HEALTHCARE FACILITIES MANAGEMENT LEADERSHIP STYLE COMPARED TO TRADITIONAL HEALTHCARE BUSINESS AND CLINICAL LEADERS

by

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Abstract

The healthcare environment presents constant challenges related to the provision of safe and quality care to patients. Interactions between traditional business and clinical healthcare leaders and healthcare facilities management leaders are increasing to meet the environment of care needs for healthcare organizations. This study examined the leadership style differences between two healthcare leadership groups, represented by the American College of Healthcare Executive members as well as members of the American Society of Healthcare Engineers and provides insight into the leadership trait differences between these groups. Transformational leadership traits and self-perception of outcomes for leadership showed higher within the ACHE group, while transactional and passive-avoidant leadership showed no statistical difference.

Key words: leadership, healthcare, facilities management, executive

Dedication

I dedicate this dissertation to God for providing me with the knowledge, provision, and stamina to complete this doctoral program, and to my wife Charlene for the strength and encouragement she provided to keep this dream alive.

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Section 1: Foundation of the Study

Healthcare leadership delivers patient care with high reliability and patient-centered results. The traditional healthcare executive oversees the clinical operations of the healthcare entity, business operations and sustainability, and a direct impact on the patient. Healthcare facilities management supports a patient care environment prepared to offer the care needed for the patient. Both areas of healthcare leadership perform vital functions affecting patient care. Therefore, leadership style differences are essential components to understand.

Background of the Problem

Healthcare facilities management executives ensure the physical environment for the hospital. Regulatory agencies having authority such as the State Department of Health, The Joint Commission, and the National Fire Protection Agency oversee hospital operations to guarantee compliance. The state of the environment allows the facility to care for patients with high reliability and ensures patients receive the care needed with limited potential for risk. Lucas, Bulbul, Thabet, and Anumba (2013) stated that managing the facilities of the healthcare environment is a primary driving force for the adequate provision of patient care with high-quality results. O'Neill and Scarborough (2013) defined the criticality placed on many of the functions performed by facilities management, which increases the need for high-quality facility management practices conforming to increased levels of regulatory oversight.

Healthcare facilities management supports proper patient care experiences within the healthcare organization through the provision of an environment conducive to healing. The facilities management function of healthcare operations works side-by-side with the full executive healthcare team to ensure results meet healthcare objectives and conform to regulatory

guidelines. Regulatory guidelines require facility management executives to operate with the proper leadership styles needed to get optimal results.

Problem Statement

As healthcare regulations increase, the demands on facilities management teams to require assurance of quality and reliability for the healthcare organization increase as well. Proper performance of the facility systems related to the healthcare environment ensures proper patient outcomes. The general problem addressed was the leadership styles within healthcare facilities management executives, which result in weak interactions with other healthcare executives. Facilities management is an essential requirement in healthcare because of the increased level of criticality placed on the equipment, and building features the facilities management team oversees (O'Neill & Scarborough, 2013). Healthcare facilities management improves the healthcare organization's outcomes for the proper delivery of healthcare projects (Lavy & Fernández-Solis, 2010). Facilities management leaders must develop the hospital position through effective leadership practices. The specific problem addressed was the discrepancy between traditional business and clinical healthcare leadership styles and the leadership styles of healthcare facilities management leaders.

Purpose Statement

The purpose of this study was to determine the similarity or differences between the leadership styles of healthcare facilities management leaders and traditional business and clinical healthcare leaders. Understanding the leadership styles in the two study groups examines if specific leadership styles dominate either group. If dominant leadership styles are present, leadership development will improve the communication path between the two groups of executive leaders. Understanding the predominant leadership styles allows for improved

development opportunities enabling healthcare facilities management executives to increase the ability to lead healthcare organizations and improve the patient care outcome within the facility.

Nature of the Study

The nature of the study was a quantitative study completed using surveys submitted to two groups of healthcare executives, traditional business and clinical leaders, and facilities management leaders. This study expanded on the previous study conducted by Wheatley (2010), who looked at the difference in leadership styles between up-and-coming healthcare executives and traditional healthcare executives. Using a qualitative study method does not fit for this study because of a review of two specific leadership styles and study groups in a prescribed survey format. The study structure eliminates the narrative design since the study addresses the nature of different leadership styles. The survey results obtained from the survey group dictate the use of a quantitative approach to analyzing the study outcome. Case study design would review a specific instance at a particular location. This study looked at practices for the industry of healthcare facilities management leadership, and therefore, did not look at one specific case. The phenomenological design looks at a particular phenomenon rather than the difference between two styles of leadership and therefore is not appropriate.

The quantitative design fit the parameters of the problem and the purpose of the study performed. The basis for this study was a previous study conducted by Wheatley (2010), who used the casual-comparative qualitative model investigating the different leadership styles between healthcare executive types. One alternative qualitative format would be the descriptive qualitative study model. Lambert and Lambert (2012) stated that the descriptive quantitative model is viable using a multitude of dataset possibilities to conduct meaningful research. Lambert and Lambert also said the descriptive method uses data sets available in research to

provide the outcome. Since this study looked at the relationship between leadership groups, and the descriptive model looks more at specific data, the descriptive model was not ideal for this research study. Another alternative was the correlational quantitative research model. Creswell (2014) described correlational research to study the correlation of data sets as they relate to one study group, not multiple study groups. Since this study reviewed two sets of study groups, the correlational model did not fit for this study.

Discussion of method. The method used in this study was the quantitative casual-comparison study model. According to Creswell (2014), casual-comparison study models use a system of comparison between two distinct study groups with specific variables that have already occurred. This study had a defined focus on two study groups, traditional business and clinical healthcare leaders and healthcare facilities management leaders. The variable being leadership style differences between the two healthcare leadership groups. Since the use of a comparison method for the review of two specific survey groups for this study, the casual-comparison quantitative research model was the best fit and it resembled the methods used in the study conducted by Wheately (2010).

Discussion of design. The study composed a survey format sent to two healthcare executive groups from national membership groups. The American College of Healthcare Executives (ACHE) and The American Society for Healthcare Engineers (ASHE) were the two groups of members sent surveys. ACHE members comprise executives in traditional business and clinical healthcare leadership roles. ASHE members include healthcare facilities management professionals who hold leadership roles. Both groups allowed for an accurate study base of sufficient quantities for this study. The MLQ survey format licensed and submitted through the use of Mind Gardens transform survey-hosting tool was the tool used for this study.

Summary of the nature of the study. The nature of this study included two diverse study groups with a shared variable, providing proper patient care with high reliability. The difference relates to the area of control. The traditional leadership group manages the clinical and financial aspects of the patient care format, while the facilities management area manages the environment supporting patient care delivery. The quantitative casual-comparison format provides the correct means to review the leadership differences between traditional and facilities management healthcare executives.

Research Questions

This study used the research questions created by Wheatley (2010), who studied the difference in leadership styles between up-and-coming healthcare executives versus traditional healthcare executives. The Wheatley study research questions and hypotheses included in this study determined the differences between healthcare facilities management executives and traditional healthcare executives. Traditional healthcare executives are healthcare leaders with multiple years of healthcare management experience in clinical areas unrelated to support areas of healthcare, such as facilities management and environmental services. The research questions used by Wheatley (2010) include:

Q1: To what extent does leadership style vary by leadership type regarding transformational leadership style?

Q2: To what extent does leadership style vary by leadership type regarding transactional leadership style?

Q3: To what extent does leadership style vary by leadership type regarding passive-avoidant leadership style?

Q4: To what extent does executive type vary regarding self-perceptions of the outcomes of leadership?

These research questions support the proper identification of research focus addressing the problem and the purpose of the study.

Hypotheses

As with the research questions, the hypotheses used for this study came from Wheatley (2010). The difference occurs with the focus groups used for this study. The hypotheses provided by Wheatley include:

For RQ1, RQ2, RQ3 and, RQ4, the study consists of the following four null and alternative hypotheses:

H10: There is no difference between leadership types regarding the transformational leadership style.

H7a: There was a difference between leadership types regarding the transformational leadership style.

H20: There is no difference between leadership types regarding the transactional leadership style.

H2a. There was a difference between leadership types regarding the transactional leadership style.

H30: There is no difference between leadership types regarding passive-avoidant leadership style.

H3a: There is a difference between leadership types regarding passive-avoidant leadership style.

H40: There is no difference between leadership types regarding the self-perceptions of the outcomes of leadership.

H4a There is a difference between leadership types regarding self-perceptions of the outcomes of leadership style.

As with the research questions, these hypotheses are proper identification of the focus of a study between two groups of healthcare executives and the leadership styles exhibited.

Theoretical Framework

Following the original study design completed by Wheatley, the Multi-factor Leadership Questionnaire (MLQ) created by Bass and Avolio (1995) was the basis for the theoretical framework for this study. The MLQ comprises a 45-question formatted survey used to determine the dominant leadership trait of the individual for one of three leadership types. Those three leadership types include transformational leadership, transactional leadership, and passive-avoidant leadership (Bass & Avolio).

A well-documented leadership research tool compatible with the casual-comparative quantitative study format is the MLQ Survey. Leadership research includes a multitude of industries using the MLQ format. For this study, the healthcare industry was the target industry analyzed. MLQ surveys to study healthcare leadership traits in recent studies in the areas of transformational leadership theory, transactional leadership theory, and passive-avoidant leadership are available in current academic literature.

Discussion of transformational leadership theory. Bernard Bass is the founder of the theory of transformational leadership that describes a leader who transforms teams to produce the results needed by the organization (Barbinta, Dan, & Muresan, 2017). Bass described leaders possessing transformational leadership traits like those that can guide the change through the

development of the team (Barbinta et al., 2017). Bass is also one creator of the MLQ, which the foundation for this study derives. One of the primary measurements conducted through this study was the prevalence of healthcare leadership and healthcare facilities management leadership and the relationship to transformational leadership traits.

