reflection, and wisdom (conceptually similar to the

Challenge the Process leadership practice); purposely create protected space founded upon

mutual respect and caring (conceptually similar to the Enable Others to Act leadership practice);

embody an environment of caring, helping, and trusting for self and others (conceptually similar to the Encourage the Heart leadership practice).

The caring style of leadership emphasizes the element of encouraging the heart, whereby a leader is authentically present within the moment experienced by the follower (Williams et al., 2011). Effective leadership in this regard is conducted via transpersonal relationships built upon a foundation of credibility, established via the integration of trust. According to the researchers, such leadership is essential creating a care-centered culture that can provide the highest quality healthcare amid an evolving healthcare system.

Leadership Effectiveness

Bhugra, Ruiz, and Gupta (2013) conceptualize leadership effectiveness along three dimensions: content, level of analysis, and target of evaluation. The content of leadership effectiveness relates to task performance and relational criteria. The level of analysis relates to how leadership effectiveness is conceptualized (i.e., at the individual, dyadic, or group level). The target of evaluation pertains to the outcomes, within the domain of leadership being targeted for evaluation.

Aitken and von Treuer (2014) researched the leadership competencies required for successful healthcare service delivery amid increasing service demands and significant healthcare reform, and determined five key areas leadership competencies important for health service delivery: leadership and governance capability; relationship management and communication skills; management of people, organizational systems and processes; practice knowledge; and the leader's personal skills and characteristics.

Hopkins, O'Neil, and Stoller (2015) examined specific leadership competencies essential for effective leadership in twenty-first century healthcare organizations. The authors found the

predominant distinguishing leadership competencies to include: empathy, initiative, emotional self-awareness, and organizational awareness. Nickolic and Robinson (2012) outline four key elements to leadership effectiveness: ethical foundation, authentic action, charisma, and transformational intent.

Leadership and Motivation

Motivation has been the subject of extensive research in the fields of management and psychology and studies have been designed to help understand and define the underlying forces, factors, as well as the antecedent attitudes and behaviors, which compel an individual to expend resources to achieve a specific need or achieve a goal (Cong & Van, 2013). Researchers generally agree that work is an important factor in assessing basic human needs and psychological wellbeing, and extends beyond working for money or to avoid penalty (Paul & Batanic, 2010). Abraham Maslow (1943) proposed a content theory of motivation that had endured the test of time and continues to prove a popular theory among scholars and practitioners (Cong & Vang, 2013; Shah et al., 2012).

Maslow's Hierarchy of Needs

Maslow (1943) defined a content theory of human motivation based on a hierarchy of sequential needs: physiological needs (e.g., health, food, sleep); safety needs (e.g., shelter, removal from danger); belonging needs (e.g., love, affection, being part of a group); esteem needs (e.g., self-esteem, esteem from others); and self-actualization (e.g., achieving individual potential). Maslow maintained physiological needs have the highest priority as they are the most essential to life and are achieved by securing the basic necessities of life (e.g., health, food, sleep). According to the hierarchy of needs model, safety needs are satisfied when a person's physical and emotional security is protected from harm and enables a person to be free of fear,

anxiety, and apprehension (Shah et al., 2012). Belonging needs related to a person's basic need for love and affection, and are satisfied by attaining membership within a group and maintaining a feeling of belonging within that group. Self-esteem needs are achieved via a sense of accomplishment and respect from others who recognize and appreciate those accomplishments. Finally, self-actualization pertains to an individual's desire to reach their fullest potential via developing their unique talents and qualities (Cong & Van, 2013; Shah et al., 2012). As such, employees are motivated by a diverse set of needs of which leaders must be cognizant.

Maslow's theory of motivation holds that increased levels of employee performance result in increased levels of job satisfaction that are fostered by the leadership styles exhibited by management. Accordingly, each need along the needs continuum must be substantially satisfied prior to the employee progressing to the next level of motivation. The needs therein have links directly to the work environment and are representative of employee job satisfaction. As employees advance up the hierarchy, needs become increasingly more social, whereby the desire for connection, esteem, and accomplishment take priority. Crowley (2011) finds Maslow's hierarchy of needs theory to be suitable for 21st century transformational leadership. Further, Crowley finds that it is the heart, not the mind, which drives human motivation and achievement.

Contemporary researchers have criticized Maslow's model on the grounds that it implies that humans are in a perpetual state of desire (Brutus & Greguras, 2008). Other critics claim the model falls short in explaining how personal values and morals are inextricably intertwined with an individual's feelings of self-worth that is essential for intrinsic motivation to exist (Kenrick, Griskevicius, Neuberg, & Schaller, 2010). A more general criticism is that Maslow's work was conducted in Western developed and industrialized nations, and overlooks the type of cognitive and relational processes valued in collective cultures (Kenrick et al., 2010). However, Maslow's

theory has also enjoyed support through contemporary research conducted in Middle-Eastern nations (Cong & Van, 2013; Ismail & Nakkache, 2014).

Theoretically, leaders may only be as effective in motivating employee behavior by taking into account the employee's position in the hierarchy of needs. More specifically, a work environment meeting employee deficiency needs will promote self-actualization and increased job satisfaction. Therefore, in order to motivate employees, leaders of organizations must be cognizant of the needs level at which each employee is functioning, and leverage those needs as levers of motivation. Regardless of the debate surrounding Maslow's Hierarchy of Needs, it remains at the root of theories of positive organizational behavior psychology that maintains that praise, encouragement, and autonomy are better motivators than coercion and control in the workplace (Wilner, 2011).

Herzberg's Two-Factor Theory of Motivation

Herzberg (1959) developed a two-factor theory dividing human needs factors into two distinct factors. The first factor of Herzberg's theory pertains to hygiene factors, which are maintenance needs (i.e., dissatisfiers) related to circumstances external to the job (e.g., working conditions, policies, supervision, salary), and essential for providing workplace motivation. The second set of needs is comprised of motivational factors (i.e., satisfiers) that relate to specific psychological factors (e.g., sense of accomplishment, recognition, and future growth), and generate sentiments of satisfaction. The two-factor theory suggests that rectifying the sources of dissatisfaction do not produce satisfaction. Rather, the two are isolated and must be managed independently by the leader. While considered a derivative of Maslow's theory of motivation, Herzberg's two-factor theory is not tied to a progressive continuum (Muchinsky, 2012).

The Two-Factor theory has provided the theoretical framework for a plethora of studies that has sought to reveal how to identify what motivates an individual employee, as well as what factors presents dissatisfaction. Critics have argued that methodologically the dual factor theory is inherently flawed because it uses the critical incident model, which may biased the results due to the effects of social desirability during data collection (Hullin & Smith, 1965; Vroom, 1964; Wall, 1972). More contemporary researchers claim it fails to distinguish between movement and motivation (Bassett-Jones & Lloyd, 2005). Others have questioned the theory's position that extrinsic factors are associated with levels of dissatisfaction that do not motivate, and favor an approach in which both extrinsic and intrinsic factors contribute to job satisfaction (Judge & Piccolo, 2010; Mafini & Dlodlo, 2014; Stringer et al., 2011).

Herzberg (1987) addressed his critics and reaffirmed his position by further emphasizing how motivators are internally generated factors that influence behavior and attitudes in a critically different manner from external rewards (or threats of punishment) that reside outside an individual. Herzberg's counterargument reinforced the importance of applying job enrichment as a means of maintaining a motivated and satisfied workforce, and of introducing work-based suggestion schemes through which employees may be moved to recommend solutions or alternatives to frustrating management policies and procedures (Sachau, 2007). These motivators pave the way to improving both task efficiency and human satisfaction via the incorporation of greater scopes for responsibility, personal achievement, and recognition

Job Satisfaction

The concept of job satisfaction has been extensively researched across various organizational management topics and reported in academic literature since the early part of the 19th century. The earliest well known research of job satisfaction reported in literature is the

Hawthorn Studies. The Hawthorn Studies were conducted between 1924 and 1932 with the host

organization Western Electric, to determine the how the productivity of workers was being

impacted by changing social, financial, and physical factors (Hassard, 2012). The Hawthorn

Studies examined a range of social and political factors that shaped industrial human relations

philosophy, including the motivational factors affecting employee behavior (e.g., hopes, desires,

fears, interests) (Whitehead, 1934). The work procedure improvements implemented during the

study enabled the company to achieve higher output via reduced resources. The value

proposition presented highlights the influence of human relationships and social interactions on

employee behavior and performance, and creates an awareness for the work values driving job

satisfaction. According to Kalleberg (1977), work values (e.g., intrinsic, convenience, financial,

career opportunities, relationships with coworkers, resource adequacy) have independent and

significant effects on job satisfaction.

Chester Barnard (1968) proposed a theory of acceptance. Barnard identified an effective

organizational leader as one who determines objectives, manipulates means, initiates action, and

stimulates coordinated effort. Barnard defined organizational efficiency as the degree to which

an organization is able to satisfy the motives of the individuals. Barnard regarded an

organization as a system of discerning coordinated individual activities. According to Locke

(1969), job satisfaction is a function of the perceived relationship between "what one wants from

one's job and what one perceives it as offering or entailing" (p. 316). This state of consciousness

proceeds from the "achievement of one's values." (Rand, 1964, p. 28).

Edmans (2012) examined the link between job satisfaction and firm value, and found

three primary implications impacting how managers approach employee retention and

motivation. First, job satisfaction has a positive relationship with firm value. A satisfying

workplace fosters "job embeddeness" which enables the development of sustainable competitive

advantage via the retention of key employees, which are both valuable and hard for competitors

to "poach" (Edmands, 2012, p. 1). Second, corporate social responsibility, which involves

considering the interests of stakeholders other than shareholders (e.g., employees, customers,

environment), can improve the financial return on investment in the firm. More specifically, the

dimension of employee welfare has an especially strong theoretical link to firm value. Third,

while the management of employee welfare may positively impact firm value, its full value may

yet to be realized by the market because the additional firm value created by enhancing

stakeholder goodwill is intangible. Therefore, managers should incorporate immediately

tangible information (e.g., employee performance, customer satisfaction), as to encourage

intangible assets to impact firm value across the long-term business horizon.

One of the most important challenges facing leaders in today's business environment is

the job satisfaction of service personnel (Yang, 2014). Gibson and Petrosko (2014) researched

the effect of leadership practices pertaining to trust on employee job satisfaction and the intent to

leave in a healthcare setting. The researchers state that employees and customers in the

healthcare industry face "immense challenges", which require a more "holistic view" of

leadership effectiveness beyond the technical aspects of patient care (p. 16). Further, success in

healthcare is a function of the people employed by the healthcare organization, which are vital to

the day-to-day delivery of healthcare services.

Gibson and Petrosko (2014) found that healthcare workers who exhibit higher levels of

job satisfaction engage in higher levels of job performance (e.g., task accomplishment) and

higher levels of organizational performance (e.g., higher customer satisfaction, increased profit).

Further, this relationship appears to be even more pronounced in healthcare where relationships

are so vital to the most important aspect of the industry, the care of the patient. Therefore, effective leadership is critical for ensuring that satisfaction and performance are at a high levels in the home healthcare industry.

Hiring and retaining quality PCA employees is essential to assuring quality of care for senior citizens (Parker-Bell, 2013). Focusing attention on the value of relationships, and fostering relationships between administrators, PCA employees, and customers, support positive PCA job satisfaction and commitment (Parker-Bell, 2013). Research of individual and organizational factors associated with job satisfaction among PCA employees finds empowerment and autonomy to be factors important to PCA job satisfaction (Squires et al, 2015). Research of current literature by Lu, Barriball, Zhang, and White (2012) found job satisfaction in the nursing industry to be closely related to working conditions, organizational environment, job stress, role conflict and ambiguity, role perception, role content, organizational commitment, and professional commitment. Organizational commitment refers to an identification with and loyalty to the organization and its goals. Further, workforce shortages in the nusing industry are placing greater demands on existing care workers, which is expected to increase work related stress and reduce the qality of workplace relationships, which is "an important source of job satisfaction and contributes to organizational commitment" (p. 1033).

Employee Turnover

Basford, Offerman, and Wirtz (2012) investigated the influence of leadership on follower motivation and intent to stay versus leave employment. The results suggested that examining and fostering supportive leadership behaviors at different levels improved the ability of the organization to predict employee motivation and intent to remain in the employment relationship. According to these authors, supportive leadership practices foster enhanced levels

of job satisfaction and are negatively associated with employee turnover, intention to quit, and burnout. Further, organizations that encourage leaders of all levels to exhibit supportive and communicative leadership behaviors have enjoyed the benefits derived from improved levels of job satisfaction and employee turnover.

Reilly, Nyberg, Maltarich, and Weller (2014) found rates of turnover in the nursing industry, in conjunction with job demands, to "comprise a dynamic, evolving system that singularly and collectively influences patient satisfaction" (p. 787). The working relationship among actors in healthcare businesses impacts quality of care, job satisfaction, and the overall survival of the business (Nijmeijer, Fabbricotti, & Huijsman, 2015). Further, successful healthcare leadership is strongly correlated with having open communication, commitment, and cooperative relationships that foster trust and idea sharing. Therefore, understanding the leadership practices of home healthcare leaders is relevant to leading PCAs in the advancement of care services throughout the various types of home healthcare organizations, and quality standards of related services. Home healthcare companies are vehicles for providing leadership opportunities to management, and meaningful employment opportunities for PCA employees.

The growing shortage of PCA employees in conjunction with the importance of job satisfaction, has led to the growing interest among researchers and healthcare administrators to design effective models for the retention of direct care workers. Galletta, Portoghese, Penna, Battistelli, and Saiani (2011) researched the job satisfaction and turnover intention among direct care employess in the healthcare industry, and found organizational support to be key in worker retention, and the woker's relationship with their supervisor to be instrumental in achieving job satisfaction. Further, the researchers found job satisfaction to be the mediating variable between resource adequacy and turnover intention. The results of this research infer that healthcare

leaders may benefit from reduced turnover by implementing strategies that facilitate the satisfaction of direct care worker needs, by promoting high quality leader-follwer relationships. Therefore, the preventive measures which have the potential to address the forthcoming PCA shortage, includes establishing an authentic leader-follower relationship.

Meyer, Raffle, and Ware (2014) research into the employment patterns of nursing assistants in long term care facilities, found the first six months of employment to have the greatest influence on employee retention. Given the costs associated with turnover, healthcare managers have a fiduciary responsibility to prioritize employee retention. More specifically, the researchers found that the leadership effectiveness of nursing managers plays a direct role in creating a culture that values and respects the work of nursing assistants.

Topaz and Doron (2013) found that identifying PCA attitudes toward older patients, and the factors that correspond with those attitudes, assist healthcare leaders in understanding, predicting, and modifying the behaviors of PCAs working with senior citizens. Further, the quality of care services provided to seniors is strongly influenced by PCA attitudes toward seniors. The authors concluded that healthcare leaders must model the way by strengthening gerontological content in training curriculum.

Abualrub and Alghamdi (2012) researched the impact of leadership styles on job satisfaction and turnover intention, and found nurses to be more satisfied with leaders who demonstrate transformational leadership styles. Further, nurses who exhibited higher levels of job satisfaction intend to say with their employer longer. The results of the study emphasized the importance of transformational leadership as effective leadership practices for healthcare leadership.

PCA recruitment and retention is a key issue facing the home healthcare industry, as turnover among these frontline workers is a critical cost driver (Seavey, 2011). PCA eomployees perform physically taxing tasks that require emotional commitment, are paid approximately 50% of the rate charged by the agency, and receive little direct supervision (Seavey, 2011). Knowledge pertaining to the specific factors contributing to PCA turnover is paramount for creating and sustaining a retention culture among home healthcare agencies. Although turnover of direct care workers has negative organizational consequences in terms of recruitment and retention costs, the greater organizational risks may reside in decreased continuity, quality of care, and productivity (Buffington, Zwink, Fink, DeVine, & Sanders, 2012).

According to Chuang et al. (2012), front-line employees play a critical role in the delivery of basic healthcare services which directly influences patient satisfaction (i.e., customer satisfaction) and other healthcare outcomes. Chuang et al. (2012) researched high performance work practices associated with the job satisfaction and perceived quality of care among front-line healthcare workers, and found that integrating front-line workers in participative decision making, positively influences job satisfaction and perceived quality of care. The study suggested that enabling staff to feel feel empowered with their job duties, and creative in how work tasks are accomplish, positively affects healthcare worker job satisfaction. According to Garcia-Garcia et al. (2011), positively affecting front-line worker motivation, productivity, effectiveness, and job satisfaction, creates a positive working environment that leads to the successful achievement of organizational goals.

Customer Satisfaction

Churchill and Surprenant (1982) describe customer satisfaction as being composed of four primary concepts: expectations, performance, disconfirmation, and satisfaction. A

customer's initial expectations anticipate the reward that will be provided by the product according to the cost and effort they invested for the product. Performance serves as the standard of comparison against the customer's initial expectations, which enables the assessment of their level of disconfirmation, and the evolution of future expectations. Disconfirmation represents the presence of any discrepancies between the customer's initial expectations and actual performance of the product. Accordingly, a customer's expectations are confirmed when the product is as expected, negatively disconfirmed when the product is less than expected, and positively disconfirmed when the product is better than expected (Churchill & Surprenant, 1982). Levels of disconfirmation produce corresponding levels satisfaction and/or dissatisfaction, which are the outcome of customers assessing the size and direction of their disconfirmation experience.

Within the healthcare industry, service quality has a direct influence on customer satisfaction (Panchapakesan, Sai, & Rajendran, 2015). Traditionally, the technichal quality of healthcare service has been measured objectively, and customer satisfaction measured by the patients' subjective assessment of quality care and expectations for it. Edlund et al. (2003) examined the relationship between satisfaction and technical quality of care, and found a robust relationship between customer satisfaction and service quality. Healthcare research conducted by Harreld et al. (2013) found patient satisfaction to correlate more with subjective than objective measures. According to Otani, Herrmann, and Kurz (2011), patient satisfaction in the healthcare industry is subjective as it is influenced by the so-called "bedside manner" of caregivers (p. 277).

Panchapakesan, Sai, and Rajendran (2015) examined the moderators and mediators of service quality in the context of healthcare from the perspectives of customers and direct care

workers, and found that direct care workers play an "indispensable role" in providing results that foster customer satisfaction with healthcare services (p. 10). Further, direct care workers serve as a bridge between healthcare service providers and customers. Otani, Herrmann, and Kurz (2011) argued that healthcare customers' highest priority is to be treated with courtesy and respect by the direct care worker. Further, well-trained and empathetic direct care workers are better poised to comfort patients and improve patient (customer) satisfaction.

Empathy appears to be a key component of service quality and customer satisfaction, as it has been directly linked to building customer trust and creating an effective patient-provider relationship (Brunero, Lamont, & Coates, 2010). According to Lopez-Perez et al. (2013), the empathic concern shown by direct care workers has a direct influence on customer satisfaction, which benefits healthcare service providers and recipients. The ability of direct care workers to manage emotions and interactions with customers is an individual trait that can be assisted through leadership practices that foster positive and authentic organizational climates (Grandey et al., 2012). Gountas et al. (2014) explored the effects of empathic concern on personal job satisfaction and customer orientation, and concluded that understanding the complex interactions between direct care worker job satisfaction and customer orientation, contributes to customer satisfaction, particularly in highly stressful service work. According to Garcia-Garcia et al. (2011), positively affecting front-line worker motivation, productivity, effectiveness, and job satisfaction, creates a positive working environment, which in turn affects customer satisfaction and leads to the successful achievement of organizational goals.

Research Variables Chosen Literature

This research examined the relationship between Kouzes and Posner's (1987) Five Practices of Exemplary Leadership® model and home healthcare productivity measures related

to job satisfaction, employee turnover, and customer satisfaction. The independent variable of exemplary leadership practices was generally defined as leadership effectiveness (i.e., impacting commitment, engagement, and satisfaction) as leaders of PCA employees. The dependent variable(s) were generally defined as leadership performance effectiveness (metrics) of job satisfaction, employee turnover, and customer satisfaction.

Kouzes and Posner (1987) developed The Five Practices of Exemplary Leadership® model (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart) to measure transformational leadership characteristics. According to Zagorsek, Stough, and Jaklic (2006), these five leadership dimensions accurately reflect the common themes found within transformational leadership theory (e.g., empowerment, recognition, values, vision). Kouzes and Ponser's (1987) Leadership Practices Inventory® (LPI) scale was created to determine specific leadership characteristics that are present within individuals. Bowles and Bowles (2000) find the LPI instrument and five practices to be relevant and cogent in the healthcare industry, and representative of the values that are attractive in healthcare leadership.

The concept of job satisfaction has been extensively researched across various organizational management topics and reported in academic literature since the early part of the 19th century. Work values (e.g., intrinsic, convenience, financial, career opportunities, relationships with coworkers, resource adequacy) have independent and significant effects on job satisfaction (Kalleberg, 1977). Job satisfaction is a function of the perceived relationship between "what one wants from one's job and what one perceives it as offering or entailing" (Locke, 1969, p. 316). Further, job satisfaction has a positive relationship with firm value (Edmans, 2012).

Employee turnover is a key issue facing the home healthcare industry, as turnover among frontline workers is a critical cost driver (Seavey, 2011). Rates of turnover in the nursing industry, in conjunction with job demands, "comprise a dynamic, evolving system that singularly and collectively influences patient satisfaction" (Reilly, Nyberg, Maltarich, & Weller, 2014, p. 787). Abualrub and Alghamdi (2012) researched the impact of leadership styles on job satisfaction and turnover intention and found nurses to be more satisfied with leaders who demonstrated transformational leadership styles. Basford, Offerman, and Wirtz (2012) found supportive leadership practices fostered enhanced levels of job satisfaction and were negatively associated with employee turnover, intention to quit, and burnout.

Customer satisfaction is composed of four primary concepts: expectations, performance, disconfirmation, and satisfaction (Churchill & Surprenant, 1982). Front-line employees play a critical role in the delivery of basic healthcare services, which directly influences customer satisfaction and other healthcare outcomes (Chuang et al., 2012). While turnover of direct care workers may have negative organizational consequences in terms of recruitment and retention costs, the greater organizational risks appear to reside in decreased continuity, service quality, and productivity (Buffington et al., 2012). Further, service quality has a direct influence on customer satisfaction (Panchapakesan, Sai, & Rajendran, 2015).

Transition and Summary

Leadership theory has roots dating back to the ancient world. The motivation to lead overarches how leadership roles emerge and what leadership is (Dede & Ayranci, 2014). The modern world necessitates effective leadership practices more than ever before. The fast pace of change in the healthcare industry has instilled a sense of urgency among effective leaders at all levels in healthcare organizations and hierarchies (Hopkins, O'Neil, & Stoller, 2015). This

requirement is predicated on a willingness to accept leadership by acting according to the view that leadership is a vital and an honorable duty. The emergence of exemplary leadership depends on a variety of factors and theories, some of which contradict each other. Building upon the foundational theories, this study applied current knowledge about leadership theory to better understand the relationship between exemplary leadership practices and organizational productivity measures.

This research focuses specifically on leadership practices and performance effectiveness of leaders of PCA employees in the home healthcare industry. The leadership effectiveness criteria chosen for this research pertains to individual leadership practices (leader focused assessment), follower job satisfaction (affective assessment), and follower performance (group level task related performance) in producing customer satisfaction. The problem to be addressed is the lack of home healthcare leaders for understanding and adopting leadership practices that enhance PCA job satisfaction and turnover, as well as customer satisfaction. The purpose of this non-experimental quantitative correlational study was to examine the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry.

The home healthcare industry is experiencing changes driven by government regulation, and the challenge to meet an expanding demand for home healthcare services with a shortage of PCA workers. Constraints on revenue and heightened awareness by the market, position home healthcare leaders for making decisions that ultimately affect the delivery of healthcare services. If home healthcare leaders are not executing leadership practices that lead to effective human resource decision-making, then the growing population of home healthcare workers and

customers stand to bear the burden. Examining the relationship between leadership practices, employee satisfaction, employee turnover, and customer satisfaction, fosters the opportunity to discover what leadership practices are most influential to effectively leading home healthcare workers, as to satisfy the growing demands of the home healthcare market.

Section 2: The Project

Section 2 is designed to show how the study was completed and the methodology for the study. The purpose statement section describes the cohesive purpose for study completion. Through the purpose statement, the researcher provides information regarding the reason for conducting and how it was completed. The role of the researcher section provides information regarding the role of the researcher in the data collection process. The participants section outlines the demographic makeup of the participants, the procedures for gaining access to the participants, the establishment of a working relationship with participants, and measures taken to ensure the ethical protection of participants and confidentiality of data were maintained. The research method and design section identifies and justifies the use of the specific research method, indicates the method to be used and why, including a discussion on why other methods were not selected. Further, the researcher identifies and justifies the use of a specific design within the method, including why it was selected and its appropriateness for selection. The population and sampling section provides a description of the population and defends the sampling method. The data collection section discusses and describes instruments used in data collection, the identification of how data was obtained for the study and justification regarding data collection techniques, and information regarding the systems used to organize data in an effective manner, as well as its security. The data analysis technique section outlines the data analysis techniques and descriptions how data was analyzed. The reliability and validity sections discuss reliability of the study itself and the instruments, and the validity of the study in both an internal and external context. The final section summarizes Section 2 and provides a transition to Section 3.

Purpose Statement

The purpose of this non-experimental quantitative correlational study was to examine the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry. The independent variable was exemplary leadership defined as home healthcare worker effectiveness (i.e., impacting commitment, engagement, and satisfaction) as leaders of PCA employees. The dependent variables were defined as home healthcare worker performance as leaders of PCA employees, and productivity effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction.

Role of the Researcher

The data collection portion of the study was largely dependent upon the researcher. The researcher determined the population to be analyzed, as well as the sample for the completion of the study. The researcher was also the one to initiate communication by email with the research participants. The researcher collected survey data from the participant upon receiving confirmation of understanding of the informed consent sheet and permissions letter. As such, even after the completion of the study, the researcher is available for questions that the participants may have regarding their data. Therefore, the researcher is instrumental in ensuring that the participant has all relevant information regarding study participation, as well as ensuring that results are obtained, organized, and analyzed in an effective manner.

Data were collected from a leading home healthcare company and its U.S. network of home healthcare leaders. The researcher does not have any authority over the participants.

Participants

This confidential research was identified as involving minimal to no risk to participants. Potential participants were identified through internal company directories and conducting research with individual offices. A total of 389 locations were invited to participate in the research. This is the total number of locations who participated in the company's quality assurance program pertaining to customer and employee satisfaction. The leaders selected for participation were invited to take the survey because of demonstrated practices in leading PCA employees. Once these leaders were determined, they were contacted regarding potential participation in the research study. Participant contact was made via an electronically distributed survey (i.e., SurveyMonkey) based upon a distribution list of email addresses harvested by the researcher from the home healthcare company's website.

Participants were involved in the research by completing a self administered, electronically distributed survey questionnaire that required 15-20 minutes of time to complete. The first page attached to the survey document consisted of questions that determined a participant's appropriateness to be included as a participant in the research. The survey began with qualifying questions pertaining to age and position to ensure that the participants were from the appropriate population and met the inclusion criteria.

The second page of the survey document included the informed consent document that addressed the participants' right to voluntary participation and provided answers to commonly asked questions (see Appendix B). Participants completing the electronic survey electronically read and signed the informed consent form before participation could commence. Participants viewed and read the informed consent information in the same manner they would have done so had they been participating in a "paper based" version of the survey. Participants were asked at

the end of that page whether or not they "consent" to participate by clicking "yes" or "no", typing their name, and entering the date.

Informed consent is important to the ethical nature of the study. Through informed consent, the participant notes their agreement and willingness to participate in the study. Moreover, informed consent allows the participant to understand the purpose of the study, procedures of the study, potential risks, and potential benefits of participation. Further, informed consent allows the participant the opportunity to consider alternatives to participation, including how declining to participate will impact the study results (Faden, Beauchamp, & Kass, 2014). Therefore, in order to participate in the study, participants were required to acknowledge their agreement to participation in the informed consent form prior to completing the survey.

Participants were not asked any other identifying questions beyond general demographic questions (i.e., gender, age, etc.). No other questions inquiring about any information that may later be used for identification (i.e., postal addresses, telephone numbers, SSN, MR#, DOB, etc.) were included in the survey. Participants neither received compensation nor incurred any cost for participating in this research. Participants did not waive legal rights by agreeing to participate in the research.

By participating in this study participants were directly contributing to the existing body of leadership research. Although no study is completely risk-free, the participants were not expected to experience harm or distress by participating in this research. Further, participants were able to withdraw at any time during the research process or contact the researcher in the event they had any concerns.

Research Method and Design

The purpose of this section is to describe the research method and design. This information is important because it provides information regarding how the research was completed. As a result, it is also possible to justify the use of the particular research method, as well as provide a discussion as to why other methods were not selected.

Method

This particular research project utilized quantitative research methods. This method was chosen by the researcher to meet the purpose of the research study, which is to examine the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry. Quantitative research is considered to be beneficial for many different reasons (Creswell, 2014). Quantitative research is based on the functional paradigm, also commonly known as positivism. Positivism is based on one particular assumption—social reality is objective and individuals respond to this objectiveness (Matveev, 2002). Therefore, quantitative research is ontological in structure. One of the purposes of quantitative research is to measure events, allowing for a statistical analysis of numerical data. It is assumed that objective truth, commonly found in positivist paradigms, can be measured and explained in a scientific manner (Matveev, 2002). As a result, quantitative research methods assume that the measurement is reliable, valid, and can be generalized to the broader population (Matveev, 2002).

Quantitative research is empirical in nature due to the deductive and particularistic nature of the research. This is because of the use of research hypotheses, allowing for verification based on data obtained in the research study (Matveev, 2002). Moreover, through use of the

quantitative approach, researcher bias, values, and subjective preferences are less likely to be noted, ensuring that the results are fairly constructed. There are different strengths regarding the quantitative method. For example, the quantitative method allows the research problem to be very specific and exact in nature. Through the quantitative method, the variables can be identified in a clear manner, which allows for clear analysis (Matveev, 2002). Moreover, reliability is increased because data is gathered based on controlled procedures, which is important in allowing for longitudinal measures of later performances. Thus, subjectivity of judgment is eliminated or reduced through the use of quantitative research (Matveev, 2002).

Comparatively, a qualitative research design was not appropriate for this study because the researcher was not exploring the qualitative consistencies of home healthcare leadership practices. Qualitative research employs direct contact with research participants and a focus on their individual experiences, as to explore the richness, depth, and complexity of phenomena (Creswell, 2014). This study was not attempting to explain leadership phenomena, rather, describe the correlation between descriptive variables. Further, mixed method research designs seek to generate conclusions from both quantitative and qualitative strands of research data (Crewsell & Plano Clark, 2011). Therefore, the researcher did not employ a mix method research design. Finally, a case study approach was not appropriate for this study, as the researchers was not conducting the study in an ordinary setting, following issues or circumstances as they emerge, or within special scenarios structured by a causal theoretical model (Abma & Stake, 2014).

There are weaknesses of the quantitative method. For example, the quantitative method does not provide information regarding the context of the situation when data is obtained (Matveev, 2002). Moreover, outcomes are limited to those within the research proposal due to

the structure of the format. This means that the investigation is not continuous through the structure of the study (Matveev, 2002). While it is impossible to fully control the environment where the survey is completed, this weakness is acknowledged by providing the same survey to all participants, including the same format in order to show continuity in the research design. In this particular study, the researcher communicated the standardized survey via electronic delivery to the participant's work email address, whereby the participant may complete the survey electronically within the survey platform and in association with a work environment.

This particular study is justified in its use of quantitative research in its use of a survey in order to answer the research questions and to test the null hypotheses. This means that the quantitative nature of the study allows for numerical instances to be used as measurements for the events in question, allowing for further analysis of the study problem. Despite the rigid structure of the research study design, it is believed that this is the most effective way to answer the research questions and to verify the hypotheses because of the straightforward nature of the technique used.

Kouzes and Posner's (1987) Leadership Practices Inventory® (LPI) scale was created to measure specific leadership characteristics that are present within individuals. The LPI instrument enjoys proven validity and reliability and was utilized by the researcher to gather data on leadership practices. The LPI instrument measures leadership competencies and behavior frequencies for The Five Practices of Exemplary Leadership®: Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, and Encourage the Heart. Kouzes and Posner (2012) outlined the five practices as: leaders modeling the way by finding their voice and setting the example, inspiring a shared vision by envisioning the future and enlisting others in a common vision, challenging the process by searching for opportunities, taking risks, and learning

from mistakes, enabling others to act by fostering collaboration and strengthening others, and encouraging the heart by recognizing contributions and celebrating values and victories.

This research focused on quantitatively examining the relationship between the total score of the five practices as identified above, and their potential relationship to job satisfaction, employee turnover, and customer satisfaction. LPI-Self total scores were statistically analyzed with PCA job satisfaction scores, PCA employee turnover percentages, and PCA services customer satisfaction scores, to see if statistically significant relationships exists. PCA job satisfaction scores were gathered via telephone surveys conducted by the home healthcare company, and are based entirely on employee and customer opinions and perceptions. PCA job satisfaction measures were comprised of factors such as job duties, staff quality, training, pay, benefits, and company performance. PCA employee turnover percentages were comprised from the annual number of terminated PCA employees divided by the existing number of PCA employees on staff. PCA services customer satisfaction measures were composed of factors such as service setup, services provided, relations with employees, and fees.

This research was conducted using self-administered questionnaires that were distributed and returned via an electronic survey format. The study employed a cross-sectional survey methodology for collecting LPI-Self scores and measured the strength of association with existing data gathered on the dependent variables. The Pearson correlation coefficient (Pearson's *r*) was employed to examine the strength of association between the independent and dependent variables, as well as Spearman's correlation coefficient (Spearman's *rho*) where the assumptions of normality were violated. This correlational design utilized the LPI-Self total score comprised by summing the scores from all five sub-components of the LPI-Self instrument.

Cohen (1988) effect sizes were utilized in determining the practical significance of the research findings. In terms of statistical significance, a 95% confidence interval level ($p \leq 0.05$) was determined to be the most appropriate value. A cut-off point in the range of $r = 0.10 – 0.30$ (Cohen, 1988) was set for the practical significance of correlation coefficients.

Research Design

The basic research method was quantitative. The specific design for this research is non-experimental. In non-experimental research, it is not possible for the researcher to manipulate the predictor variable. Rather, the researcher must rely on observation, interpretation, or interactions to develop a conclusion (Gelo, Braakmann, & Benetka, 2008). Therefore, since this study is based on surveys, non-experimental research is beneficial in this particular study. This is because the study cannot demonstrate cause and effect. Moreover, non-experimental research is high in external validity, allowing it to be generalized to a larger population (Gelo et al., 2008). Significantly, non-experimental research focuses on observations and interpretations. This means that non-experimental research cannot confirm that one variable causes another variable to occur. Non-experimental research is disadvantageous because it is not possible for the researcher to establish definitively cause and effect relationships or to manipulate variables, and the study method is mostly correlation (Gelo et al., 2008). Yet, this type of study is advantageous because it meets needs that other studies cannot. This is important because some variables cannot be manipulated, such as age, gender, ethnicity, employment title, or current opinion. Since these variables cannot be manipulated or controlled, it is possible for the non-experimental design to allow for the study of these variables (Gelo et al, 2008). This method was deemed to be the most effective because the predictor variable could not be modified. The

independent variable is exemplary leadership, which cannot be modified. As such, the study is most effectively completed as a non-experimental design.

A descriptive research design was not appropriate for this research because the researcher was not seeking to provide systematic information about the leadership phenomenon, rather, explain the relationship between leadership and performance outcomes. Further, a quasi-experimental research design was not appropriate for this study because the researcher was not seeking to establish a cause-effect relationship between the variables (Creswell, 2014). Finally, an experimental research design was not appropriate for this study because the researcher was not using the scientific method to test causality, or manipulate the independent variable to determine the effects on the dependent variable.

The independent variable was exemplary leadership defined as home healthcare worker effectiveness (i.e., impacting commitment, engagement, and satisfaction) as leaders of PCA employees. The dependent variables were defined as home healthcare worker performance as leaders of PCA employees, and productivity effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. These variables relate to the research problem because it is based on the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (customer satisfaction, job satisfaction, employee turnover) in the home healthcare industry. This allows for a comparison to be found regarding the independent variable and dependent variables.

The researcher proposed the following research questions:

R1. Is there a statistically significant relationship between home healthcare leadership practices and PCA job satisfaction?

R2. Is there a statistically significant relationship between home healthcare leadership practices and PCA employee turnover?

R3. Is there a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction?

For the first research question R1, the independent variable was exemplary leadership practices, whereas the dependent variable was PCA job satisfaction. The researcher proposed research question R1 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA job satisfaction. For the second research question R2, the independent variable was exemplary leadership practices, whereas the dependent variable was PCA employee turnover. The researcher proposed research question R2 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the PCA employee turnover metric calculated from the survey data. For the third research question R3, the independent variable was exemplary leadership practices, whereas the dependent variable was PCA services customer satisfaction. The researcher proposed research question R3 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA services customer satisfaction.

The researcher proposed the following hypotheses to answer the research questions:

H01: There is no statistically significant relationship between home healthcare leadership practices and PCA job satisfaction.

HA1: There is a statistically significant relationship between home healthcare leadership practices and PCA job satisfaction.

H02: There is no statistically significant relationship between home healthcare leadership practices and PCA employee turnover.

HA2: There is a statistically significant relationship between home healthcare leadership practices and PCA employee turnover.

H03: There is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

HA3: There is a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

For the hypotheses and null hypotheses, the independent variable and dependent variables are the same as for the research questions. The hypotheses relate to the research problem because they correspond by testing the null hypotheses concerning the statistically significant relationships between the independent variable and the dependent variables. Chapter 3 provides details on the data analysis used to answer the research questions and hypotheses.

Population and Sampling

The population for the research included leaders of PCA employees at 389 home healthcare locations. This allowed the basis of the study to be met in regard to obtaining information relating to leadership practices. Moreover, the sampling frame clarified the inclusion and exclusion criteria for participation in the study as follows:

1. The participant must be over 18 years of age.

2. The participant must work for the identified home healthcare company.

3. The participant must work in one of the 389 offices identified.

4. The participant must be identified as a leader (e.g., supervisor, manager, director) of PCA employees.

The research utilized a convenience sampling technique. There are numerous advantages associated with convenience sampling. It is low cost and easy to employ as a sampling technique (Farrokhi & Mahmoudi-Hamidabad, 2012). There are fewer rules associated with convenience sampling, making it easier to be used for research purposes. For instance, limited time and other resources may be the deciding factor in conducting research that utilizes a convenience sample. At the same time, convenience sampling is beneficial because it is possible to gather useful data and other information, possibly not accessible through other sampling techniques which require more formal access (Farrokhi & Mahmoudi-Hamidabad, 2012).

Despite the advantages of convenience sampling, there are limitations or disadvantages. For example, bias is a significant concern. In many cases, the use of convenience samples can lead to an under- or over-representation of particular groups of the population (Farrokhi & Mahmoudi-Hamidabad, 2012). Since this study only considers identical participants, this bias is decreased. However, it is recognized that the participants may be at different locations, which could lead to differing results. Moreover, through convenience sampling, it is unclear as to why participation was agreed upon. For instance, some may respond due to more free time and availability, while others may respond because they trust the survey intentions, and still others may participate out of kindness to the researcher or because they have a grievance with the organization (Farrokhi & Mahmoudi-Hamidabad, 2012). These particular biases cannot be remedied, but they are acknowledged as possibly existing within this study (Creswell, 2014).

It is believed that this sampling method was the most effective because it enabled the researcher to invite all 389 locations to participate in the study. Moreover, since the sampling frame required certain criteria to be met, it is known that the needs of the study were met through ensuring that all participants were relevant.

In order to determine the sample size, the confidence interval must be known. This is commonly known as the margin of error. As frequently accepted within the social sciences, it is assumed that a 5% margin of error and a 95% confidence level must exist. Therefore, the sample size needed for a population of 389, is 194. This is believed to be beneficial because it allows for a small range of accuracy, as well as ensures that it is possible to obtain an adequate number of responses in order to meet the expectations of the survey.

Data Collection

Instruments

The first source of data collection utilized by the researcher was Kouzes and Posner's (2001) Leadership Practices Inventory (LPI-Self) instrument. The researcher received approval from the instrument owner to use the LPI-Self instrument to conduct the research (Appendix B). The electronic survey included the 30 questions from the LPI-Self instrument (Appendix C). The 30 LPI-Self questions are subcategorized into The Five Practices of Exemplary Leadership® model (Appendix D). Each of these categories analyzes how the participants react towards subordinates (Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart).

The LPI-Self instrument utilizes a Likert-type scale ranging from 1 to 10, where 1 is almost never, 2 is rarely, 3 is seldom, 4 is once in a while, 5 is occasionally, 6 is sometimes, 7 is fairly often, 8 is usually, 9 is very frequently, and 10 is almost always. These Likert-type values were useful in conducting statistical analyses pertaining to the relationship between leadership practices and the productivity effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction.

The LPI instrument has a proven and established acceptable level of validity and reliability and has frequently been used in earlier research examining the relationship between the independent and dependent variables (Kouzes & Posner, 2016a; Posner & Kouzes, 1993). The instrument is reliable because it consistently measures leadership practices. Further, the instrument's reliability and validity is shown through acknowledgment that the instrument is subject-completed. This means that the participant answers the survey. Therefore, the results are reliable because they are the participants' opinions, and valid because they were not influenced by the researcher in any way through the completion of the survey. Most validity and reliability concerns are associated with usability. For instance, concerns often arise regarding time consumption, clearness of directions, simplicity of scoring, equivalency of forms, and problems reported by other users (Creswell, 2014). In order to prevent these concerns, an existing model was used with slight modifications to include demographic information.

The second source of data collection utilized by the researcher was archival data from home healthcare company, which included PCA job satisfaction and PCA services customer satisfaction scores. The home healthcare company provided written permission for the researcher to receive this archival (performance) data for the research project. Job satisfaction measures were comprised of factors such as job duties, staff quality, training, pay, benefits, and company performance. Customer satisfaction measures were composed of objective and subjective factors such as service setup, services provided, relations with employees, and fees. The performance data was stripped of identifying information by the corporate office prior to it being sent to the researcher.

The third source of data collection utilized by the researcher was the other survey data received from the participants. The electronic survey contained questions pertaining to the

demographic background of the research participants. The descriptive characteristics of the data

included: gender, ethnicity, age, highest degree achieved, length of employment at current

organization, and state in which the home healthcare agency operates. The electronic survey also

asked participants for two data points used by the researcher to calculate the annual turnover rate

for PCA employees: number of PCA employees currently employed; number of PCA employees

terminated/quit during the past 12 months.