Ciurea, Avram, and Mohan (2017) described how multiple leaders around the globe described the best leader they had encountered and found the leader described to be one who could transform the team based on the actions shown. The view of these leaders correlates with the perspective of Bass on transformational leadership and the results created and the viewpoint of the people served by a transformational leader.

Discussion of transactional leadership theory. Hargis, Watt, and Piotrowski (2011) discussed the attributes of transactional leadership arising from the theory of exchange-based leadership styles from the latter parts of the twentieth century. The authors expressed that in the correct usage, transactional leadership would provide a solid base to provide positive leadership results (Hargis et al., 2011). Ciurea et al. (2017) also discussed transactional leadership theory and how transactional leaders focus on the interactions with subordinates. Those interactions create influence on the group and become a mechanism for creating expectations and establishing agreed-upon acceptable levels of work (Ciurea et al., 2017). In contrast to transformational leadership, transactional leadership seeks to define the expectation of the leader towards the subordinate. Transactional leadership is an examination of the transactions and interactions conducted and identify the level of performance achieved.

Al-Touby (2012) found healthcare leadership to focus on the transactional model and focused on the operations of healthcare versus the patient outcomes and experience within the healthcare organization. Within healthcare, daily operations, cost-control, staffing matrix, and

productivity all impact the bottom line of the company. Operational conditions force leaders to view the interactions and transactions with front-line staff based on the value of the efforts of the employee towards the department goals related to these areas.

Discussion of passive avoidant leadership. Stare, Pezdir, and Boštjančič (2013) described the traits of a passive-avoidant leader as one who corrects behavior after issues arise rather than leading and as someone who refuses to take a leadership role and avoids the duty. Stare et al. also described how leaders exhibit traits from a multitude of leadership styles, while the passive-avoidant is the least desirable of all leadership traits. Many employees, in the career cycle, experience a passive-avoidant leader. It is the opposite of the micro-managing boss. This leader refuses to lead and partake in leadership responsibilities. With passive-avoidant leaders, decisions are absent, the instruction does not occur, and the team does not understand the direction of travel. The absence of decision-making leads to frustration within the group. Providing development opportunities for leaders with strong passive-avoidant traits will produce improved outcomes for the organization.

Discussion of relationships between theories and variables. Stare et al. (2013) made a strong statement concerning the relationship of the leadership theories presented in this study stating how one leader may exhibit multiple leadership styles at various times based on the environment at the time and the situation at hand. The focus of this study and the MLQ tool was to identify the strongest trait the leader taking the assessment exhibits at the time of taking the MLQ survey. By testing the strongest trait presented by the leaders, a fair assessment of the state of both leader groups occurs with documentation of potential conflicts.

Summary of the conceptual framework. Leadership is a broad term encompassing a multitude of styles and theories. These theories, when exhibited, define the traits of the leader.

Leaders may choose not to lead at all and create a system of confusion for the team waiting for leadership to occur. Leaders can test every social interaction and define success through the outcomes of those interactions. The leader can transform the team as interactions take place and create a new direction for the team in-line with the goals of the organization.

Definition of Terms

The following definitions of key terms used throughout this research ensure consistent definitions throughout this study.

Leadership: A defining factor of success for an organization because of the influence on team performance, motivation, and retention (Stare et al., 2013). It provides a primary means of success for health centers when executed (Smith, 2015). Leadership is essential to all business organizations. This study looked at three distinct leadership styles listed below.

Passive-avoidant leadership: A leadership style characterized by avoiding the traditional requirements of leaders such as taking responsibility and lack of communication with subordinates (Stare et al., 2013). Leaders who do not fulfill the defined role in leadership (Saravo, Netzel, & Kiesewetter, 2017).

Transactional leadership: a leadership style based on an exchange-based relationship with a focus on the social interactions required to get the outcome desired by the leader (Hargis et al., 2011). Functional results-oriented leadership style suited for healthcare organizations (Al-Touby, 2012). This study reviewed the prevalence of transactional leadership compared to transformational and passive-avoidant leadership.

Transformational leadership: A leadership style characterized as one resulting in the transformation of a team through the relationship built by the leader guiding the team (Barbinta et al., 2017). A leadership style that creates a focus to move employees in the direction that best

suits the organization (Al-Abrrow, 2014). Transformational leadership is a predominant focus of study for leadership research. This study looked at the dominant traits among traditional healthcare executives and healthcare facilities management executives.

Assumptions, Limitations, Delimitations

This study used the research presented by Wheatley (2010) with a changed survey sample. The study Wheatley conducted used the study sample of healthcare executives and up-and-coming executives. The study presented in this research looked at executive leadership styles in healthcare compared to healthcare facilities management for consistency and differences. For this study, the user base was like incorporating a new service line for the healthcare field rather than up-and-coming executives. Facilities management is a support service function within the healthcare setting with increased regulatory responsibility. Therefore, healthcare facilities management was a valid group to include in this study and was similar to the recommendations for further research provided by Wheatley. Because of the similarity in study design, most of the assumptions, limitations, and delimitations emulated the research conducted by Wheatley.

Assumptions. The research conducted by Wheatley included the assumption that situational leadership challenges among the participants of the study were similar because of comparable goals and objectives of the job duties of the survey study group. Since the study group remained similar for this study, the assumption of situational leadership challenges remained in place. Wheatley's assumption is fair since most healthcare operations function with related regulatory requirements and national goals to incorporate into daily situational leadership.

The study assumed healthcare facilities management participants and traditional healthcare executives would participate in the survey to gain the data required. The assumption is

fair as the basis of the study was on gathering this information from the study group. Considering the study groups derived from two national healthcare-based member groups aimed at creating an improved healthcare environment. Another assumption presented by Wheatley was that participants would be able to interpret the questions presented in the survey and make accurate rankings for the questions presented. The MLQ is a time-tested instrument used to improve knowledge surrounding leadership styles and has been in place for many years. The questions included were at a level of understanding of healthcare-related executive study groups.

Limitations. Wheatley identified multiple limitations applicable to this study. The first limitation Wheatley identified was the theoretical framework selected, based on the MLQ defines the leadership styles included in the study. This study creates a limitation since it excludes the subordinates of the leaders surveyed in the study format. The MLQ platform has a tool to survey subordinates of leaders; however, since the survey only includes leaders, the additional MLQ survey served no purpose for this study. The additional MLQ subordinate survey incorporates organizational research where the subordinates are accessible for 360-degree review processes.

Another limitation identified by Wheatley (2010) was leadership theory itself. There is a multitude of identification methods for leadership styles. Because of the long-term and wide range of use for the MLQ survey, this method determined to be the most practical for this study. Another limitation of this survey defined by Wheatley is the study used a web-based survey application through Mind Garden. This survey was difficult to predict who would respond to the survey. Sending the survey to a study sample engaged in healthcare from both the executive-level and the facilities management sector of healthcare avoided the limitation.

Emulating the study group sampling size of the Wheatley study produced a sample size lower than required for a confidence level of 95 percent and a confidence interval of five percent. Due to the small sample size, the results of this study cannot be generalized across the overall population for members of ACHE and ASHE.

Delimitations. There are two delimitations for this study identified by Wheatley (2010). The first delimitation is the web-based format of the survey and the participation rate for aging populations. Rating the age of the participants has merit in the sector of healthcare executive leadership. Having an extensive career in their respective field provides increased experience levels and could broaden study results. The delimitation of web-based survey participation of older populations diminishes, considering many of the healthcare applications used now for healthcare are in electronic format. The delimiter in 2018/2019 for a web-based survey is the concern for malware, and virus-containing solicitations, firewalls, and other means of capturing potential threats in the healthcare environment could cause decreased participation rates.

Wheatley (2010) also showed the study is a simple snapshot in time; the results obtained would not account for organizational advancements and changes in leadership development. For this study, a snapshot in time was acceptable since the information gathered looked at the current state of both healthcare executives and healthcare facilities management executives. The study was not longitudinal, looking at a long-term change in conditions; the study sought to find the current environment for leadership traits in the respective survey groups.

Significance of the Study

The research for this study creates new evidence into the field of healthcare leadership for the facilities management sector of healthcare. The healthcare facilities management field fulfills an increasing level of impact on the overall environment of care for the patient and, as a result,

must function well with executive healthcare leaders within the organization. The research conducted fills a gap in the academic research needed to understand the leadership relationship between these two distinct sectors of executive healthcare leadership.

Reduction of gaps. Because of the increasing importance of the physical facility and the direct relationship between patient care and the regulated environment, healthcare facilities executives are assuming control of patient care areas, which demand proper leadership and understanding between traditional healthcare executives. This study investigated the similarities and differences between the traditional healthcare executive and healthcare facilities management executives who will guide healthcare organizations to bridge the gap between the two leadership groups.

Implications for Biblical integration. Peter wrote in the book of 1 Peter, a message of leadership to a group of both Jews and Gentiles. In Chapter Five, Peter addressed the leadership of the groups to work with one another and learn from one another. As leaders, it is imperative to understand the leadership traits of those in other areas of the organization. The leadership styles may be different; therefore, it is prudent to understand those differences and work to minimize the negative impact and embrace the positive effects. This study worked to identify the leadership traits in two groups of high performing leadership areas vital to producing positive healthcare results for patients in healthcare centers across the globe. It is possible to improve the patient care position through the information obtained in this study and learning from each study group.