Data Collection Technique

Initially, Internet research was used to determine contact information for the home

healthcare leaders. This research is possible because the principal researcher agreed to a non

disclosure agreement, barring disclosure of confidential information possibly obtained through

the course of the study. Initial contact with participants was prefaced by a recruitment letter

inviting participation, and identifying the researcher as a graduate student in the Doctorate of

Business Administration (DBA) program in the Liberty University School of Business,

conducting research to better understand the relationship between the independent and dependent

variables.

The electronic survey was conducted through SurveyMonkey, a well-known Internet

platform for conducting surveys. The informed consent form was sent to the potential

participants as part of the electronic survey. Once the invited participant agreed to the informed

consent sheet, s/he was able to complete the survey questions. Results for the research questions

(LPI-Self, demographic, and PCA employee turnover) were obtained via the SurveyMonkey

platform in standardized fashion. Archival data for PCA job satisfaction and PCA services client

satisfaction was obtained on a blind basis directly from the home healthcare company.

Data Organization Techniques

An identification code was established via randomized numbering to replace the participant's identifying information to ensure anonymity in the questionnaire and all data obtained through the questionnaire was coded for the quantitative correlational analysis. The archival data for PCA job satisfaction and PCA services customer satisfaction was matched with the LPI-Self survey data on a blind basis, as part of the coding procedure established by the owner of the archival data. From a coding perspective, the 30 LPI-Self leadership questions were also organized by the five practices (Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart).

The results of this research study were published as group results only. Participants' individual name or identity were not revealed or reported. Participants were responsible for securing their own computers while participating in the survey. In order to maintain confidentiality of the participants' records, the researcher downloaded and saved all data electronically to a flash drive that is being stored indefinitely in a fire-resistant safe currently located at the residence of the researcher. Access to stored data is restricted only to the principal researcher. Once the three-year retention period required by federal regulation expires, the researcher will destroy the data by erasing the flash drive containing the data.

Data Analysis Technique

This research focused on quantitatively examining the relationship between the LPI-Self total score, and its potential relationship to PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. The research participants LPI-Self scores were utilized as the dependent variable. PCA employee job satisfaction scores, PCA employee turnover percentages, and PCA services customer satisfaction scores, were used as the dependent

variables. Standard correlational analysis was employed to test the null hypotheses that no statistically significant relationship exists between home healthcare leadership practices and performance effectiveness for job satisfaction, employee turnover, and customer satisfaction. The LPI-Self total score was comprised by summing the scores from all five sub-components of the LPI-Self instrument. The Likert-type ordinal data were transformed to an interval level of measurement to enable parametric testing. Job satisfaction measures were comprised of factors such as job duties, staff quality, training, pay, benefits, and company performance. Customer satisfaction measures were composed of objective and subjective factors such as service setup, services provided, relations with employees, and fees.

An identification code was established via randomized numbering to replace the participant's identifying information to ensure anonymity in the questionnaire, and all data obtained through the questionnaire was coded for data analysis. Data analysis was conducted utilizing IBM SPSS software. Descriptive data pertaining to measures of central tendency were calculated for each variable, followed by tests for the assumption of normality. The Pearson correlation coefficient (Pearson's *r*) was employed to examine the strength of association between the independent and dependent variables, as well as Spearman's correlation coefficient (Spearman's *rho*) where the assumptions of normality were violated.

The research questions were answered based on the results of the statistical analysis and compared with the literature review. The dependent variables are relevant to home healthcare leaders because each directly impact the total cost of employment, the market share captured, and the business' overall profitability. The lower the PCA employee turnover rate, the smaller the portion of the workforce is made up of newer PCA employees who are less familiar with organizational policies and procedures, which fosters quality care delivery and customer

satisfaction. Lower PCA employee turnover rates also foster the fulfillment of PCA

occupational growth and the increasing demand for home healthcare services.

Reliability and Validity

Reliability

The LPI survey instrument tool has proven reliability. Internal reliability coefficients for

the LPI-Self ranged between .814 and .913, a mean $\alpha = .858$ (Kouzes & Posner, 2016a; Posner &

Kouzes, 1993). Creswell (2014) defines reliability in terms of an instrument demonstrating

internal consistency on item responses, consistency in test-retest correlations, and consistency in

repeated administrations. This, coupled with the unique opinions of the participants, allows for a

reliable result capable of answering the research questions. Moreover, the study's reliability is

ensured through security of data collection, including the assurance of confidentiality. This is

important in order to ensure that participants will speak honestly regarding their experiences.

Validity

Creswell (2014) defines validity in terms of an instrument's output making sense, and

producing meaningful data that enables the researcher to draw conclusions for the sample of the

population under study. According to this definition, an instrument with high validity measures

what it intends to measure and produces positive consequences in practice. The LPI instrument

has a proven and established acceptable level of validity and reliability and has frequently been

used in earlier research examining the relationship between the independent and dependent

variables (Kouzes & Posner, 2016a; Posner & Kouzes, 1993).

Although many instruments for measuring leadership exist, the LPI-Self was favored

versus other alternatives with proven validity and reliability, due to its legacy. More specifically,

the validity of the LPI instrument is evidence based on 30 years of original research, and data

from over 3 million leaders around the world (Kouzes & Posner, 2016a). The instrument is valid because it consistently produces reliable measures of leadership practices. Carless (2001) assessed the discriminant validity of the LPI instrument using confirmatory factor analysis, and concluded that it accurately assesses an over-arching construct of transformational leadership. Chen and Baron (2007) researched the psychometric properties of LPI in conjunction with nurses, and found the LPI instrument to be culturally appropriate for accessing leadership behaviors in the healthcare industry.

The study is also valid because it is based on the self observed means of the participants and therefore measures what the study purports to measure. It is assumed that all participants answered honestly and fairly. Further, through the use of an external platform for administering the survey (SurveyMonkey), data collection was procedural and uniform across participants. Finally, through the use of variegated statistical analyses, the hypotheses were formally tested and results used to answer the research questions being considered.

Transition and Summary

The purpose of this non-experimental quantitative correlational study was to examine the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry. The researcher was instrumental in ensuring that participants had all relevant information regarding study participation, as well as ensuring that results were obtained, organized, and analyzed in an effective manner. Potential research participants were determined via conducting internet research about the home healthcare company and its leaders. The workers selected for invitation each carry a title signifying leadership practices over PCA employees. The potential participants were contacted

regarding participation in the research study and provided the opportunity to consent to participation prior to any research questions. Informed consent was important to the ethical nature of the research.

The specific design for this research was non-experimental. In non-experimental research, it is not possible for the researcher to manipulate the predictor variable. Rather, the researcher must rely on observation, interpretation, or interactions to develop a conclusion (Gelo, Braakmann, & Benetka, 2008). Therefore, since this research is based on surveys, non-experimental research is beneficial in this particular research. This is because the research cannot demonstrate cause and effect. Moreover, non-experimental research is high in external validity, allowing it to be generalized to a larger population (Gelo, Braakmann, & Benetka, 2008).

Significantly, non-experimental research focuses on observations and interpretations. This means that non-experimental research cannot confirm that one variable causes another variable to occur. Non-experimental research is disadvantageous because there is a tradeoff between control and context in that the researcher is unable to definitively establish cause and effect relationships or manipulate variables. Therefore, the research method is mostly correlational in nature (Gelo, Braakmann, & Benetka, 2008). Yet, this type of research is advantageous because it meets needs that other studies cannot and lends itself to studies that utilize existing data. This is important because some variables cannot be manipulated, such as age, gender, ethnicity, employment title, or current opinion. Since these variables cannot be manipulated or controlled, it is possible for the non-experimental design to allow for the research of these variables (Gelo, Braakmann, & Benetka, 2008). This method was deemed to be the most effective because the predictor variable could not be modified. The independent variable is

exemplary leadership practices, which is not being modified only measured. As such, the research is most effectively completed as a non-experimental design.

This study was also quantitative in design. Quantitative research is considered to be beneficial for many different reasons (Creswell, 2014). In fact, quantitative research is based on the functional paradigm, also commonly known as positivism. Positivism is based on one particular assumption—social reality is objective and individuals respond to this objectiveness (Matveev, 2002). Quantitative research is empirical in nature due to the deductive and particularistic nature of the research. This is because of the use of research hypotheses, allowing for verification based on data obtained in the research (Matveev, 2002).

Through the use of the quantitative approach, researcher bias, values, and subjective preferences are less likely to be noted, ensuring that the results are fairly constructed. Further, the quantitative method allows the research problem to be very specific and exact in nature. Through the quantitative method, the variables can be identified in a clear manner, which allows for clear analysis (Matveev, 2002). Therefore, reliability is increased because data is gathered based on controlled procedures, which is important in allowing for longitudinal measures of later performances. Thus, subjectivity of judgment is eliminated or reduced through the use of quantitative research (Matveev, 2002).

This quantitative method was deemed to be the most effective for this study, given its use of a survey to conduct the research. The quantitative nature of the research allows for numerical instances to be used as measurements for the events in question, allowing for further analysis of the research problem.

Next is Section 3, which provides information regarding the results of the research, including how the results relate to the previous studies. This is important because it provides a correlation between the research results and the existing knowledge in literature.

Section 3: Application to Professional Practice and Implications for Change

Section 3 is designed to present the research data, address the research questions and hypotheses, evaluate the practical and theoretical consequences of the results, make recommendations for action and future study, and clarify key findings of the research project. This section begins with an overview of the research, its purpose and the research questions being addressed, and provides a brief summary of the findings. The presentation of the findings section specifically addresses each research question and hypothesis by presenting statistical evidence concerning the relationship between the independent and dependent variables. Herein, the researcher relates the findings to the theoretical framework and review of literature in Section 1, and references outcomes described in Section 2. The applications for professional practice section discusses the applicability of the findings with respect to leadership practices as home healthcare workers who lead PCA employees, and describes the relevance of the findings for improving performance and productivity outcomes. This subsection also discusses implications of the findings in relation to biblical integration and the leadership field of study.

The recommendations for action section outlines roles impacted by the results of this study, and indicates how to disseminate the findings to key stakeholders. In the recommendations for further study section, the researcher recommends future research topics supporting new rounds of research questions for improving leadership practices of home healthcare workers who lead PCA employees. The reflections section describes the researcher's experience with the research process, highlights the researcher's preconceived professional and biblical values, and potential effects of the researcher on the participants. Finally, the summary and conclusions section summarizes the most relevant points of the research project, and identifies how the research closes gaps in the literature.

Overview of Study

The home healthcare industry has experienced changes driven by government regulation while challenged to meet an expanding demand for services with a shortage of workers (Stone et al., 2006). The problem to be addressed is the lack of home healthcare leaders who understand and adopt leadership practices for enhancing PCA job satisfaction and retention, as well as customer satisfaction, amid the expanding home healthcare industry. The purpose of this non-experimental quantitative correlational study was to examine the relationship between leadership practices (LPI inventory of exemplary practices) and performance and productivity performance metrics (job satisfaction, employee turnover, customer satisfaction) in the home healthcare industry.

The independent variable was exemplary leadership defined as home healthcare worker effectiveness (i.e., impacting commitment, engagement, and satisfaction) as leaders of PCA employees. The dependent variables were defined as home healthcare worker performance as leaders of PCA employees, and productivity effectiveness metrics of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. This study focused on the relationship between the leadership practices scores collected via the LPI-Self instrument, and business performance outcomes pertaining to PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction.

Research question R1 was to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA job satisfaction. The null hypothesis H01 was there is no statistically significant relationship between home healthcare leadership practices and PCA job satisfaction. The data distributions for the independent variable (LPI-Self scores) and dependent variable (PCA job

satisfaction sores) were both significantly non-normal. Therefore, Spearman's non-parametric

correlation coefficient (Spearman's *rho*) was calculated for the relationship between home

healthcare leadership practices and PCA job satisfaction. Spearman's *rho* was statistically non-

significant at r_s (205) = .015, p > .05. Therefore, the researcher failed to reject the null

hypothesis H01 that there is no statistically significant relationship between home healthcare

leadership practices and PCA job satisfaction.

Research question R2 was to determine if a relationship existed between the leadership

practices scores collected via the LPI-Self instrument, and the PCA employee turnover rate

calculated from the survey data and. The null hypothesis H02 was there is no statistically

significant relationship between home healthcare leadership practices and PCA employee

turnover. The data distributions for the independent variable (LPI-Self scores) and dependent

variable (PCA employee turnover rate) were both significantly non-normal. Therefore,

Spearman's non-parametric correlation coefficient (Spearman's *rho*) was calculated to examine

the relationship between home healthcare leadership practices and PCA employee turnover.

Spearman's *rho* was statistically non-significant at r_s (205) = .106, p > .05. Therefore, the

researcher failed to reject the null hypothesis H02 that there is no statistically significant

relationship between home healthcare leadership practices and PCA employee turnover.

Research question R3 was to determine if a relationship existed between the leadership

practices scores collected via the LPI-Self instrument, and the archival index data pertaining to

PCA services customer satisfaction. The null hypothesis H03 was there is no statistically

significant relationship between home healthcare leadership practices and PCA services

customer satisfaction. The data distributions for the independent variable (LPI-Self scores) and

dependent variable (PCA services customer satisfaction scores) were both significantly non-

normal. Therefore, Spearman's non-parametric correlation coefficient (Spearman's *rho*) was calculated to examine the relationship between home healthcare leadership practices and PCA services customer satisfaction. Spearman's *rho* was statistically non-significant at r_s (205) = .050, p > .05. Therefore, the researcher failed to reject the null hypothesis H0 that there is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

Presentation of the Findings

The research survey, containing the informed consent, demographic questions, LPI-Self survey instrument, and employee turnover questions, was conducted by the researcher via SurveyMonkey with the population (N = 389) of home healthcare workers who are leaders of PCA employees. The research participants were originally provided two weeks to complete the research survey. During the two week period, 165 respondents completed the survey, which did not achieve the minimum sample size of 194 (determined at a 95% confidence level and at a sampling error of .05). The researcher extended the survey to 4 weeks in order to achieve the minimum sample size. At the end of the 4 week period the minimum sample size was achieved. Of the 389 population, 205 (53%) completed the research survey in full. There were no incomplete surveys from the defined population. The following research data and statistical results are derived from the sample (N = 205).

Demographic Characteristics

The research survey contained questions pertaining to the demographic background of the research participants. The researcher exported the demographic data for the sample (N = 205) from SurveyMonkey into MS Excel to calculate frequency distributions for each, and make related observations. The frequencies distributions of the demographic data are provided in

Table 1 (Gender), Table 2 (Ethnicity), Table 3 (Age), Table 4 (Highest Degree Achieved), Table

5 (Length of Employment at Current Organization), and Table 6 (State of Home Healthcare

Agency) . No correlational analysis was performed for the demographic data because the data

does not pertain to the research questions. Therefore, the observations for demographic data

were made brief, as to not distract from the more important data distributions pertaining to the

research questions.

Table 1 presents the frequency distribution of gender.

Table 1

Frequency Distribution of Gender (N = 205)

Gender	N	%
Female	86	42%
Male	119	58%
Total	205	100%

All respondents identified their gender. Of the sample (N = 205), 119 (58%) identified their

gender as male, and 86 (42%) identified their gender as female. The frequency distribution

showed a well-balanced mix of male and female genders in the sample.

Table 2 presents the frequency distribution of ethnicity.

Table 2

Frequency Distribution of Ethnicity (N = 205)

Ethnicity	N	%
African American	1	0.5%
Asian Indian	1	0.5%
Caucasian	191	93%
European American	1	0.5%
Hispanic	5	2%
Native American	1	0.5%
Other (did not specify)	5	2%
Total	205	100%

Of the sample (N = 205), 191(93%) identified their ethnicity as Caucasian, 5 (2%) Hispanic, 1

(.5%) African American, 1 (.5%) Asian Indian, 1 (.5%) European American, 1 (.5%) Native

American, and 5 (2%) chose "Other" and did not specify a specific ethnicity. The frequency

distribution showed the ethnicity of the sample was predominately Caucasian.

Table 3 presents the frequency distribution of age.

Table 3

Frequency Distribution of Age (N = 205)

Age (in years)	N	%
18 to 29	1	0.5%
30 to 39	23	11%
40 to 49	60	29%
50 to 59	84	41%
60 to 69	30	15%
70 to 79	7	3%
Total	205	100%

Note. Calculated based on year of birth provided by participants

Age was calculated based on the year of birth returned by each respondent, and subtracted from

the year 2016 to generate the following age ranges. All respondents identified their year of birth.

Of the sample (N = 205), 84 (41%) were age 50 to 59, 60 (29%) age 40 to 49, 30 (15) age 60 to

69, 23 (11%) age 30 to 39, 7 (3%) age 70 to 79, and 1 (.5%) age 18 to 29. The frequency

distribution showed 70% of the sample were between the age of 40 and 59.

Table 4 presents the frequency distribution of highest degree achieved.

Table 4

Frequency Distribution of Highest Degree Achieved (N = 205)

Degree	N	%
Associate degree	12	6%

Bachelor degree	95	46%
Graduate degree	73	36%
High school degree or equivalent (e.g., GED)	4	2%
Some college but no degree	21	10%
Total	205	100%

Research participants were asked to report what the highest degree is they have achieved. All

respondents reported their highest degree achieved. Of the sample (N = 205), 95 (46%) reported

having a bachelor degree, 73 (36%) a graduate degree, 21 (10%) some college but no degree, 12

(6%) an associate degree, and 4 (2%) a high school degree or equivalent (e.g., GED). The

frequency distribution showed that 82% of the sample had at least a bachelor degree.

Table 5 presents the frequency distribution of highest length of employment at current

organization.

Table 5

Frequency Distribution of Length of Employment at Current Organization (N = 205)

Length of Employment (in years)	N	%
Less than 1	3	1%
1 to 5	45	22%
6 to 10	42	20%
11 to 15	75	37%
16 to 20	32	16%
More than 20	8	4%
Total	205	100%

Research participants were asked to report their length of employment at their current home

healthcare organization. All respondents reported their length of employment. Of the sample (N

= 205), 75 (37%) have 11 to 15 years, 45 (22%) have 1 to 5 years, 42 (20%) have 6 to 10 years,

32 (16%) have 16 to 20 years, 8 (4%) have more than 20 years, and 3 (1%) have less than 1 year.

The frequency distribution showed that 77% of the sample had at least 6 years of experience with the home healthcare company.

Table 6 presents the frequency distribution of U. S. region.

Table 6

Frequency Distribution of U.S. Region (N = 205)

Region	N	%
Midwest	62	30%
Northeast	37	18%
South	76	37%
West	30	15%
Total	205	100%

Note. Regions groupings according to U.S. Census Bureau definitions

Research participants were asked to report the U. S. state in which their home healthcare agency operates. All respondents reported their state. 42 states were reported in the sample. The researcher grouped the state responses into Regions according to those defined by the United States Census Bureau (2016). Of the sample (N = 205), 76 (37%) were in the South, 62 (30%) in the Midwest, 37 (18%) in the Northeast, and 30 (15%) in the West. The frequency distribution showed a well balanced mix of participants by state and U. S. region.

LPI-Self

The research survey incorporated the LPI-Self instrument's 30 questions pertaining to the self-observed leadership practices of the research participant. The survey instrument utilizes a Likert-type scale ranging from 1 to 10, where 1 is almost never, 2 is rarely, 3 is seldom, 4 is once in a while, 5 is occasionally, 6 is sometimes, 7 is fairly often, 8 is usually, 9 is very frequently, and 10 is almost always. Of the sample (N = 205), 205 (100%) completed each of the 30 LPI-Self questions.

The LPI-Self instrument sub-categorizes the 30 LPI-Self questions into The Five

Practices of Exemplary Leadership® (i.e., Model the Way, Inspire a Shared Vision, Challenge

the Process, Enable Others to Act, Encourage the Heart). Of the 30 LPI-Self questions, 6 pertain

to each of the 5 subcategories. Therefore, the lowest possible score for each of the 5

subcategories was 6, and the highest possible score was 60.

The researcher exported the 30 LPI-Self scores for the sample (N = 205) from

SurveyMonkey into MS Excel and calculated the score for each of the five practices. The

researcher then calculated the LPI-Self total score by summing the five subcategory scores. The

lowest possible LPI-Self total score was 30 and the highest possible score was 300.

Table 7 presents the frequency distribution of LPI-Self total scores.

Table 7

Frequency Distribution of LPI-Self Total Scores (N = 205)

LPI-Self Total Scores	N	%
178 to 200	9	4%
201 to 225	32	16%
226 to 250	46	22%
251 to 275	81	40%
276 to 297	37	18%
Total	205	100%

Note. 178 was the lowest score; 297 was the highest score

Of the sample (N = 205), 81 (40%) had LPI-Self total scores ranging from 251 to 275, 46 (22%)

from 226 to 250, 37 (18%) from 276 to 297, 32 (16%) form 201 to 225, and 9 (4%) from 178 to

200. The lowest LPI-Self total score was 178 (n = 1) and the highest LPI-Self score was 297 (n

= 2).

Table 8 presents the frequency distribution of LPI-Self total scores transformed from

ordinal level data to interval.

Table 8

Frequency Distribution of LPI-Self Transformed Scores (N = 205)

LPI-Self Transformed Scores	N	%
5.93 to 6.99	16	8%
7.00 to 7.99	49	24%
8.00 to 8.99	83	40%
9.00 to 9.90	57	28%
Total	205	100%

Note. 5.93 lowest mean score; 9.90 highest mean score

The survey instrument utilizes a Likert-type scale ranging from 1 to 10, where 1 is almost never,

2 is rarely, 3 is seldom, 4 is once in a while, 5 is occasionally, 6 is sometimes, 7 is fairly often, 8

is usually, 9 is very frequently, and 10 is almost always. LPI-Self total scores were computed

based on the Likert-type values from the LPI-Self instrument. Likert-type values generate

ordinal level data. Parametric tests require interval level data. To transform the LPI-Self total

scores from ordinal to interval, the researcher divided the LPI-Self total scores by 30 (i.e., the

number of LPI-Self questions) to transform the data for the sample (N = 205).

Of the sample (N = 205), 83 (40%) had LPI-Self transformed scores ranging from 8.00 to

8.99, 57 (28%) from 9.00 to 9.90, 49 (24%) from 7.00 to 7.99, and 16 (8%) from 5.93 to 6.99.

The lowest LPI-Self transformed score was 5.93 (n = 1) and the highest was 9.90 (n = 2). Most

of the participants (68%) perceived that they usually (40%) or very frequently (28%) engaged in

the typical transformational behaviors defined for each LPI practice.

The researcher imported the MS Excel file containing LPI-Self transformed scores, into

IBM SPSS to determine the normality of the data distribution and appropriate statistical test for

correlational analyses with the dependent variables. Parametric testing is utilized for normally

distributed data, whereas non-parametric testing is utilized for data not normally distributed.

Further, the Pearson correlation coefficient (Pearson's *r*) is utilized for correlational examination of parametric data, whereas Spearman's correlation coefficient (Spearman's *rho*) is utilized for correlational examination of non-parametric data.

The researcher utilized a histogram, skewness and kurtosis, Q-Q plot, and Kolmogorov-Smirnov test, to examine the normality of the LPI-Self data distribution. Normality tests of the LPI-Self data distribution are provided in Figure 2 (histogram), Table 9 (skewness and kurtosis), Figure 3 (Q-Q plot), and Table 10 (Kolmogorov-Smirnov).

Figure 2 presents the frequency histogram for the LPI-Self data distribution.
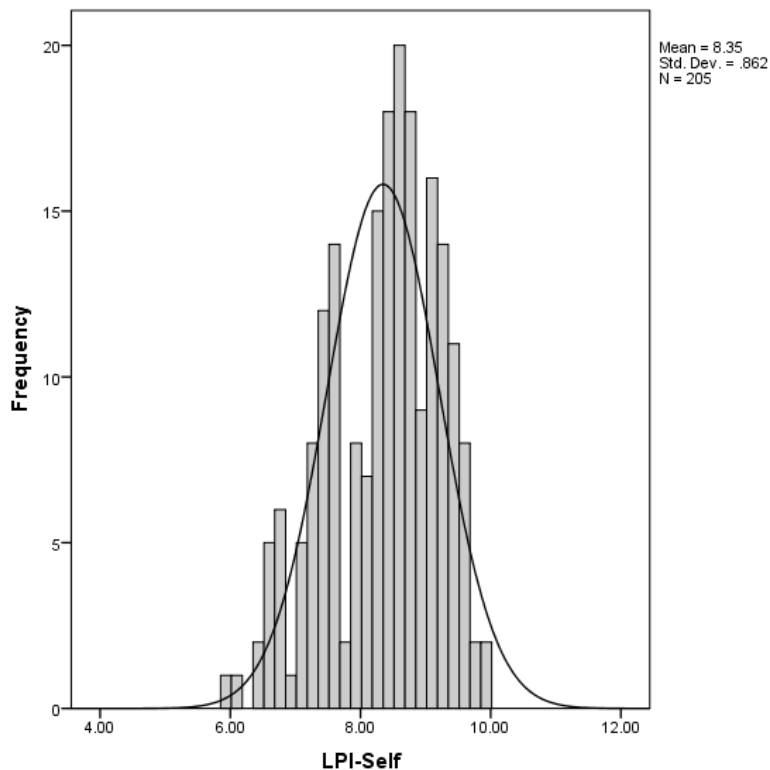

Figure 2. Frequency histogram of LPI-Self scores

Visual inspection of the histogram indicated a negatively skewed distribution with excess kurtosis, and not a symmetrical or bell shaped distribution. Further, the descriptive statistics showed the mean and standard deviation to not be equal (M = 8.35, SD = 0.862), which violated

the conditions for normality. Specifically, the low standard deviation indicated that the LPI-Self

scores tended to be closer to the mean. Therefore, the researcher concluded the LPI-Self data

distribution to be non-normal.

Table 9 presents skewness and kurtosis of the LPI-Self scores.

Table 9

Skewness and Kurtosis of LPI-Self

N	Valid	205
	Missing	0
Skewness		-0.501
Std. Error of Skewness		0.170
Kurtosis		-0.462
Std. Error of Kurtosis		0.338

Skewness of -0.501 indicated the asymmetry of the LPI-Self scores distribution to be moderately

skewed left (negative and between -1.0 and -0.5), which demonstrated the tail on the left side of

the distribution to be longer than the right side. Therefore the researcher concluded the

distribution of the sample to be non-normal. The researcher also calculated the z-score for

skewness by dividing the skew value (-0.501) by the standard error of skewness (0.170). The

absolute z-score of skewness (2.95), was greater than 2.58 (i.e., 2 standard deviations from the

mean) and significant at $p < .01$ (1% of all observations). Therefore the researcher concluded the

distribution of the sample to be non-normal.

Kurtosis of -0.462 indicated the central peak of the LPI-Self scores distribution had

excess kurtosis < 3, which demonstrated a more flat distribution. Therefore the researcher

concluded the distribution of the sample to be non-normal. The researcher also calculated the z-

score of kurtosis by dividing the excess kurtosis (-0.462) by the standard error of kurtosis

(0.338). The absolute z-score for kurtosis (1.36), was less than 1.96 (i.e., 1 standard deviations

from the mean) and not significant at p < .05 (5% of all observations). Therefore, the researcher concluded that the normality of the distribution could not be concluded based on the kurtosis value.

Figure 3 presents the Q-Q plot of the LPI-Self data distribution.
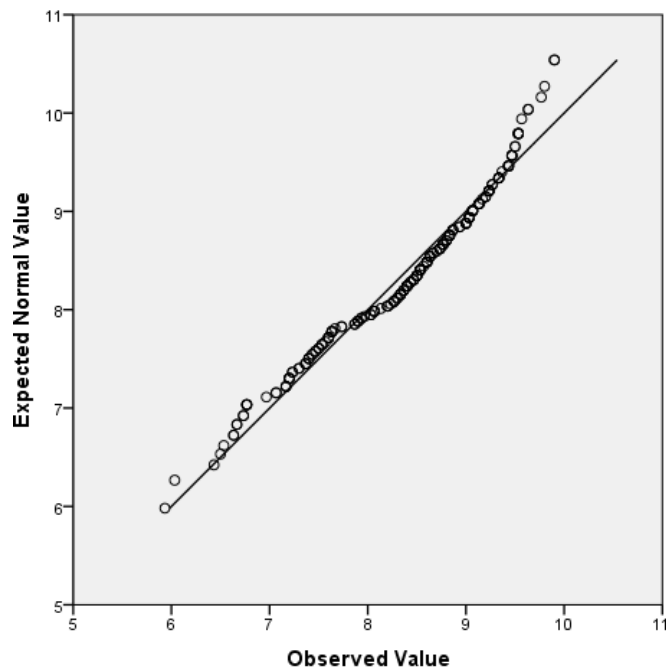
Figure 3. Q-Q plot of LPI-Self scores

Visual inspection of the Q-Q plot indicated heavy tails in the distribution, which demonstrated the LPI-Self scores data having more extreme values versus a normal distribution. Therefore, the researcher concluded the LPI-Self scores distribution to be non-normal.

Table 10 presents the Kolmogorov-Smirnov test for normality of the LPI-Self data distribution.

Table 10

Kolmogorov-Smirnov Test of LPI-Self

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
LPI-Self	0.094	205	0.000	0.966	205	0.000

a. Lilliefors Significance Correction

The LPI-Self scores of leaders of home healthcare, $D(205) = .09$, $p < .05$, was significantly non-normal. Therefore, the assumption of normality had been violated so the non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized to test the null hypotheses, in addition to the Pearson correlation coefficient (Pearson's *r*).

PCA Job Satisfaction

PCA job satisfaction scores was one of the three dependent variables for this study. Job satisfaction scores were based on archival performance data owned by the home healthcare company and collected as part of its ongoing quality assurance strategy. Job satisfaction measures were comprised of factors such as job duties, staff quality, training, pay, benefits, and company performance. An identification code was established via randomized numbering to provide the job satisfaction data to the researcher on a blind basis, and link the data to the dependent variable for quantitative correlational analysis. The home healthcare company provided the job satisfaction data set for the sample ($N = 205$), to the researcher on a blind basis via a MS Excel file.

Table 11 presents the frequency distribution of PCA job satisfaction scores.

Table 11

Frequency Distribution of PCA Job Satisfaction (N = 205)

Job Satisfaction	N	%
< 650	4	2%
650 to 699	15	7%
700 to 749	34	17%
750 to 799	79	39%
800 to 849	52	25%
850 to 899	17	8%
> 899	4	2%

Total	205	100%

Note. 551 lowest score; 969 highest score

Of the sample (N = 205), 79 (39%) had job satisfaction scores ranging from 750 to 799, 52 (25%) from 800 to 849, 34 (17%) from 700 to 749, 17 (8%) from 850 to 899, 15 (7%) from 650 to 699, 4 (2%) < 650, and 4 (2%) > 899. The lowest job satisfaction score was 551 (n = 1) and the highest score was 969 (n = 1).

The researcher imported the MS Excel file containing job satisfaction scores into IBM SPSS to determine the normality of the data distribution and appropriate statistical test for a correlational analysis with the independent variable. Normality tests of the job satisfaction scores data distribution are provided in Figure 4 (histogram), Table 12 (skewness and kurtosis), Figure 5 (Q-Q plot), and Table 13 (Kolmogorov-Smirnov).

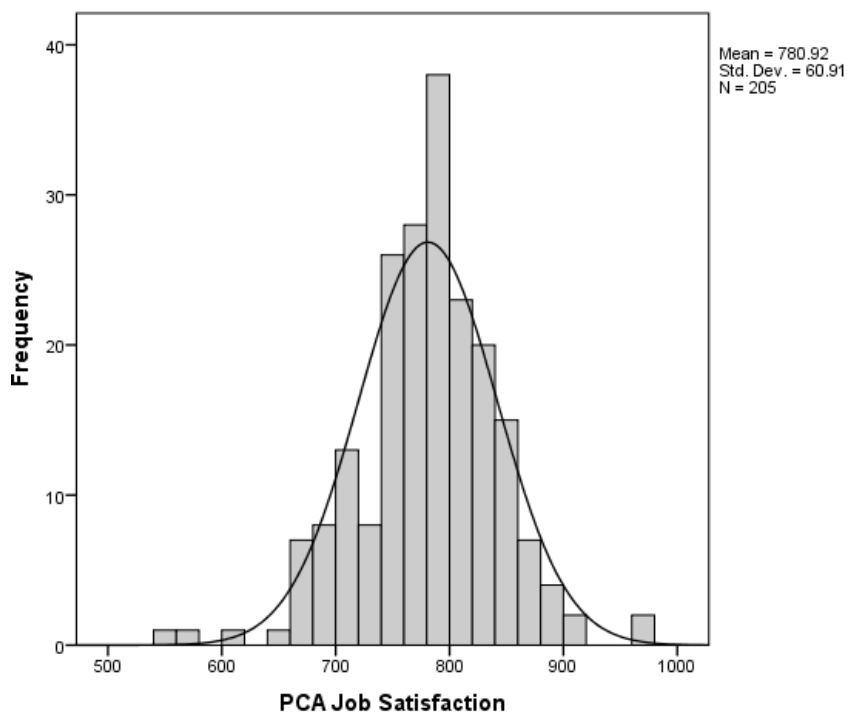Figure 4 presents the frequency histogram of PCA job satisfaction scores.

Figure 4. Histogram of PCA Job Satisfaction

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Visual inspection of the histogram indicated a relatively normally looking distribution, other than the large portion of the sample that had a PCA job satisfaction score ranging from 780-800. Further, the descriptive statistics showed the mean and standard deviation to not be equal which violated the conditions for normality (M = 781, SD = 61). Specifically, the low standard deviation indicated that the PCA job satisfaction scores tended to be closer to the mean. Therefore, the researcher concluded the job satisfaction scores distribution to be non-normal.

Table 12 presents skewness and kurtosis of PCA job satisfaction scores.

Table 12

Skewness and Kurtosis of PCA Job Satisfaction

N	Valid	205.000
	Missing	0.000
Skewness		-0.351
Std. Error of Skewness		0.170
Kurtosis		1.541
Std. Error of Kurtosis		0.338

Skewness of -0.351 indicated the asymmetry of the job satisfaction scores distribution to be negatively skewed, and approximately symmetric (between -0.5 and +0.5). Therefore, the normality of the distribution could not be concluded based on the skew value. The researcher also calculated the z-score for skewness by dividing the skew value (-0.351) by the standard error of skewness (0.170). The absolute z-score of skewness (2.06), was greater than 1.96 (i.e., 1 standard deviation from the mean) and significant at p < .05 (5% of all observations). Therefore the researcher concluded the distribution of the sample to be non-normal.

Kurtosis of 1.541 indicated the central peak of the job satisfaction scores distribution had excess kurtosis < 3, which demonstrated a more flat distribution. Therefore the researcher concluded the distribution of the sample to be non-normal. The researcher also calculated the z-

score of kurtosis by dividing the excess kurtosis (1.541) by the standard error of kurtosis (0.338).

The absolute z-score for kurtosis (4.56), was greater than 3.29 (i.e., 3 standard deviation from the

mean) and significant at p < .001 (.1% of all observations). Therefore the researcher concluded

the distribution of the sample to be non-normal.

Figure 5 presents the Q-Q plot of PCA job satisfaction scores.
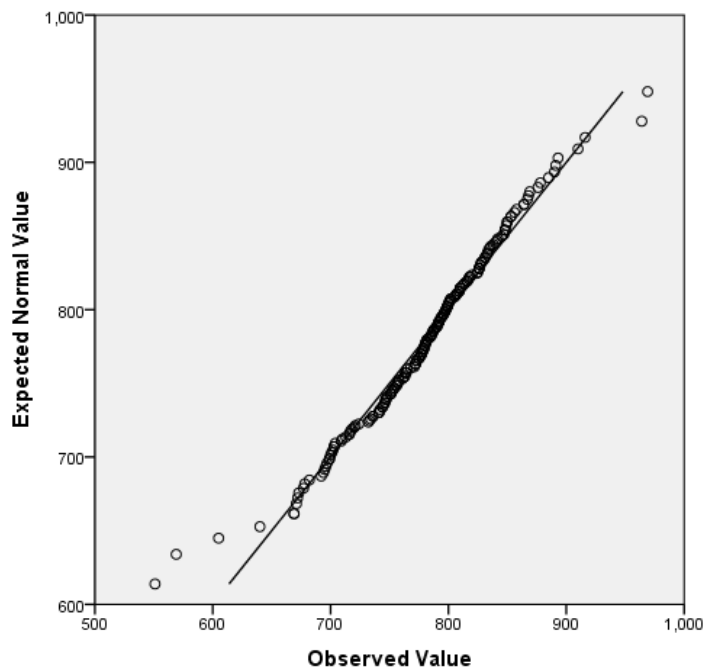
Figure 5. Q-Q plot of PCA Job Satisfaction

Visual inspection of the Q-Q plot displayed a relatively consistent set of values, with some

extreme values on the tails. Therefore, the researcher concluded the sample to be non-normal.

Table 13 presents the Kolmogorov-Smirnov test for normality of PCA job satisfaction

scores.

Table 13

Kolmogorov-Smirnov Test of PCA Job Satisfaction

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Job Sat.	0.066	205	0.029	0.979	205	0.004

a. Lilliefors Significance Correction

The PCA job satisfaction scores of leaders of home healthcare, $D(205) = .07$, $p < .05$, was significantly non-normal. Therefore, the assumption of normality had been violated, the non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized for testing the null hypothesis H02, in addition to the Pearson correlation coefficient (Pearson's *r*).

Employee Turnover Rate

PCA employee turnover rate was one of the three dependent variables for this study. The research survey asked research participants for two data points to be used by the researcher to calculate the annual turnover rate for PCA employees: number of PCA employees currently employed; number of PCA employees terminated/quit during the past 12 months. Of the sample ($N = 205$), 205 (100%) provided both data points.

The researcher exported the turnover data for the sample ($N = 205$) from SurveyMonkey into MS Excel for calculation of the turnover rates. The researcher calculated the annual turnover rate by dividing the number of PCA employees terminated/quit during the past 12 months by the number of PCA employees currently employed.

Table 14 presents the frequency distribution of PCA employee turnover rates.

Table 14

Frequency Distribution of PCA Employee Turnover (N = 205)

PCA Turnover	N	%
.05 to .49	47	23%
.50 to .99	112	55%
1.00 to 1.49	31	15%
> 1.49	15	7%
Total	205	100%

Note. 05 lowest score; 4.65 highest score

Of the sample (N = 205), 112 (55%) had PCA employee turnover rates ranging from 0.50 to 0.99, 47 (23%) from 0.05 to 0.49, 31 (15%) from 1.00 to 1.49, 15 (7%) greater than 1.49. The lowest PCA turnover rate was 0.05 (n = 1) and the highest was 4.65 (n = 2). The frequency distribution showed PCA employee turnover to be high at 77% having at least 50% turnover in their PCA workforce annually.

The researcher imported the MS Excel file containing PCA employee turnover rates, into IBM SPSS to determine the normality of the data distribution and appropriate statistical test for a correlational analysis with the independent variable. The absolute value of the turnover rates were used for quantitative correlational analysis with LPI-Self scores. Normality tests of the PCA employee turnover rates data distribution are provided in Figure 6 (histogram), Table 15 (skewness and kurtosis), Figure 7 (Q-Q plot), and Table 16 (Kolmogorov-Smirnov).

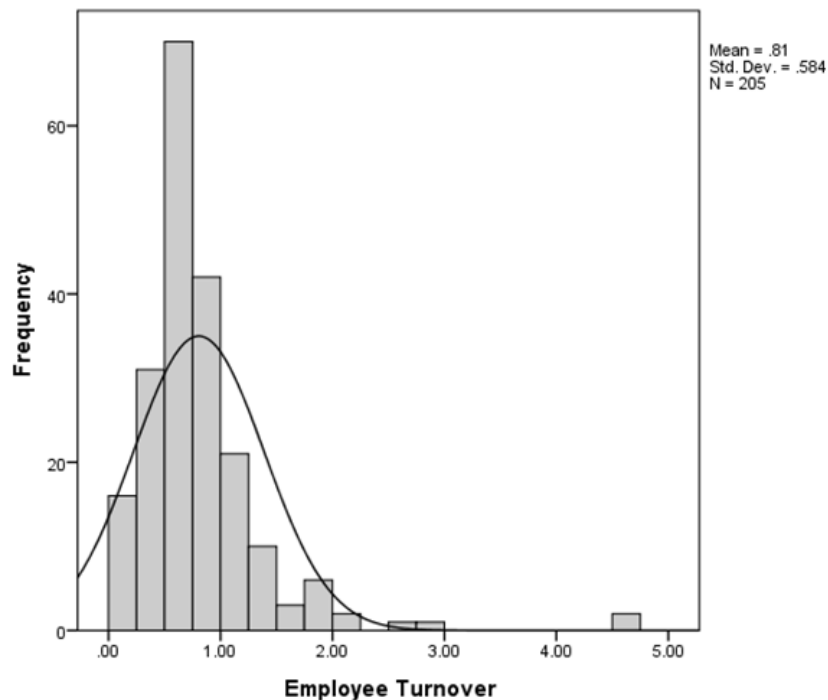Figure 6 presents the frequency histogram of PCA employee turnover rates.

Figure 6. Histogram of PCA Employee Turnover

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Visual inspection of the histogram indicated positive skewness and excess kurtosis, and not a symmetric or bell shaped distribution. Further, the descriptive statistics showed the mean and standard deviation to not be equal (M = 0.81, SD = 0.58), which violated the conditions for normality. Specifically, the low standard deviation indicated that the PCA employee turnover rates tended to be closer to the mean. Therefore, the researcher concluded the PCA employee turnover rates distribution to be non-normal.

Table 15 presents skewness and kurtosis of PCA employee turnover rates.

Table 15

Skewness and Kurtosis of PCA Employee Turnover

N	Valid	205
	Missing	0
Skewness		3.325
Std. Error of Skewness		0.170
Kurtosis		17.868
Std. Error of Kurtosis		0.338

Skewness of 3.325 indicated the asymmetry of the PCA employee turnover rates distribution to be positive and highly skewed (> 1). Therefore the researcher concluded the distribution of the sample to be non-normal. The researcher also calculated the z-score for skewness by dividing the skew value (3.325) by the standard error of skewness (0.170). The absolute z-score of skewness (19.56), was greater than 3.29 (i.e., 3 standard deviation from the mean) and significant at p < .001 (.1% of all observations). Therefore the researcher concluded the distribution of the sample to be non-normal.

Kurtosis of 17.868 indicated the central peak of the PCA employee turnover rates distribution had positive excess kurtosis > 3, which demonstrated a peaked distribution. Therefore the researcher concluded the distribution of the sample to be non-normal. The

researcher also calculated the z-score of kurtosis by dividing the excess kurtosis (17.868) by the standard error of kurtosis (0.338). The absolute z-score for kurtosis (52.86), was greater than 3.29 (i.e., 3 standard deviation from the mean) and significant at $p < .001$ (.1% of all observations). Therefore the researcher concluded the distribution of the sample to be non-normal.