Relationship to the leadership cognate. The leadership cognate of the Liberty University Doctor of Business Administration challenges students with the opportunity to explore how leadership affects business with a foundation of the word of God. Defining the

differences between the two leadership groups within the same organization type provides new insight into the healthcare leadership field. Understanding the differences existing between healthcare executives and healthcare facilities management executives improves the ability to change the future state of leadership for these groups. This study incorporated the teachings of the leadership cognate to determine new knowledge about healthcare leadership.

Summary of the significance of the study. Patient care requires multiple forms of executive leadership from the bedside, financial, and facility perspectives. Understanding the difference between the traditional healthcare executive leadership style compared to healthcare facilities management executives will create an opportunity to improve the overall care received by the patient in the healthcare setting. Patients require healthcare organizations to perform with the best potential for quality results. Without all levels of the healthcare organization working together regardless of the leadership style used, the patient is at risk, which is unacceptable.

A Review of the Professional and Academic Literature

Leadership styles in the healthcare setting are the focus of this study. Conducting a review of the academic literature is essential to understand how leadership styles impact traditional healthcare leadership and healthcare facilities management. It is also relative to see how the basis of this study, the MLQ survey format, used in healthcare leadership style research in completed studies. This review shows the significance of leadership styles impact on healthcare and the relevance of the MLQ survey format to accomplish this research. The research for this literature review will also review the leadership development impacts on healthcare organizations.

The basis for the study. Wheatley (2010) studied the difference between up-and-coming healthcare executives and traditional healthcare executives. Wheatley's research is the

foundation for this study. This study examined the difference between healthcare facilities management executives and traditional healthcare executives. Wheatley identified other service lines inside of healthcare, enjoying additional research such as nursing management. This study incorporated a supporting service line by introducing healthcare facilities management. Healthcare facilities management supports functions of the hospital infrastructure and ensures the facility of the healthcare organizations meets the needs of the service lines offered to the customer. Without proper facility management, regulatory oversight, documentation, and construction development, the needs of the organization could do not result in positive impacts on the patient.

To complete this study, a review of academic literature occurred to identify a research method tested for the analysis of leadership styles that exist in the healthcare setting. Bass (1995) provided the theoretical framework for the study based on the Multifactor Leadership Questionnaire (MLQ). The MLQ questionnaire provided the survey format for this study and provided the system needed for the theoretical framework of the survey questions submitted to participants. Licensing for the MLQ survey for duplication and the survey sent using Mind Garden. The MLQ survey format is a reliable survey format used in multiple studies for healthcare-related research in leadership study. Bass was a pioneering subject expert in leadership studies. Barbinta et al. (2017) published a biographical reference to the work of Barnard Bass in the areas of transformational and transactional leadership theories, which are two of the primary theories tested in the MLQ survey. The biography referenced the importance of transformational leadership theory in the academic understanding of leadership study and showed that transformational theory was far superior to the prevalent transactional theory

(Barbinta et al.). These examples further prove the relevance of the MLQ survey and the documented value of Bass' work related to leadership theory.

There are several documented studies showing the relevance of the MLQ survey format in leadership research. Jelača, Bjekić, and Leković (2016) created a proposal for a research framework based on the MLQ format for future leadership research applications. The MLQ was a reliable tool with a solid foundation for leadership study and could incorporate other criteria to determine if the dominant leadership trait was sufficient for the organization, or if leadership development would benefit the organization (Jelača et al., 2016). The study confirms the validity of the use of the MLQ format in leadership research.

Azar and Asiabar (2015) also conducted research founded from the MLQ survey format and described the MLQ as a validated research tool for measuring leadership styles through self-assessment techniques. Azar and Asiabar studied the correlation of leader effectiveness based on the leadership style of the participants used in the study. The findings of the study showed the study group was transformational in leadership style and showed high leader effectiveness (Azar & Asiabar, 2015). The results also showed the minority group of transactional leadership displayed less than half the impact of leaders with transformational leadership traits. Using the MLQ survey provides reliable scientific survey results and validate the use of the MLQ format for academic research.

There are specific research examples where the MLQ survey format provided the basis for the healthcare leadership style study. Martínez-Gonzalez, Monreal-Bosch, Perera, and Selva Olid (2016) used the MLQ survey process to look at leadership traits within public healthcare organizations. The study focused on testing transformational and transaction healthcare leadership approaches in the public healthcare setting (Martínez-Gonzalez et al., 2016). The

results of the study found prominent levels of both transformation and transactional leadership present in the studied organizations (Martínez-Gonzalez et al., 2016). The MLQ survey option used in multiple studies within healthcare leadership has shown reliability and validity for healthcare leadership studies. Martínez-Gonzalez et al. further validated the use of the MLQ for testing healthcare executives and healthcare facilities management executives.

Using the MLQ survey format for healthcare leadership research has helped develop a framework of the predominant styles of leadership that exist within the healthcare setting. Solà, i Badia, Delgado Hito, Campo Osaba, and Del Val García (2016) conducted a self-perception study on healthcare leaders using the MLQ survey format and found a predominance of transactional and transformational leadership styles present. The results from Badia et al.'s study found transformational leadership had a slight edge over transactional leadership traits. The study found the use of the MLQ survey format to be reliable and similar to multiple other studies and agreed with the premise of the survey to study leadership in the healthcare setting (Solà et al., 2016). This agreement provides further evidence of the academic relevance of the MLQ survey for healthcare leadership research as designed for this study.

Using the MLQ survey has produced other survey platforms for academic research in leadership styles within healthcare. Duncan, Green, Gergen, and Ecung (2017) described the development of the authentic leadership questionnaire (ALQ), which incorporates leader emotional intelligence into the study of leadership groups. The lack of emotional intelligence within the MLQ format was the primary motivator for the development of the ALQ (Duncan et al., 2017). The ALQ format expands upon the development of the MLQ format. However, the use of an expanded model varies the results. Because of the previous work conducted by Wheatley in the healthcare setting, this study implemented the use of the MLQ format for proper

study comparison. The MLQ format has a more extensive academic base of research and has a licensing component, which allows for reproducing an acceptable survey format for this study.

Healthcare leadership styles. Academic research into the leadership styles prevalent in the healthcare setting applies to the basis of this study. The healthcare setting is a complicated mix of patient care and support services in a complex and regulated environment. Understanding the impact of leadership styles in the healthcare setting is necessary for this study to determine how leadership style can affect patient outcomes. It is also essential to understand the research completed in the supporting roles of healthcare, such as facilities management in the healthcare setting. Without the use of supporting roles for direct patient care, the care delivery system ceases to exist. The function, although not direct, must exist for patient care.

One of the more significant roles in the traditional healthcare setting is nursing. Leadership styles within the nursing setting can vary based on the role given to the staff performing the nursing duties. Giltinane (2013) described the importance of nursing leadership to recognize the leadership present within the healthcare organization and offered descriptions for both transactional and transformational leadership. According to Giltinane (2013), transactional leadership focuses on specific tasks, which are useful in managing particular performance requirements and emergencies. However, transactional leadership does not look at the team dynamic. Giltinane (2013) stated that transformational leadership shows a clear vision of the desired path for the entire team, not just the individuals. Transformational leadership creates an inspired direction for all to follow, so the whole team meets the desired goal (Giltinane, 2013). This study shows how two styles of leadership can benefit the nursing team based on the needs of the staff and the tasks performed.

The information provided by Giltinane (2013) showed the importance of transformational leadership in the nursing environment in the healthcare setting. Al-Abbrow (2014) also found that healthcare leadership affected nursing care using transformational leadership. Transformational leadership is a primary area of focus of this study. Transformational leadership is the ability to take a vision and transform the organization through leading the people based on the initial vision (Al-Abbrow, 2014). Transformational leadership is beyond the day-to-day operations and focuses on imparting a vision as a guiding force for the organization (Al-Abbrow, 2014). Healthcare operations require a focus on both the daily operations as well as the mission and vision of the organization to ensure the safety and outcome for the patient. Without the use of transformational leadership, the organization can never move past the daily transactions and could lose sight of the overall vision.

Another group of authors also reviewed the impact of leadership style on the healthcare organization. Powell et al. (2017) discussed the impact full range leadership had on the application of healthcare, which differentiates the use of transformational, transactional, and passive-avoidant as identified in the MLQ survey based on the need at hand. Transformational leadership helps to guide the team in the right direction while transactional leadership accomplishes the daily routine tasks and keeps the organization running on a day-to-day basis (Powell et al., 2017). Powell et al. showed that passive-avoidant styles are a detractor for any form of leader. The area of passive-avoidant leadership in the healthcare setting is a cause for concern. Considering the safety risks and regulatory failures, which could occur from leadership avoiding issues, it is significant to this study. When high levels of passive-avoidant leaderships arise, the need for leadership development increases.

Continuing with healthcare leadership research, another group of authors found value in the healthcare setting for both transactional and transformational leadership styles based on the actions performed by employees. Saravo et al. (2017) described both transformational leadership and transactional leadership as needed traits for strong clinical leadership within the healthcare setting. The group conducted multi-module training and assessed improvement of a fifteen percent increase in the areas of transformational and transactional leadership quality improvements (Saravo et al., 2017). The author's study showed development could improve leadership performance in the healthcare setting with meaningful outcomes. The study provides valuable information for healthcare as leadership development would be a useful endeavor to improve patient outcomes and safety.

Transformational leadership in the healthcare organization is a common theme in healthcare leadership styles. Understanding what makes up a transformational leader is beneficial for organizations to understand. Benson (2015) discussed five fundamentals needs for transformational leaders, including “Define reality, articulate the vision, create alignment, become a servant, and say thank you.” The first fundamental of defining reality relates to the need for transparency with staff, so the clear vision of the current state is known (Benson, 2015). Transformational leadership must also include a clear vision of the direction for the team; without a clear vision, there is no chance of all members moving in the same direction with intention and purpose (Benson, 2015).