Figure 7 presents the Q-Q plot of PCA employee turnover rates.
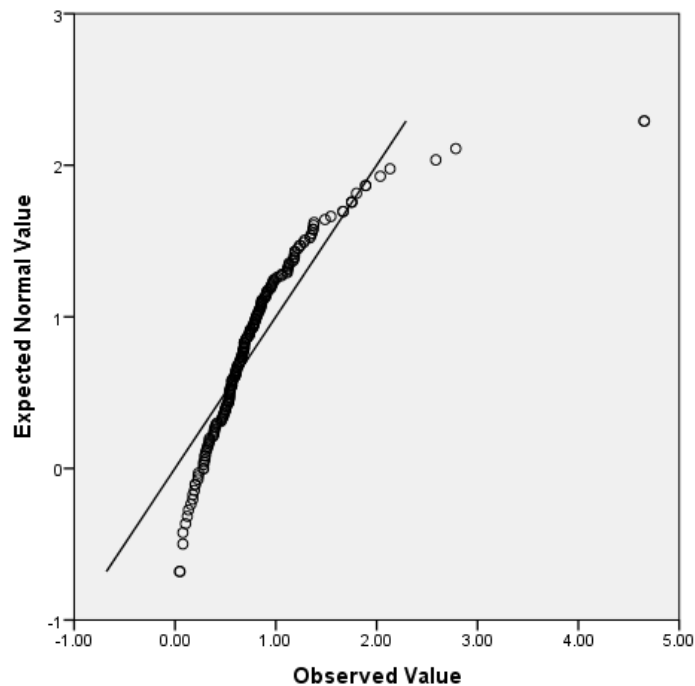

Figure 7. Q-Q Plot of PCA Employee Turnover

Visual inspection of the Q-Q plot indicated a positive skew, which demonstrated the PCA employee turnover rates data having more extreme values versus a normal distribution. Therefore, the researcher concluded the sample to be non-normal.

Table 16 presents the Kolmogorov-Smirnov test for normality of PCA employee turnover.

Table 16

Kolmogorov-Smirnov Test of PCA Employee Turnover

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PCA Employee Turnover	0.164	205	0.000	0.738	205	0.000

a. Lilliefors Significance Correction

The turnover rates of PCA employees, $D(205) = .164$, $p < .05$, was significantly non-normal. Therefore, the assumption of normality had been violated, the non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized for testing the null hypothesis H03, in addition to the Pearson correlation coefficient (Pearson's *r*).

PCA Services Customer Satisfaction

PCA services customer satisfaction scores was one of the three dependent variables for this study. Customer satisfaction scores were based on archival performance data owned by the home healthcare company and collected as part of its ongoing quality assurance strategy. Customer satisfaction measures were composed of objective and subjective factors such as service setup, services provided, relations with employees, and fees. An identification code was established via randomized numbering to provide the customer satisfaction data to the researcher on a blind basis, and link the data to the dependent variable for quantitative correlational analysis. The home healthcare company provided the customer satisfaction data set for the sample ($N = 205$), to the researcher on a blind basis via a MS Excel file.

Table 17 presents the frequency distribution of PCA services customer satisfaction scores.

Table 17

Frequency Distribution of PCA Services Customer Satisfaction (N = 205)

PCA Services Customer Sat.	N	%
< 750	5	2%

750 to 799	22	11%
800 to 849	44	21%
850 to 899	82	40%
900 to 949	45	22%
950 to 989	7	3%
Total	205	100%

Note. 668 lowest score; 989 highest score

Of the sample (N = 205), 82 (40%) had PCA services customer satisfaction scores ranging from 850 to 899, 45 (22%) from 900 to 949, 44 (21%) from 800 to 849, 22 (11%) from 750 to 799, 7 (3%) from 950 to 989, and 5 (2%) below 750. The lowest PCA services customer satisfaction score was 668 (n = 1) and the highest score was 989 (n = 1).

The researcher imported the MS Excel file containing PCA services customer satisfaction scores into IBM SPSS to determine the normality of the data distribution and appropriate statistical test for a correlational analysis with the independent variable. Normality tests of the PCA services customer satisfaction scores data distribution are provided in Figure 8 (histogram), Table 18 (skewness and kurtosis), Figure 9 (Q-Q plot), and Table 19 (Kolmogorov-Smirnov).

Figure 8 presents the frequency histogram of PCA services customer satisfaction scores.
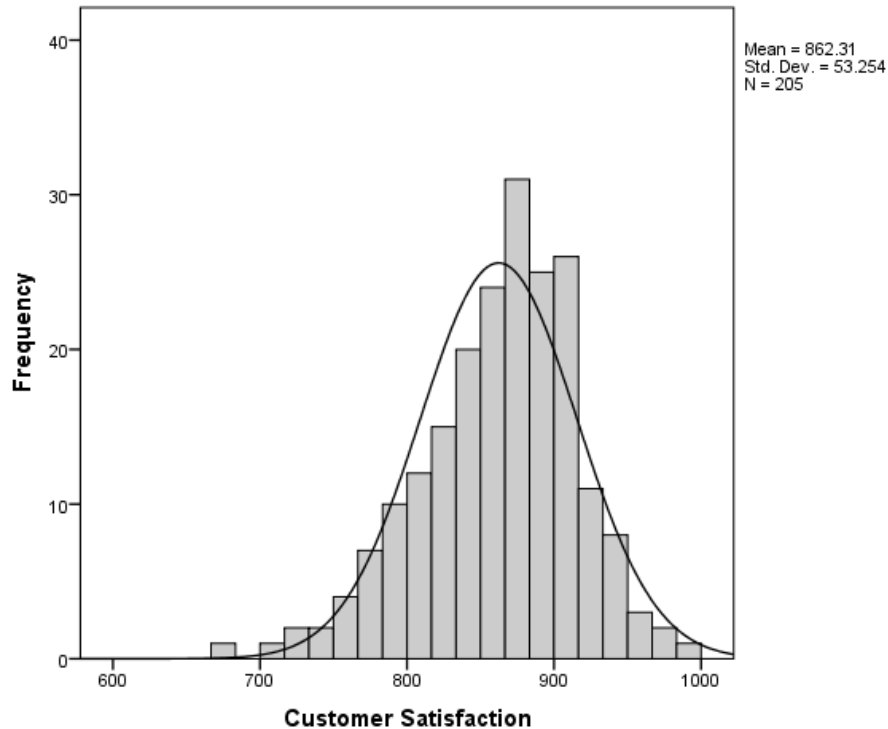
Figure 8. Frequency histogram of PCA services customer satisfaction

Visual inspection of the histogram indicated a fairly normal distribution. The descriptive

statistics showed the mean and standard deviation to not be equal (M = 862, SD = 53), which

violated the conditions for normality. Specifically, the low standard deviation indicated that the

PCA services customer satisfaction scores tended to be closer to the mean. Therefore, the

researcher concluded the PCA services customer satisfaction scores distribution to be non-

normal.

Table 18 presents skewness and kurtosis of customer satisfaction scores.

Table 18

Skewness and Kurtosis of PCA Services Customer Satisfaction

N	Valid	205
	Missing	0
Skewness		-0.545
Std. Error of Skewness		0.170

Kurtosis	0.517
Std. Error of Kurtosis	0.338

Skewness of -0.545 indicated the asymmetry of the PCA services customer satisfaction scores distribution to be moderately skewed left (negative and between -1.0 and -0.5), which demonstrated the tail on the left side of the distribution to be longer than the right side. Therefore the researcher concluded the distribution of the sample to be non-normal. The researcher also calculated the z-score for skewness by dividing the skew value (-0.545) by the standard error of skewness (0.170). The absolute z-score of skewness (3.20), was greater than 2.58 (i.e., 2 standard deviations from the mean) and significant at $p < .01$ (1% of all observations). Therefore the researcher concluded the distribution of the sample to be non-normal.

Kurtosis of 0.462 indicated the central peak of the PCA services customer satisfaction scores distribution had excess kurtosis < 3, which demonstrated a more flat distribution. Therefore the researcher concluded the distribution of the sample to be non-normal. The researcher also calculated the z-score of kurtosis by dividing the excess kurtosis (0.517) by the standard error of kurtosis (0.338). The absolute z-score for kurtosis (1.53), was less than 1.96 (i.e., 1 standard deviations from the mean) and not significant at $p < .05$ (5% of all observations). Therefore, the researcher concluded that the normality of the distribution could not be concluded based on the kurtosis value.

Figure 9 presents the Q-Q plot of PCA services customer satisfaction scores.
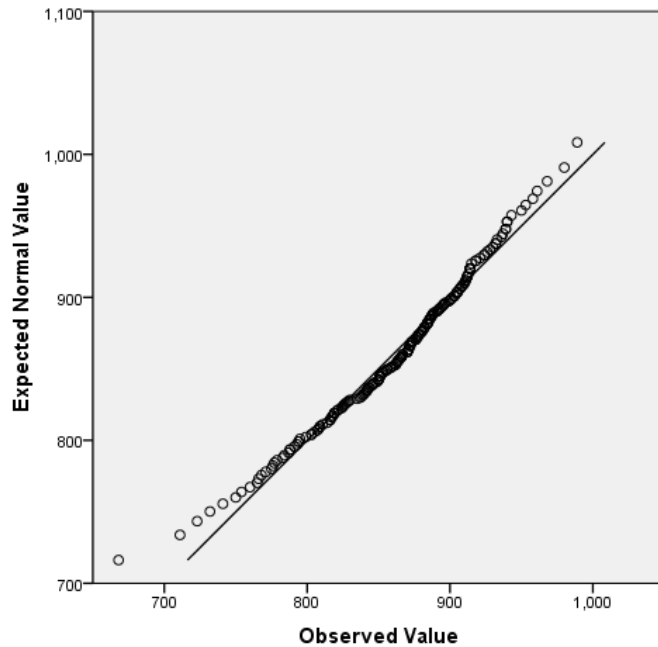
Figure 9. Q-Q plot of PCA services customer satisfaction

Visual inspection of the Q-Q plot indicated heavy tails in the distribution, which demonstrated

the PCA services customer satisfaction scores data having more extreme values versus a normal

distribution. Therefore, the researcher concluded the sample to be non-normal.

Table 19 presents the Kolmogorov-Smirnov test for normality of PCA services customer

satisfaction scores.

Table 19

Kolmogorov-Smirnov Test of PCA Services Customer Satisfaction

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Customer Sat.	0.073	205	0.009	0.982	205	0.010

a. Lilliefors Significance Correction

The PCA services customer satisfaction scores of leaders of home healthcare, $D(205) = .07$, $p <$

.05, was significantly non-normal. Therefore, the assumption of normality had been violated, the

non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized for testing the

null hypothesis H01, in addition to the Pearson correlation coefficient (Pearson's *r*).

Research Question R1

R1. Is there a statistically significant relationship between home healthcare leadership practices

and PCA job satisfaction?

For the first research question R1, the independent variable was exemplary leadership

practices, whereas the dependent variable was PCA job satisfaction. Researcher question R1

was to determine if a relationship existed between the leadership practices scores collected via

the LPI-Self instrument, and the archival index data pertaining to PCA job satisfaction.

H01: There is no statistically significant relationship between home healthcare leadership

practices and PCA job satisfaction.

HA1:   There is a statistically significant relationship between home healthcare leadership

practices and PCA job satisfaction.

The null hypothesis H01 was there is no statistically significant relationship between

home healthcare leadership practices and PCA job satisfaction. The researcher tested null

hypothesis H01 based on the sample of the defined population, and conducted the Pearson

correlation coefficient (Pearson's *r*) to infer with a probability (p <.05 cut off) that findings in the

sample may also be found in the population at a 95% confidence level.

The Pearson correlation coefficient (Pearson's *r*) was conducted in IBM SPSS software

to examine the strength of association between the independent and dependent variable. The

correlational design to test H01 utilized the LPI-Self sores and PCA employee job satisfaction

scores for the sample (N = 205).

Table 20 presents the Pearson correlation coefficient for null hypothesis H01.

Table 20

Pearson Correlation for Null Hypothesis H01

		LPI-Self	PCA Job Sat.
LPI-Self	Pearson Correlation	1	0.029
	Sig. (2-tailed)		0.682
	N	205	205
PCA Job Sat.	Pearson Correlation	0.029	1
	Sig. (2-tailed)	0.682	
	N	205	205

Pearson correlation coefficient was statistically non-significant at r (205) = 0.029, p < .05.

Therefore, the researcher failed to reject the null hypothesis H01 that there is no statistically

significant relationship between home healthcare leadership practices and PCA job satisfaction.

The results of normality testing of LPI-Self scores and PCA employee job satisfaction

scores, using the histogram, skewness and kurtosis, Q-Q plot, and Kolmogorov-Smirnov,

demonstrated both data distributions to be non-normal. Since the assumptions of normality were

violated, the non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized

for testing null hypothesis H01, in addition to the Pearson correlation coefficient (Pearson's *r*).

Table 21 presents Spearman's correlation coefficient for null hypothesis H01.

Table 21

Spearman's Correlation for Null Hypothesis H01

			LPI-Self	PCA Job Sat.
Spearman's *rho*	LPI-Self	Correlation Coefficient	1.000	0.015
		Sig. (2-tailed)		0.832
		N	205	205
	PCA Job Sat.	Correlation Coefficient	0.015	1.000
		Sig. (2-tailed)	0.832	
		N	205	205

Spearman's *rho* resulted in statistically very weak evidence r_s (205) = .015, p < .05) against the

null hypothesis H01. Therefore, the researcher failed to reject the null hypothesis H01 that there

is no statistically significant relationship between home healthcare leadership practices and PCA

job satisfaction.

Research Question R2

R2. Is there a statistically significant relationship between home healthcare leadership practices

and PCA employee turnover?

For the second research question R2, the independent variable was exemplary leadership

practices, whereas the dependent variable was PCA employee turnover. Research question R2

was to determine if a relationship existed between the leadership practices scores collected via

the LPI-Self instrument, and the PCA employee turnover metric calculated from the survey data.

H02: There is no statistically significant relationship between home healthcare leadership

practices and PCA employee turnover.

HA2:   There is a statistically significant relationship between home healthcare leadership

practices and PCA employee turnover.

The null hypothesis H02 was there is no statistically significant relationship between

home healthcare leadership practices and PCA employee turnover. The researcher tested null

hypothesis H02 based on the sample of the defined population, and conducted Pearson

correlation coefficient (Pearson's *r*) to infer with a probability (p <.05 cut off) that findings in the

sample may also be found in the population at a 95% confidence level.

The Pearson correlation coefficient (Pearson's *r*) was conducted in IBM SPSS software

to examine the strength of association between the independent and dependent variable. The

correlational design to test H03 utilized the LPI-Self sores and PCA employee turnover rates for

the sample (N = 205).

Table 22 presents the Pearson correlation coefficient for null hypothesis H02.

Table 22

Pearson Correlation for Null Hypothesis H02

		LPI-Self	PCA Turnover
LPI-Self	Pearson Correlation	1	-0.123
	Sig. (2-tailed)		0.080
	N	205	205
PCA Turnover	Pearson Correlation	-0.123	1
	Sig. (2-tailed)	0.080	
	N	205	205

Pearson's *r* resulted in statistically very weak evidence r (205) = -.123, p < .05 against the null

hypothesis H02. Therefore, the researcher failed to reject the null hypothesis H02.

The results of normality testing of LPI-Self scores and PCA employee turnover rates,

using the histogram, skewness and kurtosis, Q-Q plot, and Kolmogorov-Smirnov, demonstrated

both data distributions to be non-normal. Since the assumptions of normality were violated, the

non-parametric Spearman's correlation coefficient (Spearman's *rho*) was utilized for testing the

null hypothesis H02, in addition to the Pearson correlation coefficient (Pearson's *r*).

Table 23 presents Spearman's correlation coefficient for null hypothesis H02.

Table 23

Spearman's Correlation for Null Hypothesis H02

			LPI-Self	PCA Turnover
Spearman's *rho*	LPI-Self	Correlation Coefficient	1.000	-0.106
		Sig. (2-tailed)		0.131
		N	205	205

PCA Turnover	Correlation Coefficient	-0.106	1.000
	Sig. (2-tailed)	0.131	
	N	205	205

Spearman's *rho* resulted in statistically very weak evidence r_s (205) = -.106, p < .05) against the null hypothesis H02. Therefore, the researcher failed to reject the null hypothesis H02 that there is no statistically significant relationship between home healthcare leadership practices and PCA employee turnover.

Research Question R3

R3. Is there a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction?

For the third research question R3, the independent variable was exemplary leadership practices, whereas the dependent variable was PCA services customer satisfaction. The researcher proposed research question R3 to determine if a relationship existed between the leadership practices scores collected via the LPI-Self instrument, and the archival index data pertaining to PCA services customer satisfaction.

H03: There is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

HA3: There is a statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

The null hypothesis H03 was there is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction. The researcher tested null hypothesis H03 based on the sample of the defined population, and conducted

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Pearson correlation coefficient (Pearson's *r*) to infer with a probability (p <.05 cut off) that

findings in the sample may also be found in the population at a 95% confidence level.

The Pearson correlation coefficient (Pearson's *r*) was conducted in IBM SPSS software

to examine the strength of association between the independent and dependent variable. The

correlational design to test H03 utilized the LPI-Self sores and PCA services customer

satisfaction scores for the sample (N = 205).

Table 24 presents the Pearson correlation coefficient for null hypothesis H03.

Table 24

Pearson Correlation for Null Hypothesis H03

		LPI-Self	Customer Sat.
LPI-Self	Pearson Correlation	1	0.055
	Sig. (2-tailed)		0.432
	N	205	205
Customer Sat.	Pearson Correlation	0.055	1
	Sig. (2-tailed)	0.432	
	N	205	205

Pearson's *r* resulted in statistically very weak evidence *r* (205) = 0.055, p < .05 against the null

hypothesis H03. Therefore, the researcher failed to reject the null hypothesis H03.

The results of normality testing of LPI-Self scores and PCA services customer

satisfaction scores, using the histogram, skewness and kurtosis, Q-Q plot, and Kolmogorov-

Smirnov, demonstrated both data distributions to be non-normal. Since the assumptions of

normality were violated, the non-parametric Spearman's correlation coefficient (Spearman's *rho*)

was utilized for testing the null hypothesis H03, in addition to the Pearson correlation coefficient

(Pearson's *r*).

Table 25 presents Spearman's correlation coefficient for null hypothesis H03.

Table 25

Spearman's Correlation for Null Hypothesis H03

			LPI-Self	Customer Sat.
Spearman's *rho*	LPI-Self	Correlation Coefficient	1.000	0.050
		Sig. (2-tailed)		0.476
		N	205	205
	Customer Sat.	Correlation Coefficient	0.050	1.000
		Sig. (2-tailed)	0.476	
		N	205	205

Spearman's *rho* resulted in statistically very weak evidence r_s (205) = .050, p < .05) against the null hypothesis H03. Therefore, the researcher failed to reject the null hypothesis H03 that there is no statistically significant relationship between home healthcare leadership practices and PCA services customer satisfaction.

Applications to Professional Practice

Results in this study did not indicate a correlation between the leadership practices of workers in the home healthcare industry who manage Personal Care Aide (PCA) employees, and leadership performance effectiveness (metrics) of PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction. The results also do not imply that relationships do not actually exist. Given the non-experimental design of the research, the researcher relied on observation, interpretation, and interactions to develop a conclusion (Gelo, Braakmann, & Benetka, 2008). Therefore, the research cannot confirm that one variable causes another variable to occur. Further, the correlation coefficient calculations do not infer any cause and effect relationship between the variables, nor was the researcher seeking to provide systematic

information about the leadership phenomenon, rather, explain the relationship between these specific variables.

Previous research of the relationship between leadership practices and job satisfaction, turnover, and customer satisfaction, have revealed that employees and customers in the healthcare industry face "immense challenges", which require a more "holistic view" of leadership effectiveness beyond the technical aspects of patient care (Gibson & Petrosko, 2014, p. 16). Responsible leadership practices require an understanding of leadership theory beyond the economist paradigm (e.g., transactional leadership), and the development of skills to manage drivers of employee motivation (Lawrence & Pirson, 2015). "Conscious application" of leadership practices can assist healthcare leaders in honing leadership skills, meeting the challenges set forth by an "everchanging" healthcare system, and answering the profession's "call for leaders with the power to influence" (Fleming-Castaldy & Patro, 2012, p. 200).

Leaders experience growth and development via opportunities to engage in and practice leadership behaviors (Burbank, Odom, & Sandlin, 2015). The LPI instrument has been shown to be an effective instrument for assessing the over-arching construct of transformational leadership, and culturally appropriate for measuring leadership practices in the healthcare industry (Chen & Baron , 2007; Carless, 2001). Further, The Five Practices of Exemplary Leadership® have been shown to be relevant and cogent in the healthcare industry, and representative of the values that are attractive in healthcare leadership (Bowles & Bowles, 2000).