Benson mentioned three items to create assured alignment; leaders must “set the direction, chart the course, and talk the walk.” Vision is nothing unless the leader creating that vision can make the vision real for those who follow. Employees must also see how to get the

vision. By taking the steps mentioned by Benson, leaders can create a direct pathway to ensure the vision becomes a reality.

Not all healthcare leadership style studies agreed on both transformational and transactional leadership was valuable in the healthcare setting. Hargis et al. (2011) reviewed the impact of both transformational and transactional leadership on the healthcare organization. The results concluded that transformational leadership was a far more impactful leadership style for healthcare organizations (Hargis et al., 2011). Transactional leadership was less desirable and incorporated a near-sighted approach to healthcare leadership (Hargis et al., 2011). These findings were consistent with other research reviewed in this literature review, where transformational was the preferred leadership style for healthcare services. One primary candidate for this outcome is the demand for change required in the current healthcare environment. It is imperative to have leadership abilities to transform the healthcare organization to meet the needs of the patient. Without proper transformation, the healthcare organization will do not rise to the new standard required in the healthcare field.

Healthcare organizations are lacking in transactional leadership, according to some studies. Smith (2015) looked at the implications of healthcare leadership for both transformational and transactional leadership and found that transactional leadership is predominant in traditional healthcare executives. The implications, however, concluded the need for transformational leadership in the healthcare setting was essential to the long-term success of the healthcare organization and improved patient outcomes (Smith, 2015). Without the adoption of transformational leadership practices in the healthcare setting, the chances of making significant change will prove detrimental to healthcare organizations. Transactional leadership is the expectation for newer leaders who were high-level performers in the organization before

being in a leadership position. Providing development opportunities to allow these leaders to rise to the level of transformational leaders will improve the outcomes of the organization.

There is some academic research that expands on the traditional view of transformational leadership styles to include alternative styles better suited for the healthcare environment. Harris and Mayo (2018) performed a case study review that found post-heroic transformational leadership theories such as engaging, collective, and authentic leadership styles help improve the quality of patient care delivery for healthcare organizations. This form of leadership style alternative takes the foundation of transformational leadership and focuses on specific drivers aimed at improving healthcare delivery. The cautionary statement from Harris and Mayo is the lack of academic research conducted for these theory types as they are infantile in development. It is encouraging, however, to find new research that expands the current definition of leadership to the areas related to patient care. One consistent theme in academic research for healthcare is the amount of rapid change occurring. New norms of relative leadership styles, which improve the healthcare setting, help fill the gap between change and service delivery for patients.

Using transformational leadership provides a positive impact on patient care. Understanding additional traits that affect leadership styles help create improved outcomes from a leadership perspective. Jambawo (2018) studied the impact of transformational and ethical leadership styles in the mental health field and found that transformational leaders possessing high levels of morals and ethics were most valuable to the healthcare industry. The additional dive into the moral and ethical choices of a leader can provide insight into how well the transformational leader would perform. Transformational leaders help create positivity in the workplace and drive positive results related to patient care (Jambawo, 2018). The need for transformational leaders in healthcare refers to the amount of change occurring in the healthcare

industry with increasing regulations and requirements driven by patient care results (Jambawo, 2018).

Understanding what makes up the best traits for healthcare leadership is beneficial to understand. Leadership styles for multiple industries could look different because of the differences in industry dynamics. Hudak, Russell, Fung, and Rosenkrans (2015) studied the leadership traits needed for leadership in the federal healthcare sector and found twelve overall characteristics best suited to guide current leadership toward successful outcomes. Twelve traits best described what the author concluded to make up the best leadership outcome for healthcare organizations. Through implementing these 12 leadership traits, healthcare organizations in the federal sector would have the best chance for success in leading those who provide patient care or patient care support functions.

With the study of leadership styles in the healthcare setting, that one style dominates the other would be plausible. Nizami, Latif, Hussain, and Rashid (2017) studied the leadership styles in medical professionals and found no specific leadership trait among the participants of the study. There were equal numbers of transformational and transactional leadership styles within the participants of the study (Nizami et al., 2017). The primary takeaway from the study was the need for leadership development within the medical sector to develop professionals in a manner consistent with the ever-changing healthcare environment (Nizami et al., 2017).

One consistent finding throughout healthcare leadership style academic studies is the negative impact of passive-avoidant leadership styles in the healthcare organization. Stare et al. (2013) studied the effect on healthcare workers with passive-avoidant leadership use in the healthcare setting. The results showed increased levels of stress compared to environments when transformational and transactional styles are standard in the healthcare settings (Stare et al.,

2013). The negative impact of passive-avoidant leadership occurs in other healthcare-related leadership studies listed in the literature review. Passive-avoidant leadership styles create a void where leadership is no longer present. Without proper leadership, it is impossible to guide a team in the direction required and perform to the level demanded by healthcare customers. Healthcare organizations should strive to identify passive-avoidant leadership styles and work to develop improved leadership qualities from the leader.

The only way to change leadership styles from an unfavorable outcome was to transform through the use of transformational leadership. Delmatoff and Lazarus (2014) studied the need to change to a leadership style is emotionally and behaviorally centered in healthcare organizations. To change leadership styles would require vision and transformation, which would become a transformational leadership style once developed and implemented within the organization. Healthcare faces increasing and significant changes that require the transformation of the leadership to ensure success and improve patient care (Delmatoff & Lazarus, 2014). Being a preferred style confirms the need for transformational leadership within healthcare.

Some academic studies related to healthcare leadership styles include additional styles included in the studies performed. These styles, although not covered in this study, shed light on the needs of leadership within the healthcare setting. Penny (2017) studied the leadership styles prevalent in healthcare, including transactional leadership, transformational leadership and servant leadership, transformational leadership, and servant leadership. Penny stated that although transactional leadership is the most prevalent leadership style in healthcare that most employees in the healthcare setting regard transaction very low in the motivation of daily activities (Penny, 2017). Transformational and servant leadership are desirable and yield the best outcome for leadership style in healthcare settings (Penny, 2017). Emotional intelligence assists

those who lead healthcare systems through transformational or servant leadership styles (Penny, 2017). Emotional intelligence is a teachable skill set that supports leaders in understanding those they lead, what motivates them, and how to address specific concerns related to their needs.

Servant leadership is not a new concept in healthcare-related leadership styles. Servant leadership is a derivative of transformational leadership with an emphasis on supporting those dealing with changes through servitude. Savel and Munro (2017) described the aspects of servant leadership, which include other's needs first, humility, and understanding those that the organization serves. As a leader works to transform the organization, the use of emotional intelligence allows the leader to understand other needs and concerns from the employee's perspective and drive change through helping employees overcome obstacles in the changing environment. Savel and Munro (2017) also described the fact that servant leadership is a philosophical view of more than just a leadership style. Because of the need for healthcare workers to care for the patient, servant leadership makes perfect sense for the healthcare field.

The academic literature for the healthcare environment is not all positive, however. Özer, Uğurluoğlu, Kahraman, and Avci (2017) studied the effects of toxic leadership on healthcare workers and found a lack of literature regarding the adverse impact of leadership on the healthcare environment. The authors also found the overall academic findings in research studies highlighting only the positive impact of leadership (Özer et al., 2017). Of the participants in the study conducted by Özer et al., the vast majority of participants expressed encounters in the workplace with leaders who showed traits of toxic leadership. The need for leadership development in healthcare to reduce the adverse effects in leadership is essential to ensure proper organizational culture health.

There is an adage stating, “the only thing constant is change.” Change is real in healthcare as regulations, legislation, and competition drive regulations, legislation, and competition drive daily change needs in the healthcare organization. Herd, Adams-Pope, Bowers, and Sims (2016) studied what leadership styles worked best in the healthcare setting. The authors found when change leadership (transformational leadership) is a primary driver of success in the healthcare organization (Herd et al., 2016). Change leadership should be a primary competency for leadership in healthcare for a continual focus on leading the needed changes in healthcare organizations (Herd et al., 2016). The transformational leadership style is the closest representative to change leadership style. Again, the need to implement and inspire change within an organization is the desired leadership trait to improve the healthcare setting. Without the ability to advance change, the healthcare organization falters in a series of transactions with customers. There is no development of improved care without the ability to inspire meaningful change.

Clinical leadership implications. The literature reviewed for this study included the leadership studies conducted for the healthcare organization and studies looking at the clinical leadership styles examined. Clinical leadership is one of the more extensive traditional healthcare executive roles in the healthcare organization. It is crucial to understand how the main drivers in providing patient outcomes and experience implement leadership style into the daily work for the patient. It is also relative to understand what the focus for traditional clinical leadership daily.

Patients are logical to assume clinical leadership has a primary focus on the outcome leadership provided creates. However, the business of running healthcare can assume the lead role if the proper focus is out of alignment. Al-Touby (2012) proposed that traditional healthcare

leadership focus has a robust proprietary focus on the business results of the healthcare organization. The focus must be on the impact the delivery of care made to the patient and the resulting outcome of the patient in the care of the healthcare organization (Al-Touby, 2012). With the focus on the business functions of the healthcare organization, missing the outcome of the patient occurs, reducing the potential for higher levels of patient-centered care for the healthcare organization (Al-Touby, 2012). Because of the significant role of the business aspects of healthcare, this is not a far-fetched result. Business results matter to ensure the organization is sound. However, the patient is the reason for the business to exist.

Providing front-line clinical service is the nursing team. The nursing staff is vital to ensure the production of proper patient outcomes and patient safety. Asamani, Naab, and Ofei (2016) studied the implications of nursing leadership styles on the job satisfaction of nurses in the healthcare setting. What they found was more directive styles affected job satisfaction while supportive styles increased job satisfaction (Asamani et al., 2016). Job satisfaction improves with the use of transformational leadership styles within the healthcare setting, allowing for improved levels of support for the people involved in the delivery of care for patients. The nurse will determine the success of the front-line driven support given to the patient. Transforming this vital team with transformational leadership will ensure the proper results occur.