Figure 10 displays the LPI group percentile ranking report of the sample in this study.
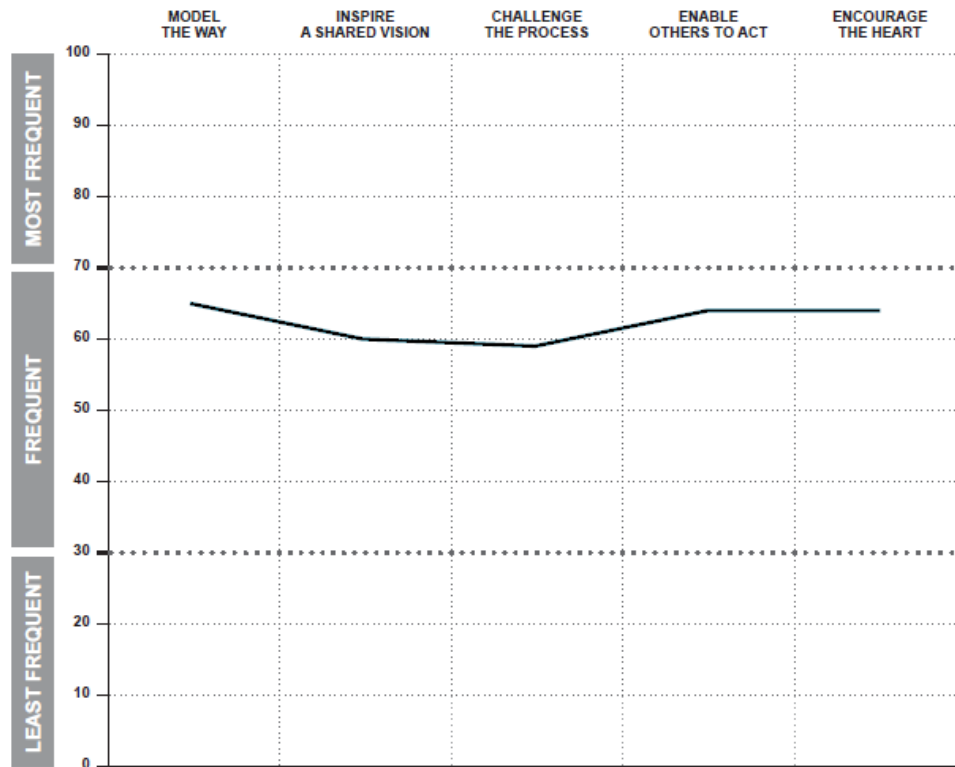
Figure 10. LPI group percentile ranking report

The researcher utilized the LPI Scoring software to generate the Group Percentile Ranking

report, which compared the sample (N = 205) average LPI-Self score, to over 1 million

responses for other leaders who have taken the LPI. The horizontal lines at the 30th and 70th

percentiles divide the graph into 3 segments, roughly approximating a normal distribution of

scores (Kouzes & Posner, 2016a). Each line on the graph shows what percentile the group's

average LPI-Self responses fall into for each practice. The results for the sample display group

scores on the high end of the frequent segment (i.e., near the 60th percentile), for each of the five

practices. Based on this ranking, it is logical to assume a higher than average level of leadership

engagement exists within the home healthcare industry, and therefore, a certain capacity for

enhancing PCA job satisfaction, PCA employee turnover, and PCA services customer

satisfaction, amid the expanding home healthcare industry.

Hiring and retaining quality PCA employees is essential to assuring quality of care for senior citizens (Parker-Bell, 2013). Home healthcare workers who exhibit higher levels of job satisfaction have been shown to engage in higher levels of organizational performance (Gibson & Petrosko, 2014). Workforce shortages in the nursing industry are placing greater demands on existing care workers, which is expected to increase work related stress and reduce the quality of workplace relationships, job satisfaction, and organizational performance (Lu, Barriball, Zhang, & White, 2012, p. 1033).

Supportive leadership focuses on developing leader-follower relationships by demonstrating sensitivity to individual needs and taking steps to make decision in the best interests of individual employees, with the goal of maximizing organizational achievements via the dyadic relationship. House (1971) argued that a supportive leadership style is more effective when work tasks are stressful. The apparent connection between supportive leadership approaches and higher satisfaction levels in literature, merits future examination of leadership models that test the mutlivariate influences on the relationship between leadership and organizational outcomes (Wong, Cummings, & Ducharme, 2013).

From a Biblical worldview perspective, businesses should seek to maximize the unique gifts of its employees and foster the potential to glorify God with their profession and calling. Maximizing the unique gifts of employees requires business leaders to provide meaningful and creative work, for which employees may utilize their God-given talents and gifts for the greater good of humanity (Van Duzer, 2010). Further, leaders of home healthcare businesses have a responsibility to reward PCA employees with fair earnings for the home healthcare services they render (Romans 4:4).

Home healthcare businesses serve as a two-edge sword, providing quality products for the "needs of the body" (James 2:16 EXB), and meaningful work for the laborers (Genesis 3:17-19). The Word of God is also descirbed as a sword, "penetrating into the dividing line of the breath of life and the spirit" (Hebrews 4:12 AMP). From this perspective, home healthcare leaders have an obligation to steward a Christian spirit (i.e., Christian leadership style) across the organizational environment and its hierarchies, and assist PCA employees in enduring the toil of work for the redemption of humanity. Leadership practices, which include biblical tools and behaviors, can help to more clearly discern the knowledge, skills, competencies, work habits, and motivations, of each employee.

Recommendations for Action

Dissemination of the research findings are restricted by the research agreement established between the researcher and the home healthcare company. In order for the researcher to stay in compliance with the research agreement, this research will not be published beyond Liberty University's Digital Commons (e.g., via ProQuest), without prior written consent from the researcher and the home healthcare company for such publication and use.

The lack of home healthcare leaders who understand and adopt leadership practices for enhancing PCA job satisfaction and retention, as well as customer satisfaction, amid the expanding senior citizen population, is an important consideration for the home healthcare industry. The research herein holds significance for the various stakeholders in the home healthcare industry (e.g., business leaders, customers, human resource administrators, policy makers). Hiring, training, and developing leadership that can address the significant challenges posed by market constraints and leverage internal resources, is essential to maintaining a sustainable home healthcare business.

The forthcoming constraints in the home healthcare industry will inevitably require more effective leadership practices for rendering adequate volumes of PCA's to the market, and promoting positive change in those who follow an established vision for high quality healthcare services. Understanding the factors that enhance the retention of home healthcare workers is critical to addressing the forthcoming demand for PCA workers in the healthcare industry (Butler, Brennan-Ing, Wardamasky, & Ashley, 2014). For home healthcare businesses to remain competitive amid industry growth and increased federal regulation, the costs associated with effective recruitment and retention of adequate volumes of low risk PCAs must be optimize.

Further, for businesses to remain profitable, any increases in the cost of providing home healthcare services are likely to be passed along to the consumer. Any lack of leadership effectiveness in this regard may result in higher prices for the care services rendered by each PCA, which may negatively impact customer satisfaction levels of the consumer. In contrast, home healthcare leaders who produce higher employee and customer satisfaction levels, may enjoy lower rates of employee turnover, which in turn serve to optimize the overall cost of deploying workers to the home healthcare market.

This research sought to demonstrate the importance of employing home healthcare leaders who practice leadership behaviors in a manner consistent with delivering high-value care services, via low-risk PCAs, in conjunction with the financial pressures of market expansion and increased competition. Customers seeking home healthcare services face strikingly different value propositions from market providers, based on leadership effectiveness over PCA employees. This value proposition is a composition of the leadership practices utilized in deploying PCAs into the home healthcare market, and the leader's effectiveness in generating high employee job satisfaction, low employee turnover, and high customer satisfaction levels, for

the home healthcare services it renders to customers. Lack of leadership engagement is common in home healthcare services, where solitary of work limits the possibility of control and mediates the quality (i.e., value) of services (Westerberg & Tafvelin, 2014).

This research also highlighted an opportunity for human resource administrators to develop more consistent practices pertaining to leadership development. At the very core of human resource development (HRD) is the intent for growing the value of human capital, by developing personal and organizational skills, knowledge, and abilities. Organizational values form the framework for which all other strategic decisions are made, including HRD (Garza & Morgeson, 2012). Strategic HRD efforts build upon organizational values by developing consistent practices, programs, and policies, which facilitate the achievement of the business purpose and objectives.

Further, The Five Practices of Exemplary Leadership® model (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable Others to Act, Encourage the Heart), focuses on developing leader-follower relationships by demonstrating leadership practices in the best interests of individual employees, with the goal of maximizing organizational achievements. HRD programs that incorporate the five practices and its subcategories enable leadership training to be conducted across more the more specific leadership categories pertaining to how leaders react towards subordinates.

This research also highlighted an opportunity for human resource administrators to explore instruments for measuring employee job satisfaction. Although a plethora of research literature exist supporting relationships between the research variables, no statistically significant relationships were found in this research. In this case, the researcher utilized archival data pertaining to employee job satisfaction, collected by the home healthcare company as part of its

ongoing quality assurance program, rather than administering a job satisfaction survey with proven reliability and validity. The research results may suggest that a more accurate job satisfaction survey instrument may exist, than the one used to generate the archival data.

Finally, this research highlighted an opportunity for policy makers to further evaluate worker protection acts pertaining to PCA employees, licensing requirements pertaining to home healthcare businesses, and customer protection measures for senior citizens receiving home healthcare services. For example, healthcare economics suggest a growing demand for PCA employees. Policy makers have already recognized the pressing need by passing the Personal and Home Care Aide State Training (PHCAST) Program to assist states in recruiting and training unemployed individuals as qualified PCAs in high demand areas, and the Companion Exemption Protection Act (CEPA) granting overtime protections for all PCA employees (Department of Labor, 2013).

Recommendations for Further Study

In lieu of time constraints and financial restrictions, the sample for this research was limited to a leading home healthcare company. Limiting the sample size could decrease the representativeness of the population under study and the ability to generalize the findings (Creswell, 2014). Although the company selected for this research was well established, large in size, and representative of a significant population of home healthcare workers and customers, understanding the leadership practices of the many other networks in this sector can further assess gaps in research literature of leadership theory, and address them.

Further research of exemplary leadership practices should be conducted in a broader set of specific contexts to further the study of leadership practices in the healthcare industry (Lingam & Lingam, 2015). Individual leadership practices may have less of an influence on the decision-

making culture of an organization due to prevailing factors (e.g., norms, values, policies)

stemming from the parent organization (Leech & Fulton, 2008). This research was limited to

leaders operating within a single network of the U. S. home healthcare sector of the healthcare

industry, which may be subject to such prevailing factors. As a result, the sampling method was

not truly randomized and may be subject to organizational bias. The examination of leadership

practices within the home healthcare industry should be expanded beyond the ones selected for

this research, and into broader segments of the market.

The LPI-Self instrument groups the 30 LPI-Self questions into The Five Practices of

Exemplary Leadership® (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process,

Enable Others to Act, Encourage the Heart). These five subcategories enable research to be

conducted across the more specific leadership categories pertaining to how leaders react towards

subordinates. The research questions for this study did not incorporate these five subcategories

individually as variables.

Table 26 presents descriptive statistics of the five sub-categories from the LPI-Self data

collected in this research.

Table 26

Descriptive Statistics of The Five Practices of Exemplary Leadership

		Model	Inspire	Challenge	Enable	Encourage	LPI-Self
N	Valid	205	205	205	205	205	205
	Missing	0	0	0	0	0	0
Mean		50.80	47.91	47.96	53.59	50.14	250.40
Std. Deviation		5.855	7.687	6.740	3.968	6.852	25.861

Further research into the leadership practices of home healthcare leaders should examine the statistical significance of the relationship for the five practices individually, with performance outcomes, in an effort to improve business practice.

Next, the demographic information in this research highlighted several avenues to further evaluate exemplary leadership practices in the home healthcare industry. Leader participants in this study consisted of primarily Caucasian (93%), age 40 to 59 (70%), with a bachelor or graduate degree (82%), and at least 6 years of experience (77%) with the home healthcare company. Several new research questions are possible simply based on demographic information.

For example, do leaders of PCA employees in the home healthcare industry, who hold a bachelors degree (46%), display exemplary leadership practices at lower rates than those with a graduate degree (36%). Further, individuals over the age of 40 have been shown to score significantly higher on Model the Way, Challenge the Process, Enable Others to Act, and Encourage the Heart leadership practices, compared to individuals under the age of 40 (Hillman Jr., 2008). Also, length of job service has been found to be positively correlated with the Inspire a Shared Vision leadership practice (Kelley, 2008).

A more purposeful sampling method could target specific groups within the home healthcare industry, and close addition gaps in leadership theory literature. For example, female leaders have been shown to have stronger self-concepts pertaining to the leadership practices of Encourage the Heart and Inspiring a Shared Vision, which have been shown to exhibit the highest effect of the five practices on positive leadership outcomes (Garrett-Staib & Burkman, 2015).

Finally, the LPI instrument also includes a LPI-Observer instrument which enables the opportunity for 360 degree feedback by comparing a leader's self-observed leadership practices with perceptions of those who directly observe the leader's practices. In lieu of time constraints and financial restrictions, the instrument for this study was limited to the LPI-Self instrument. Utilizing the LPI-Self instrument in conjunction with the LPI-Observer instrument would likely provide more meaningful results for the researcher, research participants, and professional application.

<div align="center">**Reflections**</div>

Exemplary leadership practices can indeed be taught (Smith, 2011). Although the results of this study did not indicate a correlation between leadership practices and leadership effectiveness, the study did provide a baseline from which to delve into potential solutions to the research problem. By simply examining the relationships between leadership practices and organizational outcomes, the researcher presented the opportunity for 205 individual home healthcare leaders to adopt practices shown in previous studies to enhance PCA job satisfaction and turnover, as well as customer satisfaction.

For example, the LPI instrument purchased by the researcher included LPI scoring software that enabled the researcher to generate and provide an Individual Feedback Report (Appendix E) for each research participant in the sample (N = 205). The Individual Feedback Report summarizes each participant's rating for the 30 LPI-Self questions and responses within each of the five leadership practices, including graphs, rankings, and recommended readings (Kouzes & Posner, 2016a). Each research participant in the sample (N = 205) received an email containing their Individual Feedback Report, along with a brief explanation of the LPI tool and a link to the instrument owner's supporting website. Therefore, the researcher influenced

participants beyond the survey questions, and into a greater awareness for exemplary leadership practices and the potential to dive deeper into the leadership challenge. Accepting the leadership challenge requires "practice, reflection, humility, and commitment to making a difference" (Kouzes & Posner, 2012, p. 6).

Through the use of the quantitative approach, researcher bias, values, and subjective preferences were less likely to be noted, ensuring that the results were fairly constructed (Matveev, 2002). A potential source of bias in this study stems from using an instrument with Likert-type values, which may be subject to extreme response style (ERS) and/or acquiescence response style (ARS) by respondents. ERS is the tendency of respondents to choose the extreme endpoints of a rating scale, while ARS is the tendency of respondents to agree (rather than disagree) with the content of what is being rated (Kieruj & Moors, 2013). For example, most of the participants in this study (68%) had rating that averaged 8.0 to 9.9 (out of 10), and may have provided more positive responses to each of the LPI-Self questions because they were unable or unwilling to allocate the time and effort to effectively weigh each question.

Biblical Integration

According to the Genesis account, work is the designed avenue for humans to express their creativity and unique talents (Genesis 2:15). Business is a two-edge sword, that provides quality products for the "needs of the body" (James 2:16 EXB), and meaningful work for the laborers (Genesis 3:17-19). Home healthcare leaders should seek to maximize the unique gifts of PCA employees, and foster their potential to glorify God with their profession and calling. Maximizing the unique gifts of PCA employees requires home healthcare leaders to provide meaningful and creative work, for which PCA employees may utilize their God-given talents and gifts for the greater good of humanity (Van Duzer, 2010).

Leadership practices in home healthcare are an influence based on interpersonal relationships and personal characteristics, which serves to attract and motivate followers toward organizational goals and improve healthcare services (Bowles & Bowles, 2000). Leadership practices are contingent upon the sociological manner in which behaviors are developed within the context of working together with others (Posner, Crawford, & Denniston-Stewart, 2015). A proactive and serving style of leadership in performing management duties has been shown to be a precursor to exhibiting exemplary leadership practices (Bento, 2013). The principles of servant leadership emphasize the importance of providing quality care services, and assists healthcare leaders in supporting the performance of PCA workers, enabling their best efforts, and having a vision that brings all efforts together for a common purpose. This desire to serve tends to be relevant in all caring professions, where leadership effectiveness is dependent upon the congruency of worker actions with their values and beliefs (Willcocks, 2012).

Biblically, the life of Jesus Christ is depicted as the ultimate example of servant leadership. It is the inherent ability to understand and share the feelings of others that enables a servant leader to "do unto others" (Mathew 7:12 AMP) and "seek the welfare of his neighbor" (1 Corinthians 10:24). True servant-leadership begins with the "natural feeling that one wants to serve, to serve first" (Greenleaf, 1977, p. 7). Servant leadership influences leadership practices by fostering a balance between the spectrums of desired organizational outcomes, and the fulfillment of personal needs. Further, servant leadership demonstrates an "altruistic mind-state" motivated by an empathetic desire to benefit another person (Beck, 2014).

Within the servant leader construct are four core principles essential for moral authority: sacrifice, commitment to a worthy cause, belief that ends and means are inseparable, and relationships (Greenleaf, 1977). Each aligns well with The Five Practices of Exemplary

Leadership® (i.e., Model the Way, Inspire a Shared Vision, Challenge the Process, Enable

Others to Act, Encourage the Heart), and the values held as important by stakeholders in the

home healthcare industry. Leaders who model the way for others regarding how goals should be

pursued, foster positive results in follower behaviors and self-discipline (Gomez, 2013). Leaders

who model the example exhibited by the life of Jesus Christ exhibit practices that produce love,

joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control (Galatians

5:22-25).

Leaders who follow the example of Jesus Christ also passionately promote an ideal image

of the organization and its destination, as to inspire a shared vision and invigorate followers to

contribute in a meaningful way. Inspiring a shared vision requires building a vision for the

future that offers meaningful opportunities that motivate others to contribute and rally around

shared ideals and values (Vito, Higgins, & Denny, 2014). The ability to involve others as

meaningful contributors requires the practice of stewardship which elevates service over self-

interest, treats employees as valued partners, and redistributes power, privilege, and wealth in

accordance with ability and performance (Block, 1993).

Further, leaders who follow the example of Jesus Christ also challenge the process as to

continually improvement upon the status quo. By taking calculated risks and enabling the

organization to learn under an umbrella of mercy and grace, leaders create an innovative culture

and the aptitude for exercising outsight. According to the Apostle Paul, it is the continual and

transformative process of testing change which fosters the knowledge of what is good, pleasing,

and perfect to God (Romans 12:2).

Leadership effectiveness comes as a result of enabling others to optimize their personal

and organizational potential. Leaders enable others to act via intentional employee engagement

that involves the entire workforce the organizational mission, which produces increased levels of collaboration and trust throughout (Hage & Posner, 2015). Grand visions become realities via the discretionary efforts exhibited by many, rather than the righteous work of a few. Further, by fostering a collective bearing of burdens across stakeholders, the law of Christian love is fulfilled (Galatians 6:2).

Finally, the practice of encouraging the heart appears to hold the strongest relationship with worker perceptions of leadership support (Patrick, Laschinger, Wong, & Finegan, 2011). Exemplary leaders find ways to creatively celebrate shared values and victories, as to build a strong sense of community and belonging. Christians in business are called to enable the community to flourish, as to serve the common good (Van Duzer, 2010). Biblically, the greatest encouragement a leader can offer is the hope in Jesus Christ for those who belive in His promises (Romans 15:4).

Caring is at the heart of leadership and serves to unlock commitment and potential in others (Kouzes & Posner, 2012). Williams, McDowell, and Kautz (2011) proposed a caring leadership model for the healthcare industry, which builds upon Kouzes and Posner's (1987) Theory of Exemplary Leadership (specifically, The Five Practices of Exemplary Leadership® model). The researchers suggested that caring leaders embrace five core values: always lead with kindness, compassion, and equality; generate hope and faith through co-creation; actively innovate with insight, reflection, and wisdom; purposely create protected space founded upon mutual respect and caring; embody an environment of caring, helping, and trusting for self and others.

The caring style of leadership emphasizes the practice of Encouraging the Heart, whereby a leader is authentically present within the moment experienced by the follower.   Effective

leadership in this regard is conducted via transpersonal relationships built upon a foundation of credibility, established via the integration of trust. Accordingly, such leadership is essential creating a care-centered culture that can provide the highest quality home healthcare amid an evolving healthcare system.

Summary and Study Conclusions

Leadership continues to be one of the most popular topics studied within the context of business. Home healthcare businesses are vehicles for providing leadership opportunities to management, and meaningful employment opportunities for PCA employees to utilize their God-given talents and gifts for the greater good of humanity. A number of factors may influence the degree to which a home healthcare leader produces effective leadership performance. This study focused on the relationship between the leader's self observed leadership practices and business performance outcomes pertaining to PCA job satisfaction, PCA employee turnover, and PCA services customer satisfaction.

Research specific to leadership practices in the clinical setting of the healthcare industry (e.g., hospitals, institutions), and its related impact on satisfaction/turnover and quality of care for nursing roles (e.g., RN, CNA), is prevalent. Research specific to the leadership practices of home healthcare workers, their leadership over PCA employees, and the impact on organizational productivity measures, is scarce. To my knowledge, this is the only study that relates exemplary leadership practices specifically to those of U. S. home healthcare workers who lead PCA employees. The current study built upon previous research pertaining to leadership practices in healthcare, by focusing on the home healthcare sector. This research added to the existing body of literature documenting potential relationships between leadership

practices and job satisfaction, employee turnover, and customer satisfaction, in a specific network of the home healthcare sector.

Utilizing the LPI-Self instrument to measure leadership practices provided a direct link for the study, back to transformational leadership theory. Kouzes and Posner's (2012) Five Practices of Exemplary Leadership® model describes exemplary leaders as modeling the way by finding their voice and setting the example, inspiring a shared vision by envisioning the future and enlisting others in a common vision, challenging the process by searching for opportunities, taking risks, and learning from mistakes, enabling others to act by fostering collaboration and strengthening others, and encouraging the heart by recognizing contributions and celebrating values and victories. Effective leaders are able to adapt these leadership practices to unique contextual factors, and learn leadership skills through practice with "mastering the context" in order to achieve goals through hard work, determination, and perseverance (Muna, 2011, p. 877). "Context matters a great deal when it is given an importance equal to leadership" (Osborn & Marion, 2009, p. 205).

In summary, the phenomenon of leadership exists within the context of the leader-follower dyad, where leadership practices take place. The leadership practices displayed by leaders "of" organizations are very likely to resonate "in" the organization (Oreg & Berson (2011, p. 650). A supportive leadership style, as emphasized by The Five Practices of Exemplary Leadership® model, focuses on developing leader-follower relationships by demonstrating leadership practices in the best interests of individual employees, with the goal of maximizing organizational achievements. The principles of servant leadership emphasize the importance of supporting the performance of PCA employees, enabling their best efforts, and

having a vision that brings all efforts together for a common purpose. Biblically, the life of Jesus

Christ is depicted as the ultimate example of servant leadership.

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Appendix A: IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

8/9/2016

William Travis Hodge
IRB Exemption 2579.080916: The Quantitative Examination of the Relationship between Leadership Practices and Leadership Effectiveness in Personal Care Aide Satisfaction and Turnover and Customer Satisfaction in the Home Healthcare Industry

Dear William Travis Hodge,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

> (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
> (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
The Graduate School

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Appendix B: Informed Consent

**THE QUANTITATIVE EXAMINATION OF THE RELATIONSHIP BETWEEN LEADERSHIP PRACTICES
AND LEADERSHIP EFFECTIVENESS IN PERSONAL CARE AIDE SATISFACTION AND TURNOVER AND
CUSTOMER SATISFACTION IN THE HOME HEALTHCARE INDUSTRY**
Informed Consent

My name is William T. Hodge, and I am a doctoral student in the School of Business at Liberty University. I am conducting a research study titled "The Quantiative Examination of the Relationship between Leadership Practices and Leadership Effectiveness in Personal Care Aide Satisfaction and Turnover and Customer Satisfaction in the Home Healthcare Industry".

This research is being supervised by Dr. Eric Richardson. I would like to invite you to participate in this research study. The main purpose of this form is to provide information about the research so that you can make an informed decision about whether you wish to participate. If you choose to participate, please click "yes", type your name, and enter the date, at the end of this form. If you choose not to participate please click "no".

WHAT IS THE RESEARCH ABOUT?

The purpose of this study was to examine Kouzes and Posner's (1987) Theory of Exemplary Leadership (specifically, The Five Practices of Exemplary Leadership® model) among franchise owners in a leading in-home, non-medical, senior-care franchise network, wherein the franchisor promotes a faith-based (i.e., God-centered) and for-profit (i.e., profit-centered) approach and their related franchise performance metrics (i.e., employee satisfaction, employee turnover, and customer satisfaction).

WHAT DOES PARTICIPATION IN THIS RESEARCH STUDY INVOLVE?

If you agree to participate in this study, you will be asked to complete the following confidential electronic survey. Your participation should take about 15-20 minutes. The survey will be delivered via SurveyMonkey.com.

WHY ARE YOU BEING ASKED TO PARTICIPATE?

You have been invited to participate in this research because you were identified as a franchise owner of a professional, in-home, non-medical, senior-care agency.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY?

Although no study is completely risk-free, we don't anticipate that you will be harmed or distressed by participating in this research. If you find yourself becoming uncomfortable, you may stop your participation at any time.

ARE THERE ANY BENEFITS TO PARTICIPATION?

All research contributes to the existing body of knowledge, and some research directly benefits participants. By participating in this study, you are directly contributing to the existing body of leadership research.

HOW WILL THE RESEARCHER PROTECT PARTICIPANTS' CONFIDENTIALITY?

The results of this research study will be published as group results only. Your individual name or identity will not be revealed by the researcher or reported. The researcher will download and save all data electronically to a flash drive that will be stored indefinitely in a fire-resistant safe currently located at the residence of the researcher. Access to stored data is restricted only to the principal researcher. Participants are responsible for securing their own computers while participating in the survey.

WHAT HAPPENS IF A PARTICIPANT DOESN'T WANT TO CONTINUE IN THE STUDY?

Participation in this study is voluntary. If you choose not to participate, or if you choose to withdraw from the study, you may do so at any time prior to completing the survey. Your decision whether or not to participate will not affect your current or future relations with Liberty University.

WILL IT COST ANYTHING TO PARTICIPATE IN THE STUDY? WILL I GET PAID TO PARTICIPATE?

There is no cost or compensation involved in participating in this study.

*Note: This document is dual sided, copied front and back. Please view next side
➡

CONTACT INFORMATION

The researcher will be happy to answer any questions you have about the research. If you have any questions, please feel free to contact William T. Hodge by phone at 336-408-6070, or by email at wthodge@liberty.edu. In addition, you may contact Dr. Eric L. Richardson at 434-592-6946, or by email at elrichardson@liberty.edu.

If you have questions about your rights as a research participant, the Institutional Review Board is available to help. If you have any concerns about the research process or the researcher, please contact the Institutional Review Board, 1971 University Blvd, Green Hall Suite 1887, Lynchburg, VA 24515 or email at irb@liberty.edu. If there are any unexpected problems with the research, please also be sure to contact us. Your identity, questions, and concerns will be kept confidential.

_____

Signature   Date

Appendix C: LPI Permission Letter

WILEY

May 31, 2016

William Hodge
5750 Novack Street
Winston Salem, NC 27105

Dear Mr. Hodge:

Thank you for your request to use the LPI®: Leadership Practices Inventory® in your dissertation. This letter grants you permission to use either the print or electronic LPI [Self/Observer/Self and Observer] instrument[s] i your research. You may *reproduce* the instrument in printed form at no charge beyond the discounted one-time cost of purchasing a single copy; however, you may not distribute any photocopies except for specific research purposes. If you prefer to use the electronic distribution of the LPI you will need to separately contact Eli Beck (ebecker@wiley.com) directly for further details regarding product access and payment. Please be sure to revie the product information resources before reaching out with pricing questions.

Permission to use either the written or electronic versions is contingent upon the following:

(1) The LPI may be used only for research purposes and may not be sold or used in conjunction with a compensated activities;
(2) Copyright in the LPI, and all derivative works based on the LPI, is retained by James M. Kouzes ar Barry Z. Posner. The following copyright statement must be included on all reproduced copies of the instrument(s); "Copyright © 2013 James M. Kouzes and Barry Z. Posner. Published by John Wiley & Sons, Inc. All rights reserved. Used with permission";
(3) One (1) **electronic** copy of your dissertation and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data must be sent **promptly** to my attention at the address below; and,
(4) We have the right to include the results of your research in publication, promotion, distribution and sale of the LPI and all related products.

Permission is limited to the rights granted in this letter and does not include the right to grant others permission reproduce the instrument(s) except for versions made by nonprofit organizations for visually or physically handicapped persons. No additions or changes may be made without our prior written consent. You understand that your use of the LPI shall in no way place the LPI in the public domain or in any way compromise our copyright in the LPI. This license is nontransferable. We reserve the right to revoke this permission at any time, effective upon written notice to you, in the event we conclude, in our reasonable judgment, that your use of the LPI is compromising our proprietary rights in the LPI.

Best wishes for every success with your research project.

Cordially,

Ellen Peterson
Permissions Editor
Epeterson4@gmail.com

Appendix D: LPI-Self Questionnaire

Your name: _____

To what extent do you engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

1. I set a personal example of what I expect of others.

2. I talk about future trends that will influence how our work gets done.

3. I seek out challenging opportunities that test my own skills and abilities.

4. I develop cooperative relationships among the people I work with.

5. I praise people for a job well done.

6. I spend time and energy making certain that the people I work with adhere to the principles and standards we have agreed on.

7. I describe a compelling image of what our future could be like.

8. I challenge people to try out new and innovative ways to do their work.

9. I actively listen to diverse points of view.

10. I make it a point to let people know about my confidence in their abilities.

11. I follow through on the promises and commitments that I make.

12. I appeal to others to share an exciting dream of the future.

13. I search outside the formal boundaries of my organization for innovative ways to improve what we do.

14. I treat others with dignity and respect.

15. I make sure that people are creatively rewarded for their contributions to the success of our projects.

16. I ask for feedback on how my actions affect other people's performance.

17. I show others how their long-term interests can be realized by enlisting in a common vision.

18. I ask "What can we learn?" when things don't go as expected.

19. I support the decisions that people make on their own.

20. I publicly recognize people who exemplify commitment to shared values.

21. I build consensus around a common set of values for running our organization.

22. I paint the "big picture" of what we aspire to accomplish.

23. I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.

24. I give people a great deal of freedom and choice in deciding how to do their work.

25. I find ways to celebrate accomplishments.

26. I am clear about my philosophy of leadership.

27. I speak with genuine conviction about the higher meaning and purpose of our work.

28. I experiment and take risks, even when there is a chance of failure.

29. I ensure that people grow in their jobs by learning new skills and developing themselves.

30. I give the members of the team lots of appreciation and support for their contributions.

LPI: LEADERSHIP PRACTICES INVENTORY SELF

Appendix E: LPI Self Report – Sample Report

Leadership Practices Inventory

JAMES M. KOUZES & BARRY Z. POSNER

Self Report

Prepared for Amanda Lopez | August 12, 2013

Company ABC

CONTENTS

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

The Five Practices of Exemplary Leadership®

Created by James M. Kouzes and Barry Z. Posner in the early 1980s and first identified in their internationally best-selling book, *The Leadership Challenge*, The Five Practices of Exemplary Leadership approaches leadership as a measurable, learnable, and teachable set of behaviors. After conducting hundreds of interviews, reviewing thousands of case studies, and analyzing more than two million survey questionnaires to understand those times when leaders performed at their personal best, there emerged five practices common to making extraordinary things happen. The Five Practices are:

1 MODEL THE WAY

2 INSPIRE A SHARED VISION

3 CHALLENGE THE PROCESS

4 ENABLE OTHERS TO ACT

5 ENCOURAGE THE HEART

The Leadership Practices Inventory (LPI) instrument is an essential tool to help you gain perspective into how you see yourself as a leader and what actions you can take to improve your use of the Five Practices, which research has demonstrated, year after year, make for more effective leaders.

ABOUT YOUR LPI REPORT

The LPI measures the frequency of 30 specific leadership behaviors on a 10-point scale, with six behavioral statements for each of The Five Practices. You rated how frequently you engage in each of these important behaviors associated with The Five Practices. The response scale is:

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

In the following report pages, you'll see your responses presented in various manners.

LPI | SELF
LEADERSHIP PRACTICES INVENTORY
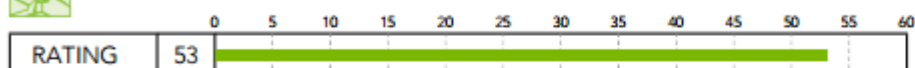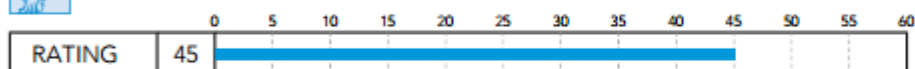
The Five Practices Bar Graphs

These bar graphs, one for each leadership Practice, provide a graphic representation of your total rating. Total responses can range from 6 to 60, which represents adding up the response score (from 1—Almost Never to 10—Almost Always) for each of the six behavioral statements related to the Practice.

Model the Way

		0	5	10	15	20	25	30	35	40	45	50	55	60
RATING	53													

Inspire a Shared Vision

		0	5	10	15	20	25	30	35	40	45	50	55	60
RATING	45													

Challenge the Process

		0	5	10	15	20	25	30	35	40	45	50	55	60
RATING	54													

Enable Others to Act

		0	5	10	15	20	25	30	35	40	45	50	55	60
RATING	53													

Encourage the Heart

		0	5	10	15	20	25	30	35	40	45	50	55	60
RATING	39													

LPI | SELF
LEADERSHIP PRACTICES INVENTORY
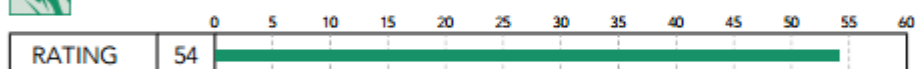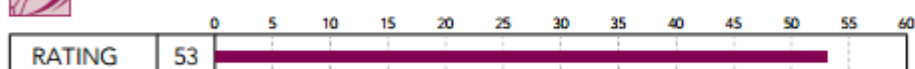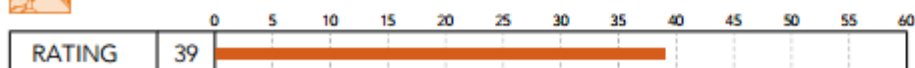
Leadership Behaviors Ranking

This page shows the ranking, from most frequent to least frequent, of all 30 leadership behaviors based on your self-rating. Horizontal lines separate the 10 most and the 10 least frequent behaviors from the middle 10. The response scale runs from 1—Almost Never to 10—Almost Always.

MOST FREQUENT

#		LEADERSHIP PRACTICE	RATING
1.	I set a personal example of what I expect of others	Model	10
2.	I talk about future trends that will influence how our work gets done	Inspire	10
3.	I seek out challenging opportunities that test my own skills and abilities	Challenge	10
11.	I follow through on the promises and commitments that I make	Model	10
14.	I treat others with dignity and respect	Enable	10
23.	I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on	Challenge	10
24.	I give people a great deal of freedom and choice in deciding how to do their work	Enable	10
6.	I spend time and energy making certain that the people I work with adhere to the principles and standards that we have agreed on	Model	9
8.	I challenge people to try out new and innovative ways to do their work	Challenge	9
9.	I actively listen to diverse points of view	Enable	9
10.	I make it a point to let people know about my confidence in their abilities	Encourage	9
12.	I appeal to others to share an exciting dream of the future	Inspire	9
21.	I build consensus around a common set of values for running our organization	Model	9
28.	I experiment and take risks, even when there is a chance of failure	Challenge	9
4.	I develop cooperative relationships among the people I work with	Enable	8
13.	I search outside the formal boundaries of my organization for innovative ways to improve what we do	Challenge	8
18.	I ask "What can we learn?" when things do not go as expected	Challenge	8
19.	I support the decisions that people make on their own	Enable	8
26.	I am clear about my philosophy of leadership	Model	8
29.	I ensure that people grow in their jobs by learning new skills and developing themselves	Enable	8
30.	I give the members of the team lots of appreciation and support for their contributions	Encourage	8
7.	I describe a compelling image of what our future could be like	Inspire	7
16.	I ask for feedback on how my actions affect other people's performance	Model	7
17.	I show others how their long-term interests can be realized by enlisting in a common vision	Inspire	7
5.	I praise people for a job well done	Encourage	6
22.	I paint the "big picture" of what we aspire to accomplish	Inspire	6
25.	I find ways to celebrate accomplishments	Encourage	6
27.	I speak with genuine conviction about the higher meaning and purpose of our work	Inspire	6
15.	I make sure that people are creatively rewarded for their contributions to the success of our projects	Encourage	5
20.	I publicly recognize people who exemplify commitment to shared values	Encourage	5

LEAST FREQUENT

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

SELF REPORT   **PAGE 3**

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Model the Way Bar Graphs

■ Clarify values by finding your voice and affirming shared values
■ Set the example by aligning actions with shared values

The set of bar graphs for each of the six leadership behaviors related to this Practice provides a graphic representation of your responses for that behavior. Responses can range from 1–Almost Never to 10–Almost Always.

1. Sets a personal example of what he/she expects of others	RATING	10
6. Spends time and energy making certain that the people he/she works with adhere to the principles and standards that we have agreed on	RATING	9
11. Follows through on promises and commitments he/she makes	RATING	10
16. Asks for feedback on how his/her actions affect other people's performance	RATING	7
21. Builds consensus around a common set of values for running our organization	RATING	9
26. Is clear about his/her philosophy of leadership	RATING	8

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

LPI | SELF
LEADERSHIP PRACTICES INVENTORY
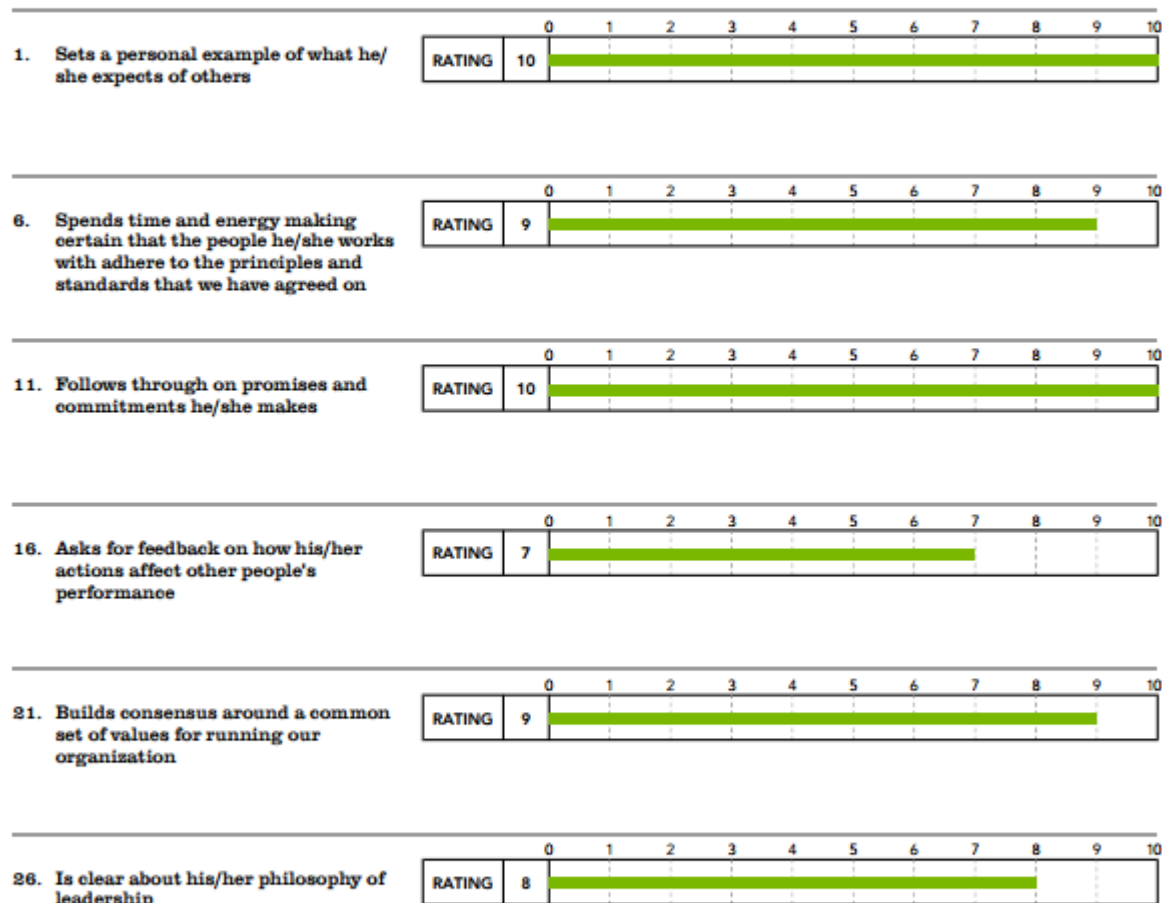
Reflections:

What is your immediate reaction to viewing your Model the Way ratings? Why?

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Please describe anything in your Model the Way ratings that is confusing or contradictory:

(Remember to review your Leadership Behaviors Ranking page to consider the individual behaviors that relate to this practice.)

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Suggestions for Becoming a Better Leader

1. At the end of every day, ask yourself, "What have I done today that demonstrated one of my key values? What have i done today that might have sent the signal that I wasn't committed to the key value? What can i do tomorrow to live out a key value?