Because of the changing environment of nursing care, it is critical to creating an environment providing successful results for the patient. Zawawi and Nasurdin (2015) found a combination of team knowledge and transformational leadership style improves the team outcome related to nursing care within the healthcare organization. The addition of knowledge to the transformational style leads to a higher level of empowerment and creates the potential for

improved patient outcomes (Zawawi & Nasurdin, 2015). Having an empowered nursing team who knows the why behind the actions performed creates a positive patient impact.

Nursing teams work together, and because of the work performed to have a strong opinion of the leadership implemented in the healthcare organization. Saleh et al. (2018) studied the impact leadership styles had on the ward nursing staff. The study found that nurses felt nationality played a role in determining the leadership style implemented (Saleh et al., 2018). The study group preferred a leadership style absent from favoritism creating and fostering positive communication (Saleh et al., 2018). The leadership style displayed by the ward manager affected the job satisfaction of the nurse performing patient care (Saleh et al., 2018). The importance of leadership style is far-reaching, even to the front lines in the healthcare organization. Providing leadership development opportunities allow managers and leaders in healthcare to improve nurse satisfaction. Higher nurse satisfaction enables the patient to reap the benefits of those efforts.

Clinical leadership style plays a vital role in overall patient outcomes. Asiri, Rohrer, Al-Surimi, Da'ar, and Ahmed (2016) studied the organizational commitment of clinical leaders based on the dominant leadership styles presented by the management of the organization. Asiri et al. (2016) discussed the criticality of nursing management to the outcome of patients in the healthcare setting. The group found having the proper leadership style in place improved the commitment level of the nurses in the study group (Asiri et al., 2016). Most nurses responded to commitment when led by a transactional leader while having a transformational leader resulted in a limited or negative impact on a personal commitment by the nursing staff. For some healthcare organizations, this would make sense for the need for nurses to have direct leadership with multiple tasks in a tight period. However, the result for transformational leadership varies

from other research in this study, which shows positive outcomes for the patient when transformational styles occur with nursing teams.

Some academic research suggests a limited overall clinical impact from leadership style because of reduced clinical leadership roles in the organization. Kenmore (2008) discussed the effectiveness of the ward manager's leadership styles and found that most effective leaders showed a high range of leadership ability to vary the style based on the need at hand. Adapting leadership styles would display an elevated level of emotional intelligence and suggest the leader was working to create change by transforming the style used in the moment of need. The challenge presented by Kenmore (2018) was ward leaders' roles have diminished, and therefore, the impact produced by the ward from the ward manager is impactful. Reduced ward manager impact would cause decreased patient care results, which are undesirable for any healthcare organization. Although the role of nursing leadership, such as ward managers in some healthcare organizations, may have diminished, this is not true for all healthcare organizations. Nursing leadership still provides a vital front-line role, which affects patient outcomes. The healthcare organization must understand the importance of this role and develop leaders.

The reality for traditional healthcare leadership is today's leaders once performed clinical duties at the bedside. Changing to a leadership role changes the perspective of the leader, which can affect patient care. Kerfoot (2013) explained the challenge with nursing leaders who no longer perform the bedside nursing function and how the change affects patient care. The primary noted means of leadership by many nursing leaders is the command-and-control approach, which wants to have a stronghold on everything related to patient care (Kerfoot, 2013). Command-and-control approach leadership results from the lack of training for leadership styles within the healthcare field (Kerfoot, 2013). Command-and-control most resemble

transactional leadership. If healthcare organizations create proper leadership development and promote clinical leaders who resemble the management force desires, the impact on patient care improves.

Leadership style in the clinical setting can have a significant impact on the ability of the clinical team to develop. Raes et al. (2013) studied the impact of transformational leadership and laissez-faire (passive-avoidant) leadership on the ability of team learning to occur. The study found transformational leadership had a positive impact on the learning ability of the group (Raes et al., 2013). The group also found little information that exists for Laissez-fair leadership styles. However, the information available shows overall the leadership styles attributed to negative results for the organization and the learning ability of teams. This research is consistent with the literature review conducted for this study. Overall, transformational leadership has achieved professional regard for organizational leadership styles. It is easy to understand laissez-faire leadership, or the absence of leadership can create harm to an organization and team.

The primary concern for all clinical leadership should always be the patient. Cliff (2012) wrote about a reignited focus on patient-centered care for healthcare organizations to instill a focus on what matters in healthcare, the patient. Transformational leadership most enables leaders to shift the focus from traditional healthcare operations to a patient-centered model of care. Implementing patient-centered care would also improve the focus on regulatory requirements and improve the positive impact of legislative requirements resulting in improved operations (Cliff, 2012).

Other factors impact clinical leadership, and the styles of leadership in the clinical setting are the most effective. Satyadi (2013) studied the impacts of healthcare leadership on unionized healthcare labor forces. The added stress of labor unions to an already stressed healthcare

environment because of increased regulatory compliance requirements and legislative implications requires improved healthcare leadership practices (Satyadi, 2013). The high-level of change in the healthcare environment now dictates proper leadership to ease the pain and frustration for the people caring for the patients and support those functions within healthcare organizations to bring stability to the healthcare organization (Satyadi, 2013).

Another area impacting clinical leadership are environmental factors and regulatory changes which occur in the healthcare setting. Deshpande and Hill (2015) studied the impact of leadership style on the changing environment of the healthcare setting because of the increasing amount of regulation and legislative changes experienced in the healthcare setting. Leadership style was a factor for improving healthcare quality and patient outcomes (Deshpande & Hill, 2015). Leadership style was also a reliable indicator of how dedicated staff would be to implement and maintain the healthcare organization's mission, vision, and values (Deshpande & Hill, 2015). Leadership style within the healthcare sector is vital to ensuring the outcome of the patient is positive. Proper leadership development opportunities within the organization improved the potential of the leader's effectiveness. Developing the leadership environment is a critical path item correlating to patient care results. Without proper attention, the patient bears the results of the efforts the organization puts forth to prepare leaders in the competitive market of healthcare.

It goes without question that the amount of change occurring in the healthcare setting and the demands on healthcare careers can, over time, impact the employee providing patient care. Hockaday (2017) studied the impact of trauma team operations and the resulting increase of burnout in healthcare because of increasing acuities, higher regulations, and higher healthcare census numbers. The stress factors imposed on patient care because of the rise in demand and

complexity in care over time can affect employees providing care to the point of burnout. What Hockaday (2017) found was the need for trauma team leadership to identify and address signs of burnout early using effective leadership strategies. Without a proper response, the loss from burnout affects the delivery of patient care in the highest criticality resulting in a critical breakdown of the healthcare organization's ability to care for patients. Burnout could impose additional constraints on retaining quality healthcare employees. The impact of clinical employee burnout affects the point of care by the patient and would reflect on the ability of the hospital to comply with quality and outcome metrics for patient care.

Healthcare clinical leadership style research also produced some radical theories contradicting the value and use of transformational leadership in the healthcare setting. Ibrahim (2011) defined heroic leadership styles, such as transformational leadership, as too traditional and lacking in the ability to manage the team environment, which is detrimental to patient care delivery. The focus instead should be on leadership styles to promote effective team management aimed at improving how a workgroup within a healthcare organization performs (Ibrahim, 2011). The challenge then is how best to implement this change, which would require a return to the heroic forms of leadership, such as transformational, which has become a focus for healthcare organizations (Ibrahim, 2011). The author stated that transformational leadership is too traditional, but the need for change would be to use transformational leadership to convert to a new leadership style. The root of the research was a transactional model more lead the team’s daily functions. However, the need for transformational styles still exists in clinical healthcare applications.

Research shows that clinical healthcare staff notices the transformational leadership style, and the impact is positive for the role they perform. Ciurea et al. (2017) discussed the

implications leadership style had on the private healthcare clinic environment, considering the stresses and environmental conditions at hand. Transformational leadership was the leadership most often referenced from subordinates regarding past leaders and the impressions the leaders left on them long-term (Ciurea et al., 2017). Transformational leadership leaves a positive impression on those who follow a transformational leader. This acknowledgment of impact is a sign of the positive impact made on front-line clinical staff by transformational leaders who influence the direction of the healthcare environment.

The traditional healthcare executive leadership style is one of the primary focus groups for this study. Traditional healthcare executives provide the fundamental levels of leadership for the organization and drive the vision for the healthcare organization. Understanding the leadership styles implemented in healthcare facilities management or other support service functions in the healthcare setting is also critical for this study. Academic research exists showing implications of leadership style in healthcare facilities management.

Healthcare facilities management leadership implications. This researcher has been in the facilities management field since 1999, and in the healthcare facilities management field since 2013, the subject of facilities management is significant to the healthcare industry. Understanding the leadership style implications and how they translate to traditional healthcare leadership styles will provide an area for improvement in healthcare leadership for the future. As the needs of the healthcare infrastructure and regulatory stability increase, the role healthcare facilities management plays in the healthcare format will only increase. Healthcare facilities management is the second focus group for this study.

One significant impact on the facilities management services of healthcare organizations is the increase in legislative requirements, which increase the amount of regulation on healthcare

organizations. Balasubramanian (2017) reviewed the near century-old political movement to improve healthcare in the US and found multiple changes by the executive branch of the American government to improve the healthcare landscape in the US. The most recent action being the adoption of the Affordable Care Act, which intended to improve the ease of acquisition of healthcare while increasing regulatory requirements on healthcare providers, aiming to increase the overall quality of healthcare delivery in the US (Balasubramanian, 2017). One component of the Affordable Care Act is tying patient outcomes to reimbursement of federal dollars to healthcare organizations. Items such as infection rates, readmissions, patient quality scores, and regulatory survey results all influence the rate of return or the ability to access federal dollars. The facilities management function has a primary aim to ensure compliance and reduce the risk of environmental factors in the healthcare setting.