2. Answer the question, "What are the values that should guide my decisions and actions?"

3. Do something dramatic to demonstrate your commitment to a team value. For instance, if customer service is a value, spend a day answering the phones in the call center, working behind the counter at a store, or visiting customers at their locations.
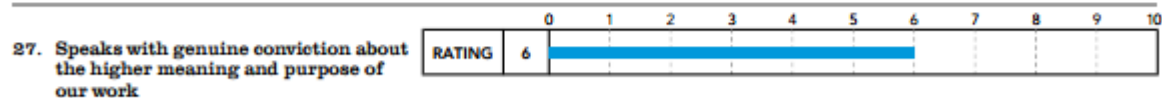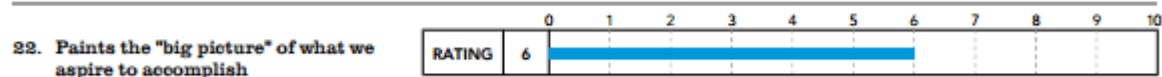
LPI | **SELF**
LEADERSHIP PRACTICES INVENTORY

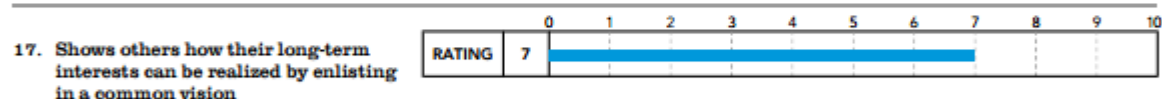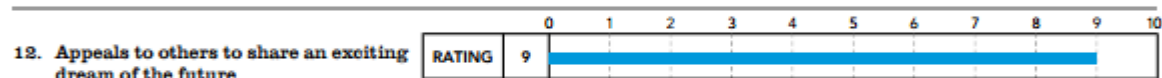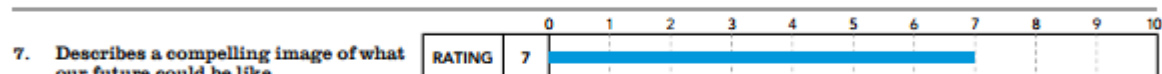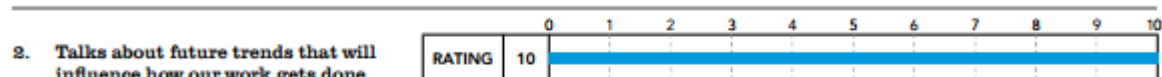## Inspire a Shared Vision Bar Graphs

- Envision the future by imagining exciting and ennobling possibilities
- Enlist others in a common vision by appealing to shared aspirations

The set of bar graphs for each of the six leadership behaviors related to this Practice provides a graphic representation of your responses for that behavior. Responses can range from 1–Almost Never to 10–Almost Always.

#	Behavior	Rating
2.	Talks about future trends that will influence how our work gets done	10
7.	Describes a compelling image of what our future could be like	7
12.	Appeals to others to share an exciting dream of the future	9
17.	Shows others how their long-term interests can be realized by enlisting in a common vision	7
22.	Paints the "big picture" of what we aspire to accomplish	6
27.	Speaks with genuine conviction about the higher meaning and purpose of our work	6

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

SELF REPORT

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Reflections:

What is your immediate reaction to viewing your Inspire a Shared Vision ratings? Why?

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Please describe anything in your Inspire a Shared Vision ratings that is confusing or contradictory:

(Remember to review your Leadership Behaviors Ranking page to consider the individual behaviors that relate to this practice.)

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Suggestions for Becoming a Better Leader

1. Become a Futurist. Join the World Futures Society. Read American Demographics or other magazines about future trends. Use the Internet to find a "futures" conference that you can attend. Make a list of what reputable people are predicting will happen in the next ten years.

2. Every week interview one of your constituents—a direct report, peer, manager, or customer—and ask, "What are your aspirations for the future?"

3. Be positive, upbeat and energetic when talking about the future of your team and organization.
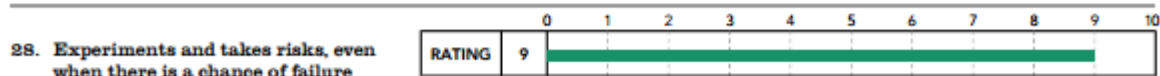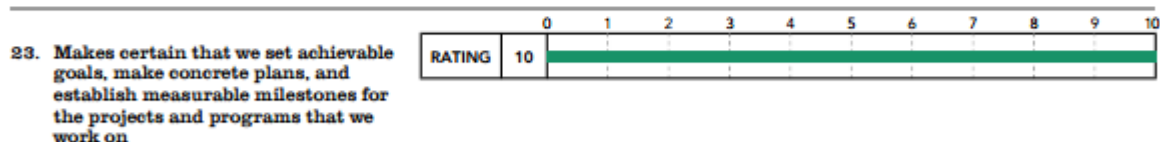
LPI | SELF
LEADERSHIP PRACTICES INVENTORY

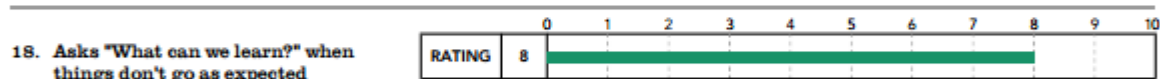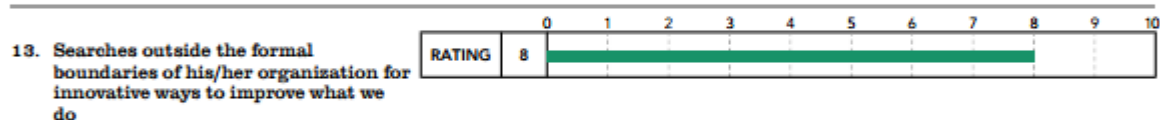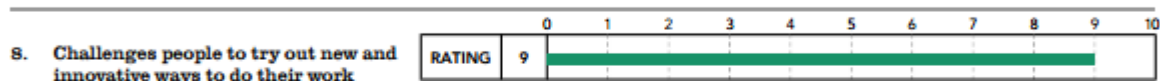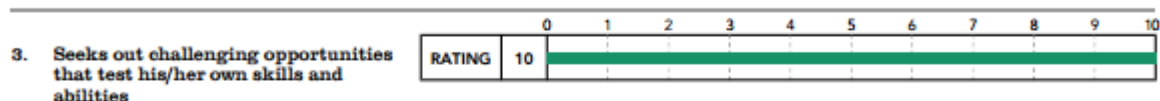## Challenge the Process Bar Graphs

- Search for opportunities by seizing the initiative and by looking outward for innovative ways to improve
- Experiment and take risks by constantly generating small wins and learning from experience

The set of bar graphs for each of the six leadership behaviors related to this Practice provides a graphic representation of your responses for that behavior. Responses can range from 1–Almost Never to 10–Almost Always.

		0	1	2	3	4	5	6	7	8	9	10
3. Seeks out challenging opportunities that test his/her own skills and abilities	RATING 10											

		0	1	2	3	4	5	6	7	8	9	10
8. Challenges people to try out new and innovative ways to do their work	RATING 9											

		0	1	2	3	4	5	6	7	8	9	10
13. Searches outside the formal boundaries of his/her organization for innovative ways to improve what we do	RATING 8											

		0	1	2	3	4	5	6	7	8	9	10
18. Asks "What can we learn?" when things don't go as expected	RATING 8											

		0	1	2	3	4	5	6	7	8	9	10
23. Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on	RATING 10											

		0	1	2	3	4	5	6	7	8	9	10
28. Experiments and takes risks, even when there is a chance of failure	RATING 9											

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Reflections:

What is your immediate reaction to viewing your Challenge the Process ratings? Why?

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Please describe anything in your Challenge the Process ratings that is confusing or contradictory:

(Remember to review your Leadership Behaviors Ranking page to consider the individual behaviors that relate to this practice.)

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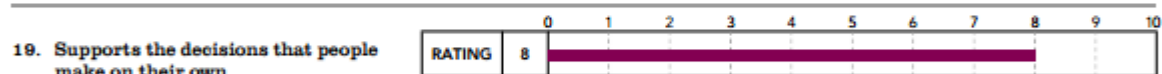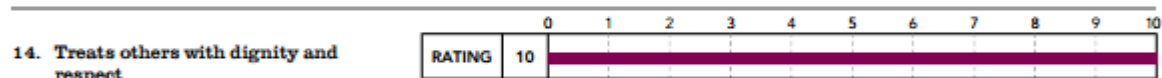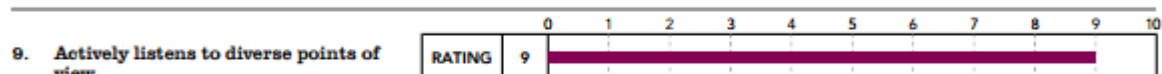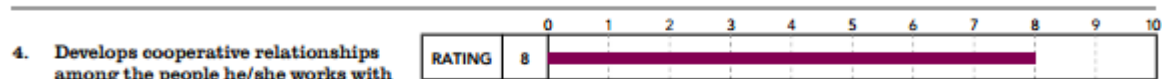## Suggestions for Becoming a Better Leader

1. At least once a month, set aside time to think about what challenging opportunities-new experiences, job assignments, tasks- you could seek to test your skills and abilities. Look for opportunities for tough assignments.

2. At least once a month, identify something you can do to challenge the way things are done—the status quo—at work. For example, think about what product or process innovations would help your organization improve. Then take the initiative to make change happen.

3. Once a week at a regular meeting, ask each team member to answer this question: "What have you done in the last week to improve so that you are better this week than you were a week ago?"

Profile for Amanda Lopez
Company ABC
August 12, 2013

Enable Others to Act Bar Graphs

- Foster collaboration by building trust and facilitating relationships
- Strengthen others by increasing self-determination and developing competence

The set of bar graphs for each of the six leadership behaviors related to this Practice provides a graphic representation of your responses for that behavior. Responses can range from 1–Almost Never to 10–Almost Always.

#	Behavior	Rating
4.	Develops cooperative relationships among the people he/she works with	RATING 8
9.	Actively listens to diverse points of view	RATING 9
14.	Treats others with dignity and respect	RATING 10
19.	Supports the decisions that people make on their own	RATING 8
24.	Gives people a great deal of freedom and choice in deciding how to do their work	RATING 10
29.	Ensures that people grow in their jobs by learning new skills and developing themselves	RATING 8

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Reflections:

What is your immediate reaction to viewing your Enable Others to Act ratings? Why?

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Please describe anything in your Enable Others to Act ratings that is confusing or contradictory:

(Remember to review your Leadership Behaviors Ranking page to consider the individual behaviors that relate to this practice.)

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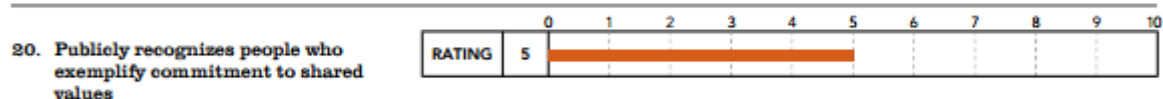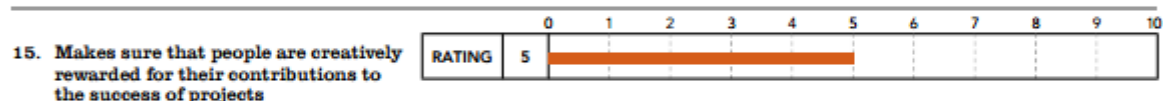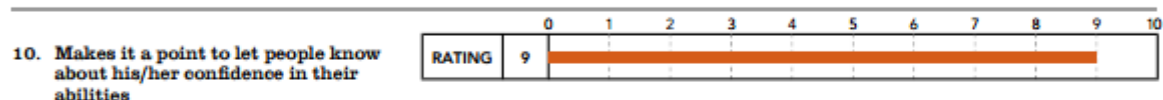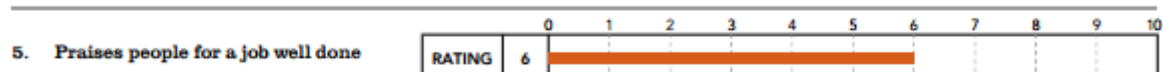## Suggestions for Becoming a Better Leader

1. Think about the ways in which projects are planned and decisions made in your organization. Then come up with several actions you can take to involve others in the planning and decision-making process.

2. Before every interaction, regardless of length, ask yourself this question: "What can I do in this interaction to make this person (or persons) feel more capable and powerful?"

3. Talk one-on-one with your team members to find out what kind of support and coaching they would like from you and what training opportunities they need. Find ways to connect people to the resources they need—other people, materials, funding, training, information, and so on.

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Encourage the Heart Bar Graphs

- Recognize contributions by showing appreciation for individual excellence
- Celebrate the values and victories by creating a spirit of community

The set of bar graphs for each of the six leadership behaviors related to this Practice provides a graphic representation of your responses for that behavior. Responses can range from 1–Almost Never to 10–Almost Always.

5. **Praises people for a job well done**
   RATING **6**

10. **Makes it a point to let people know about his/her confidence in their abilities**
    RATING **9**

15. **Makes sure that people are creatively rewarded for their contributions to the success of projects**
    RATING **5**

20. **Publicly recognizes people who exemplify commitment to shared values**
    RATING **5**

25. **Finds ways to celebrate accomplishments**
    RATING **6**

30. **Gives the members of the team lots of appreciation and support for their contributions**
    RATING **8**

RESPONSE SCALE	1-Almost Never	3-Seldom	5-Occasionally	7-Fairly Often	9-Very Frequently
	2-Rarely	4-Once in a While	6-Sometimes	8-Usually	10-Almost always

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LEADERSHIP PRACTICES INVENTORY
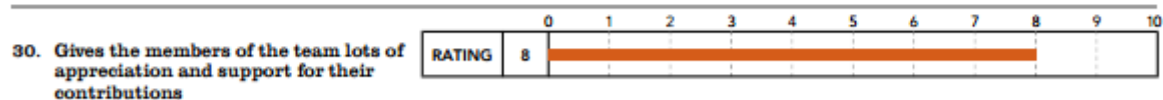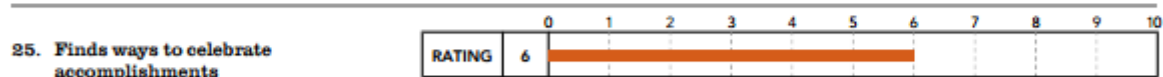
Reflections:

What is your immediate reaction to viewing your Encourage the Heart ratings? Why?

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Please describe anything in your Encourage the Heart ratings that is confusing or contradictory:

(Remember to review your Leadership Behaviors Ranking page to consider the individual behaviors that relate to this practice.)

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Suggestions for Becoming a Better Leader

1. Think of ten small ways in which you can reward people who have done something especially well. Then reward those extraordinary efforts. Don't let them go by unnoticed.

2. Identify those constituents who best embody your values and priorities and think of three ways to single them out in the weeks to come, to praise and reward them.

3. Tell a public story about a person in your organization who went above and beyond the call of duty.

LPI | SELF
LEADERSHIP PRACTICES INVENTORY

Percentile Ranking

The leaders and observers who make up the LPI database include a mix of males and females at all levels, from all types of organizations, and from all over the world. This page compares your responses to more than one million Observer responses for other leaders who have taken the LPI. The horizontal lines at the 30th and 70th percentiles divide the graph into three segments, roughly approximating a normal distribution of scores. Each line on the graph shows what percentile your response falls into for each Practice. For example, if your score for Model the Way is at the 50th percentile, half of the leaders in the entire LPI database were rated higher (by their Observers who also rated them on the Practice), and half were rated lower.

LPI | SELF
LEADERSHIP PRACTICES INVENTORY
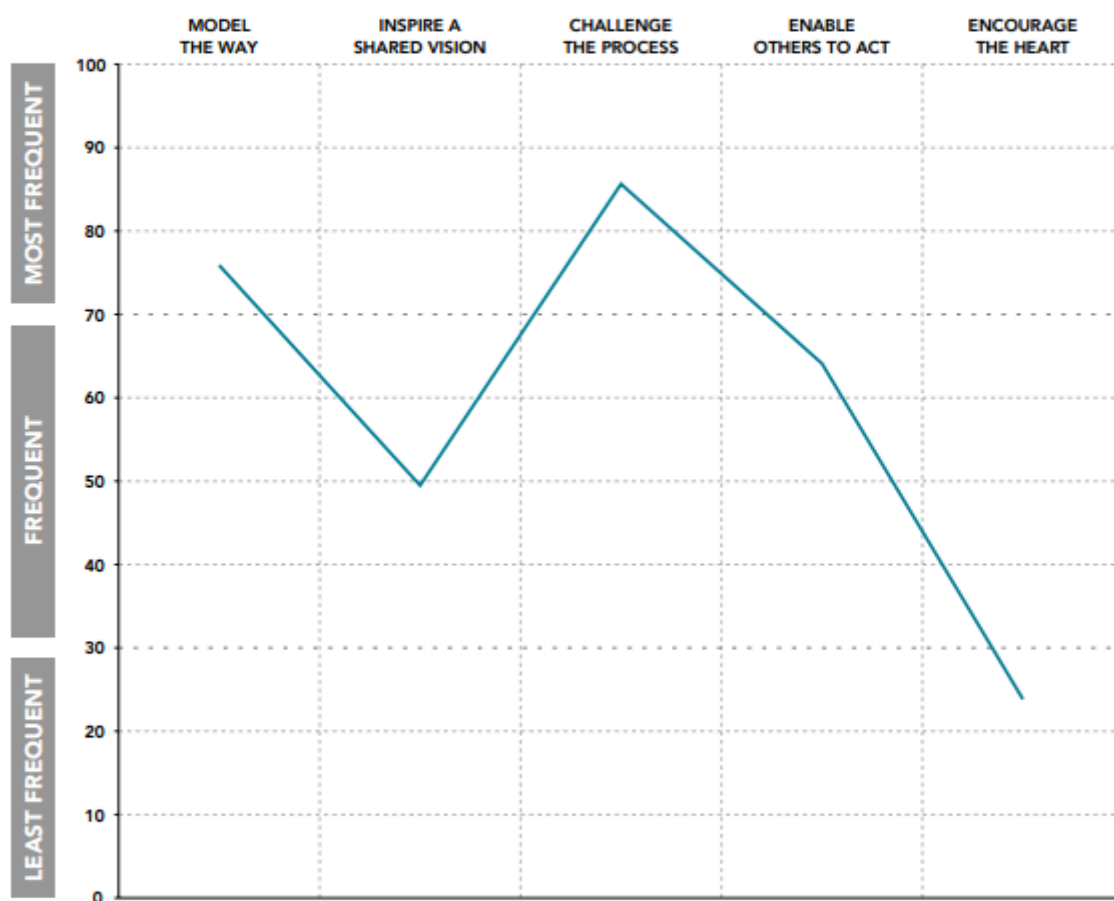
Suggested Reading

GENERAL LEADERSHIP

Kouzes, J. M., and Posner, B. Z. *A Leader's Legacy.* San Francisco: Jossey-Bass, 2006.

Kouzes, J. M., and Posner, B. Z. *The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations.* 5th Edition. San Francisco: Jossey-Bass, 2012.

Kouzes, J. M., and Posner, B. Z. *The Truth About Leadership: The No-Fads, Heart-of-the-Matter Facts You Need to Know.* San Francisco: Jossey-Bass, 2010.

MODEL THE WAY

Conant, D., and Norgaard, M. *TouchPoints: Creating Powerful Leadership Connections in the Smallest of Moment.* San Francisco:Jossey-Bass, 2011

Kouzes, J. M., and B. Z. Posner. *Credibility: How Leaders Gain and Lose It, Why People Demand It.* (2nd ed.). San Francisco: Jossey-Bass, 2011.

Kraemer, H. M. J., Jr. *From Values to Action: The Four Principles of Values-Based Leadership.* San Francisco: Jossey-Bass, 2011.

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Schein, E. *Organizational Culture and Leadership.* (4th ed.). San Francisco: Jossey-Bass, 2010.

INSPIRE A SHARED VISION

Geary, J. *I Is an Other: The Secret Life of Metaphor and How It Shapes the Way We See the World.* New York: Harper, 2011.

Schuster, J. P. *The Power of Your Past: The Art of Recalling, Recasting, and Reclaiming.* San Francisco: Berrett-Koehler, 2011.

Sinek, S. *Start with Why: How Great Leaders Inspire Everyone to Take Action.* New York: Portfolio, 2010.

Spence, R. M. *It's Not What You Sell, It's What You Stand For: Why Every Extraordinary Business Is Driven by Purpose.* New York: Portfolio, 2010.

Sullenberger, C. B. *Making a Difference: Stories of Vision and Courage from America's Leaders.* New York: William Morrow, 2012.

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Johnson, S. *Where Good Ideas Come From: The Natural History of Innovation.* New York: Riverhead, 2010.

Seligman, M.E.P. *Flourish: A Visionary New Understanding of Happiness and Well-Being.* New York: The Free Press, 2011.

Sims, P. *Little Bets: How Breakthrough Ideas Emerge from Small Discoveries.* New York: The Free Press, 2011.

ENABLE OTHERS TO ACT

Brooks, D. *The Social Animal: Hidden Sources of Love, Character, and Achievement.* New York: Random House, 2011.

Burchell, M., and Robin, J. *The Great Workplace: How to Build It, How to Keep It, and Why It Matters.* San Francisco: Jossey-Bass, 2011.

Hurley, R. F. *The Decision to Trust: How Leaders Create High-Trust Organizations.* San Francisco: Jossey-Bass, 2012.

Merchant, N. *The New How: Creating Business Solutions Through Collaborative Strategy.* San Francisco: O'Reilly Media, 2010.

Shockley-Zalabak, P. S., Morreale, S. and Hackman, M. *Building the High-Trust Organization: Strategies for Supporting Five Key Dimensions of Trust.* San Francisco: Jossey-Bass, 2010.

Wiseman, L. *Multipliers: How the Best Leaders Make Everyone Smarter.* New York: HarperCollins, 2010.

ENCOURAGE THE HEART

Achor, S. *The Happiness Advantage: The Seven Principles of Positive Psychology That Fuel Success and Performance at Work.* New York: Crown Books, 2010.

Gostick, A., and Elton, C. *All In: How the Best Managers Create a Culture of Belief and Drive Big Results.* New York: The Free Press, 2012.

Kouzes, J. M., and Posner, B. Z. *Encouraging the Heart: A Leader's Guide to Rewarding and Recognizing Others.* San Francisco: Jossey-Bass, 2003.

Rath, T., and Harter, J. *Well-Being: The Five Essential Elements.* New York: Gallup Press, 2010.

Seligman, M. E. *Flourish: A Visionary New Understanding of Happiness and Well-Being.* New York: The Free Press, 2011.