Healthcare facilities management is a support function of the hospital, providing skilled services to the healthcare organization to assist in the delivery of effective patient care. Bennett (2009) studied the implications of transformational, transactional, and passive-avoidant leadership styles on IT subordinates, which would correlate well with facilities support staff since both teams support infrastructure components with advanced support staff. The study found IT staff preferred transformational leadership the most and passive-avoidant leadership the least (Bennett, 2009). Using transformational leadership also developed the highest level of extra-effort among IT support staff yielding an improved operational result as well (Bennett, 2009).

It is relative to recognize clinical leadership is not the only function of healthcare, providing an impact on patient outcomes. Lucas et al. (2013) stated the function facilities management provides in the healthcare setting as it relates to patient outcomes. These influences

are most significant in the areas of proper building design, proper conditioning and pressure relationships, and proper equipment maintenance (Lucas et al, 2013). As regulatory requirements increase in the healthcare organization in the areas of life safety, the environment of care, and emergency management, the role of facilities management will continue to play a vital role. This role requires high-level communication abilities with healthcare executives. Without a proper understanding of the dominant leadership styles, the potential for improved communication diminishes. Dominant leadership styles are the primary focus of this study. Understand the leadership style present between these two groups and discuss opportunities for improving communication paths through leadership development.

As noted in this literature review, clinical leadership faces increased regulatory demands. Facilities management must also face an ever-changing regulatory landscape. O'Neill and Scarborough (2013) explained the criticality placed on healthcare facility management to support a facility and environment free from the risk promotes improved patient care. Without proper facilities management, the ability to ensure quality patient care is nonexistent (O'Neill & Scarborough, 2013). The importance of including facilities management executives in the leadership format for healthcare is imperative to ensure all levels of patient care lead from the executive-level of the healthcare organization. Facilities management must have the capability of proper communication between executive healthcare executives to define the needs of the healthcare organization and define an appropriate path to success.

The need to perform effective healthcare facilities management practices is in other academic research. Shohet (2006) studied key performance indicators (KPI's) used for effective healthcare facilities management and defined the need to improve facilities management practices due to the increase of resources required to perform these functions over the next

decade. The KPI's identified included facility performance, specific building system performance, personnel performance and efficiency, and the need for capital over the next five-year period. Because of the increased demand for resourced to maintain the healthcare facilities' infrastructure, the need for improved leadership interactions increases. The development of proper facilities management leadership styles ensures a coordinated and strategic facilities management approach, meeting the healthcare facilities requirements into the next decade.

Another area complicating multiple healthcare organizations is the use of third-party facilities management firms to provide facilities support for the healthcare organization. One company providing this third-party facilities management support is Medxcel (Argir, 2017). Argir (2017) described the focus of the company, which is a leading provider of third-party healthcare facilities management services. The description outlines the role facilities management plays in providing proper life safety, the environment of care, emergency management, and construction services for healthcare providers (Argir). The primary reason Medxcel believes they have an advantage in the market is experienced leaders in the field and years of relationship development between healthcare executive teams (Argir, 2017). Providing superior facilities management services using internal resources or third-party services is a challenging endeavor. Leadership development aimed at improving the level of communication and interaction between healthcare executives and healthcare facilities managers is crucial to the success of patient care and reducing facilities-related costs.

Another area of impact on the healthcare facilities management element is the need to reduce expenses to improve the financial aspect of the healthcare organization. Facilities management is a cost of doing business as a healthcare organization. Reducing expenses while still providing reliable and positive outcomes is a primary focus for healthcare organizations. Lee

(2012) described a method used by Adventist healthcare aimed at reducing facilities management and real estate costs focusing primarily on patient care. This alignment system, called Fred, an acronym used for the facilities and real estate department (Lee, 2012). Lee described the challenges related to facilities maintenance costs and the desire to save money, increase sustainability, and improve healthcare through strategic methods. The result was about one million dollars in annual savings for the organization (Lee, 2012). The example by Lee shows the ability for facilities management to collaborate with executive leaders to improve the bottom line of the company and improve patient outcomes. Without proper development, the communication between executive leaders and facilities management leaders in the healthcare sector will suffer, and the result will not produce the desired results.

Because of the ever-changing environment of the healthcare organization, construction, and infrastructure affect patient outcomes. Lavy and Fernández-Solis (2010) discussed the importance of facilities management and construction product delivery and the impact these processes have on the delivery of patient care as they relate to the potential downtime of critical systems. The primary indicator of effective project delivery is the relationship and involvement created by the healthcare facilities management team (Lavy & Fernández-Solis, 2010). Healthcare facilities management is an element of success for the proper delivery of healthcare construction projects (Lavy & Fernández-Solis, 2010). Without appropriate leadership development and interactions with influential healthcare executives, the healthcare facilities management function would suffer and hinder the delivery of healthcare projects with objectives met.

The facilities management function of the healthcare organization requires considerable attention because of the amount of regulation this function controls. Lavy and Shohet (2007a)

discussed a proposed facilities management model based on strategic influencers allowing the healthcare facility to operate and gave healthcare executives the information needed to support the facilities management function. The premise behind the development of this model is the need to improve healthcare facilities management while dealing with the need to reduce expenses and resources to meet financial objectives for the healthcare organization (Lavy & Shohet, 2007a). It is not possible to maintain the level of importance needed to achieve quality healthcare facilities management without the proper level of evaluation and analysis of the methods required to communicate with executive healthcare leadership. Understanding the differences between executive healthcare leadership styles and healthcare facilities management leadership styles is crucial.

In a separate article related to computer-aided healthcare facilities management, Lavy and Shohet (2007b) defined the high-level of importance placed on healthcare facilities management to support the platform needed to achieve the objectives of the clinical side of healthcare. Healthcare facilities management improves using high-level computer management systems to document all the work produced through the facilities management function (Lavy & Shohet, 2007b). Tailoring this information into a valuable resource for executive healthcare leaders to understand leadership styles is vital to continuing the evaluation of change. A report based on work completed and the goals impacted can guide the healthcare organization to improve patient outcomes.

Healthcare leadership education implications. Healthcare organizations provide development opportunities to leadership based on the needs of the organization and the understanding of the future direction for the organization. This literature review includes information related to academically documented studies associated with the impact of leadership

education and the implications provided for improved patient outcomes. Schwartz, Spencer, Wilson, and Wood (2011) explained the correlation of healthcare organizations seeking magnet status, an industry-leading display of nursing care capabilities, and the use of transformational leadership styles within the organization. Schwartz et al. (2011) showed the conditions for magnet status require the implementation of transformational leadership among the leadership team for the organization. The reality of healthcare is without the ability to transform healthcare leadership; the ability to achieve top-level nursing and healthcare results is almost impossible. Focusing on the transactions, occurring, or entirely avoiding leading will create a massive void filled only by the competition seeking to take the healthcare customer's market share for themselves. The need for impactful leadership development in transformational leadership within the healthcare organization is a critical path item. The organizations that have yet to implement this development program are already behind the curve and could suffer long-term.

For an organization to develop a leadership development strategy, the organization must first understand what areas to focus on development opportunities. Love and Ayadi (2015) surveyed to determine the development needs for future healthcare executives and found that leadership was the top need sited in the survey results. Developing a leadership strategy, which creates a focus on the actual need and keeps less beneficial development needs out of the way, will produce more significant long-term outcomes for the leadership culture in the organization.

Healthcare organizations have options related to the delivery of leadership education. Budhoo and Spurgeon (2012) studied the implications of coaching as a leadership development tool when working with healthcare executives to improve leadership styles and abilities. The study found clinical executives showed support towards a coaching model for developing leadership capabilities (Budhoo & Spurgeon, 2012). Providing a coaching program aimed at

increasing awareness towards the differences between leadership styles and the need for those styles could help improve the ability for different healthcare executive groups to work together to improve the result of patient care.

Healthcare organizations must also consider future leaders in healthcare and how to sustain current levels of employment to care for patients. Beck, Leider, Coronado, and Harper (2017) completed a gap analysis for public health departments and found the most impacted areas are the current changes in the workforce because of generational differences, legislative and regulatory changes. Salary requirements and education opportunities have the highest level of impact on public health organizations over the next decade for recruitment and retention of healthcare employees (Beck et al., 2017). Every industry can list the salary as a contributing factor to future recruitment and retention potentials. The addition of proper education to equip healthcare employees with the tools needed to perform and provide appropriate and compliant care to patients will improve retention. It is also likely that the ability to grow through a development program that shows potential candidates the growth opportunities in an organization would yield a higher level of recruitment potential for current generations.

As healthcare organizations work to create leadership development opportunities, understanding what factors create a higher rate of success when incorporated with leadership styles. Skinner and Spurgeon (2005) studied the impact of empathy on leadership behavior. The study considered transformational, transactional, and laissez-faire leadership styles and found a direct relationship between transformational and laissez-faire leadership styles and empathy (Skinner & Spurgeon, 2005). Transactional leadership had no significant correlation with empathy in the study (Skinner & Spurgeon, 2005). When looking at the education of leadership styles in the healthcare setting, empathy is another factor when working to incorporate

transformational leadership training. Without empathy, it is hard to implement change through transformation. The leader must be able to see at the level of those the leader is trying to guide through change. Without empathizing with the challenges present, the leader may miss profound opportunities for meaningful change.

One significant advantage for the healthcare organization is the availability of improved educational offerings used to enhance leadership education. Desir (2014) described the challenges and benefits to healthcare executives around collegiate opportunities with healthcare administration, which can enhance the outlook for healthcare professionals. With the increased number of online and classroom offerings for healthcare administrative level courses and degree work, executives at all levels of the organization can improve the career potential and prepare for the healthcare executive environment (Desir, 2014). These improved higher education offerings can also better prepare future leaders with the leadership skills needed to advance healthcare into the future and defeat all the challenges present in the healthcare environment. Education could lead to healthcare becoming as reliable as air transportation and nuclear power generation processes.

Primary to the success of any healthcare organization is the network of physicians supporting patient care within the healthcare organization. Hana and Kirkhaug (2014) described the leadership environment surrounding physicians and how leadership development for this group is lacking. Physicians lean on other factors such as clinical training and experience to lead on a daily (Hana & Kirkhaug, 2014). Because of the authority gradient represented at the physical level towards the nursing and clinical staff, proper leadership development is an aspect of healthcare performance to ensure the best outcome for the patient. The study conducted by Hana and Kirkhaug also found a significant correlation between gender type and age compared

to how the respondents viewed the need for task style, relational style, and change style leadership types.

Implementing transformational leadership to drive change in the healthcare setting was prevalent in academic research. Richter et al. (2016) studied the implications of introducing transformational leadership in the healthcare setting to improve the implementation processes of change needed in healthcare organizations. The training improved the implementation process and created a more influential healthcare organization as a result (Richter et al., 2016). Bennett (2003) also described the role nursing managers' play in the world of healthcare as an active change agent and how leadership style relates to the effectiveness of the changes occurring. Without a defined leadership style and proper managerial training, the ability for a manager to start change through the ranks of clinical workers, the change will remain ineffective, and the patient has not assured the best level of care (Bennett, 2013).

The involvement of increased levels of intelligence to produce desired outcomes for leadership development is critical for healthcare organizations to understand due to the amount of formidable legislation passed in recent years with a direct impact on healthcare funding and reimbursement of medical care expenses. Improper leadership development is costly to healthcare organizations, as this does not prepare the organization to address the regulatory needs of the organization. Delmatoff and Lazarus (2014) defined the most effective leadership style for the affordable care act healthcare environment as one incorporating emotional and behavioral intelligence. Transformational leadership describes the person displaying this level of intelligence and would use the findings to transform the team to meet the changes at hand. Demonstrating a high level of emotional and behavioral intelligence is critical for the changing landscape of the healthcare environment (Delmatoff & Lazarus, 2014). The most effective way

for an organization to improve the level of emotional and behavioral intelligence is through a strategic leadership development program with a specific aim implementing change through leadership effectiveness (Delmatoff & Lazarus, 2014).

As healthcare regulations increase, the need for effective leadership development also increases. Healthcare organizations must ensure compliance with all aspects of new regulatory guidelines. The only way to ensure consistent and reliable compliance is for the message to come from top levels of organizational leadership. Snell (2015) described factors influencing healthcare compliance over the next decade, the demand from the public, which drives legislative changes in the healthcare industry. The increased legislative focus is driving increased regulatory requirements on compliance and therefore increasing the need for high reliability in the healthcare industry (Snell, 2015). To comply at the level required as well and providing a clear path to compliance readiness, the healthcare organization leadership and executives must drive compliance into the culture of the organization (Snell, 2018). As the cultural development of the organization catches on to the need for compliance readiness, the compliance officer can take the reins and guide the organization (Snell, 2018).

Attacking all levels of organizational change will require leaders at the highest level to take on roles designed to drive the new organizational culture. All the leading members in the organization cannot play the same role, or the result will never come into reality. The functions of the leadership must be complementary and ensure the successful message distribution throughout all levels of the organization. Kammerlind, Dahlgaard, and Rutberg (2004) developed a leadership profile model that looked at more defined categories of leadership styles, including the captain, the creative leader, the involved leader, the task leader, the strategic leader, the impulsive leader, the specialist, and the team builder. These traits derived back to

Transformational, transactional, and passive-avoidant leadership styles just simplified down to the specific causal impacts of each type listed. The importance of the work of Kammerlind et al. (2004) related to the ability to define leadership and create a focus within the organization associated with the education of leadership styles. Without improved leadership development within the healthcare system, it is impossible to generate long-term and meaningful change within the healthcare organization.

With all the change occurring in healthcare and the demand for improved compliance with healthcare regulation, leadership development is critical for the executive team in the organization. Kusserow (2017) described the need for executive leadership in healthcare to drive a compliance culture within the organization to ensure high levels of compliance among those providing patient care and support services. Often the course provided by executive leadership derives from the origin of intent, and the result is compliance rates that are lacking compared to the expectations of the organization and the governing bodies (Kusserow, 2017). Benchmarking the organization based in survey result data benchmarked with other similar healthcare institutions provides relatable data to use as a road map for improvement within the organization (Kusserow, 2017). Knowing how the organization compares to peers in the industry allows the organization to drive specific needs due to the organization lagging peer organizations. Having a pointed leadership model with a clear direction will create an improved vision and roadmap for employees to follow and drive the organization towards compliance-minded culture.

Madden (2015) defined the soft skills required for healthcare finance executives in today's healthcare environment. Madden also explained the demand for healthcare executives that have a clear vision of what success for the organization should be and how to eliminate challenges that impede progress. Vision is a reoccurring theme for this literature review. Vision

creates the roadmap for the organization's success. Finding what is wrong with an organization may not be too difficult. Understanding what it will take to get the organization from where it is today, to the place of success through a concise vision is invaluable. It does, however, take specific skill sets to implement the vision are just as important. Some soft skills Madden (2015) described were the ability to be strategic, courageous, passionate, inspirational, influential, and excellent communicators. Strategy surrounding the vision implementation ensures understanding of the why behind the effort. Implementing what is unrealized takes the courage to pursue and passion for sustaining the challenges ahead. Inspiring others to follow what may seem impossible takes the effort of an inspirational leader with the ability to communicate at the right tone and level that all who hear the vision can follow.

Healthcare should never lose focus on the need to provide service to the patient first as well and ensure to learn from other service-based industries. Nowicki and Summers (2007) described the lessons healthcare leadership could take from other service-based sectors such as the airline industry in creating meaningful change to the leadership philosophy for the organization. The primary focus of healthcare should be to improve from a service provider to a people-focused organization aimed and creating impactful service (Nowicki & Summers, 2007). Often healthcare has been relevant because of the lack of competition. For many, the options for the delivery of healthcare were few. The changing healthcare landscape enables consumers with multiple health care options and a customer base focused on defining the best service for the lowest cost. With available patient care scores and cost matrix, it is putting the healthcare decisions in the hands of the consumer, where it belongs. Creating a leadership force able to inspire the organization in the proper direction will cause positive and meaningful impacts on the consumers who chose them for healthcare service.

Ultimate, healthcare improves with the development of healthcare leadership if the proper focus remains. Lipley (2008) discussed how a study conducted regarding nursing leadership showed no improvement in the healthcare leadership style after completing leadership development. The reason for the failure occurred because of an ever-increasing pressure to conform to new regulations and processes (Lipley, 2008). One potential cause could be the development program and the ability of nursing leaders to take part. Creating a meaningful development opportunity for leaders in the proper format over the appropriate time while allowing for participation could impact this result.

Summary of the literature review. The review of academic research in healthcare leadership styles and the use of the MLQ survey format showed the MLQ survey format used in healthcare leadership style research and a viable format for this casual-comparison study. Academic literature also showed a significant amount of work researchers performed in the areas of clinical healthcare leadership and the need to improve leadership capabilities to enhance the patient impact of the future. Sources of research on healthcare facilities management research showed a strong correlation between healthcare facilities management and patient outcomes. This study will merge the two leadership styles and look at the relationships and differences between the two healthcare executive groups.

Transition and Summary of Section 1

This study tested traditional and healthcare facilities management executive's leadership styles with the MLQ survey format. The information obtained through the MLQ survey allows healthcare organizations information required to advance healthcare with the common goal of improved reliability and patient outcomes. Because of the diverse background of the study groups used for this study, having information related to the differences in leadership styles

between the two group offers healthcare organizations the data needed to develop leadership education aimed at improving leadership in both study groups.

Section 2: The Project

This quantitative study focused on determining the leadership style differences between two sets of healthcare executives, traditional and facilities management. The leadership styles included in this study include transformational, transactional, and passive-avoidant leadership styles within these two executive types. Because of the increased interactions between these two executive groups in healthcare, understanding leadership traits among the groups applies to leadership study.

The study used the MLQ survey format to derive leadership trait information as a comparison between the two survey groups included in this study. This section comprises the methods used to complete the study of leadership styles between the two executive groups. This section contains seven parts, including the role of the researcher, participants, research methods and design, population sampling, data collection, data analysis, and quantitative reliability and validity.

Purpose Statement

The purpose of this study was to determine the similarity or differences between the leadership styles of healthcare facilities management executives and traditional healthcare executives. Understanding the leadership styles in the study groups examines if specific leadership styles dominate. If dominant leadership styles are present, leadership development will improve the communication path between the two groups of executive leaders. Understanding the predominant leadership styles allows for improved development opportunities enabling healthcare facilities management executives to increase the ability to lead healthcare organizations and improve the patient care outcome within the facility.

Role of the Researcher

The role of the researcher for this project included four functions. The first function required accessing participants for survey submission. This study used the MLQ survey format submitted to two study groups. The first group is the American Council of Healthcare Executives (ACHE). The researcher is a member of this leadership group, used to gain participants for traditional healthcare executive roles. The second study group is from the American Society of Healthcare Engineers (ASHE). The researcher is also a member of this group and used membership to gain access to members in the healthcare facilities management executive group. Membership to both ASHE and ACHE provided the researcher with the names, current roles, and contact information for members. This contact information provided the means to send the MLQ survey to the participants for the study. This contact information was entered into the survey program with Mind Garden and submitted through the Mind Garden MLQ Transform survey-hosting distribution network for anonymous participation with the study.

The second function of the researcher was to procure and distribute the survey materials to the participants. This study used the MLQ format as the basis for the study and licensing obtained through Mind Garden to administer the survey to participants using the Mind Garden MLQ Transform survey-hosting system. All required contact information provided to Mind Garden through the MLQ Transform survey-hosting platform allowed participants to receive the survey for use. The participant then chose if they would take part in the study. All survey responses received were compiled through the Mind Garden MLQ Transform survey-hosting platform. This process allowed for anonymous survey responses from participants and enabled the researcher to survey without impeding on privacy.

The third step for the researcher required analysis of the data from survey results provided through Mind Garden using the group-reporting tool in the MLQ Transform survey-hosting platform. This tool offered the researcher tabulated results for each of the responses, including demographic information. Compellation and coding of the information obtained from the survey responses occurred for the report out in this study through the survey-reporting tool provided through MindGarden. The researcher then provided a conclusion of the results based on the original hypotheses and suggestions for further research related to leadership styles in the healthcare setting.

Participants

Getting participants for this study occurred through two national healthcare leadership groups, which the researcher is a member. Those groups were the American Council for Healthcare Executives (ACHE) and the American Society for Healthcare Engineers (ASHE). Both groups have a membership of executives ideal for this study. ACHE members in the study group represented the traditional business and clinical healthcare leadership group, and ASHE members took part in the healthcare facilities management leadership group. Each participant received a request to join through the online web-based survey format conducted through Mind Garden called the MLQ Transform survey-hosting platform. The MLQ Transform survey-hosting platform provided the study participants with assured full anonymity in the participation process. Demographic information obtained for this survey did not contain any personal information, names, workplaces, or other identifying information.

Research Method and Design

To evaluate the leadership style differences between healthcare facilities, management leaders were compared to traditional business and clinical healthcare leaders, and choosing the

proper research method and design had to occur. Criteria for the appropriate method and design, such as the evaluation of leadership style traits and the use of two specific study groups, were critical factors in the study. The selection of the proper method and design provided the best possible evaluation of the study groups.

Discussion of method. The method used in this study was the nonexperimental quantitative survey method studying two sample groups related to healthcare leadership. According to Creswell (2014), survey design for quantitative research provides descriptions of factors such as trends, attitudes, and opinions in a numeric means for a specific set of the study population(s). The leadership style evaluation for the two groups within this study occurred based on the relevant experience of the participants for specific tangible criteria. The evaluation occurred through the use of the MLQ 5X survey providing numerical results used to evaluate the leadership trait presence for each of the participant groups.

Discussion of design. The survey design for this study was a quantitative casual-comparison survey format. According to Creswell (2014), casual-comparison study models use a system of comparison between two distinct study groups with specific variables, which have already occurred. This study had a defined focus on two study groups. The first study group was traditional healthcare executives, which included members of healthcare leadership, providing administrative oversight of the business, and clinical functions of the healthcare organization. The second group was healthcare facilities management executives responsible for the administrative oversite of the physical facilities and infrastructure of the healthcare organization. The variable for this study was leadership style.

Summary of research method and design. Using a casual-comparison design for the review of a set of two specific survey groups required for this study suggested the casual-

comparison qualitative research model was the best fit for this study. Using the casual-comparison study also emulated the method used in the survey conducted by Wheatley (2010).

Population and Sampling

Just as important as the proper selection of the method and design, understanding the population and sampling for the study groups was a vital component for this study. Participation from appropriate groups affiliated in the area of leadership ensured the information gathered was useful for the research. Also, providing the proper number of participants to survey for each group as well as how the groups sampled ensured valid responses were critical components to the study's success.

Discussion of population. The population used for this research study were healthcare professionals holding an executive-level role in the business, clinical, and facilities management fields based in the United States of America. The participants used for this study were members of two specific healthcare-focused membership group. The first group was The American Council of Healthcare Executives (ACHE), and the second group was The American Society for Healthcare Engineers (ASHE). ACHE members comprise executives in traditional healthcare executives in the business and clinical functions of healthcare organizations. ASHE members include healthcare facilities management professionals who hold executive-level roles.

Discussion of sampling. This study used homogeneous sampling to get participants for survey completion. Creswell (2012) described homogeneous sampling as purposeful sampling based on membership to a specific group related to the field of study. Since both of the population groups used to complete this casual-comparison quantitative study were obtained through membership to either ACHE or ASHE, homogeneous sampling was the best fit for this study. The sampling for this study was single-stage as the published names of members were

accessible with email addresses to forward the survey materials. Creswell (2014) defined single-stage sampling as having access to participant names and direct access for communicating the survey materials.

To achieve a 95 percent confidence level (CL) with a five percent confidence interval (CI), a sample group of appropriate size would be required to ensure population representation. The total population size of the ACHE group with all world-wide members is 48,000 members and would require 381 participants for 95% CL and 5% CI. The ASHE group with 12,500 members would require 373 participants for the same CL/CI levels. This study was unable to achieve the required population size with a total response from both groups of 131 participants, which yielded an Alpha of 20%. Due to the use of a lower number of participants than required for a proper confidence level of 95% and confidence interval of 5%, the results of this study cannot be generalized to the overall population for ACHE and ASHE.

The population sampling achieved for this study is still relevant through the use of the Krejcie and Morgan's (1970) population sample formula. Due to the low number of responses from the study groups, the alpha is higher than a standard .95/.05 CL/CI study. The alpha in the power formula for this study provided an alpha of .20 (Alpha = 1- CL) with a Confidence level or Beta (Beta = 1-power) of 80% due to the total number of responses of 131 for the study. The two types of errors that occur during statistical analysis are type I and type II errors (Creswell, 2012). Type I errors occur by rejecting the null when it should be accepted (Creswell, 2012). The ability to determine this potential occurs within the confidence level, which for this study is eighty percent; however, power baed studies focus on type II errors. A type II error happens by not rejecting the null hypothesis when it should have been rejected (Creswell, 2012). With an Alpha of 20%, there is a 20% probability that the results are false for this study. In total, 131

participants responded to represent the two study groups. The survey conducted by Wheatley sought to achieve a total count of 128 participants for the review.

Summary of population and sampling. Using members of the ACHE and ASHE groups ensured homogenous sampling of groups, and the data collected were from appropriate members of healthcare leadership related to the specific areas of leadership targeted for this study. The sample size of 65 participants from each group allowed a valid number of participants and emulated the research sample size previously used by Wheatley (2010).

Data Collection

The data collection instrument provides a compatible device to collect data from the study group for evaluation. The tool must also include proper information to evaluate the specific areas of leadership involved in the study. To evaluate the two study groups in the areas of transformational, transactional, and passive-avoidant leadership styles along with self-perceptions of outcomes for leadership, assessment of the MLQ 5X form occurred.

Instruments. The data collection tool used to survey participants for this study was the MLQ survey 5X short form leader questionnaire. The MLQ questionnaire provided through Mind Garden through purchased licensing attached in Appendix B. The questionnaire used a set of 45 questions to determine the level of transformational, transactional, and passive-avoidant leadership traits displayed by the sample group. Survey administration occurred through the Mind Garden survey-hosting format. The researcher entered the email addresses of all identified participant requests, and Mind Garden submitted the studies and compiled the results into a final MLQ group report, which provided the combined scores for each of the two user groups. This report purchased from Mind Garden as a complementary solution used in combination with the

MLQ survey platform used to gather data for this study. The report cataloged the data collected by the groups for comparison to the study hypotheses.

Data collection techniques. Participants received an email explaining the purpose of the survey and a request to take part in the study with a guarantee of anonymity. The participants that participated selected the link to the survey in the email provided and completed the demographic information selections and answered the 45 survey questions. The questions were ranked by the participant from 0 = not at all to 4 = frequently, if not always. According to MindGarden, the survey process took 15 minutes to complete, on average. Once the participant completed the survey, the participant was required no further obligation for the study. The answers for all participants were stored by MindGarden, which has an extensive privacy policy to ensure the information was secure, encrypted, password-protected, and only kept for the period needed to research unless more extended legal requirements dictate otherwise. The researcher purchased a report of the data to use for analysis and destroyed after reporting and publishing this dissertation. The report contained the tabulated data for all questions and behavior trait groups.

Data organization techniques. The grouping of scores for the MLQ survey into correlating sections occur based on question numbers, and the scores averaged across the survey groups by scale for the transformational, transactional, and passive-avoidant leadership behavior traits. Transformational leadership traits measured include idealized attributes (IA), idealized influence (II), inspirational motivation (IM), intellectual stimulation (IS), and individual consideration (IC). Transactional behaviors measured include contingent reward (CR) and management-by-exception active (MBEA). Passive avoidant leadership behaviors measured include management-by-exception passive (MBEP) and laissez-faire (LF). The MLQ 5X survey

format measures three additional behavior characteristics for each leadership trait group involving the level of the outcome of leadership for the areas of extra-effort (EE), effectiveness (EFF), and satisfaction (SAT). Each of these behaviors correlates to specific questions on the MLQ survey form.

The higher the score for a particular group of questions, the more frequent the trait for that category is for that leadership group. The results with the highest averaged scores show the leadership traits the survey group favors. The calculation of results for both survey groups, traditional healthcare executives, and healthcare facilities management executives provide results for comparison. Comparing the results determine the statistical differences between the two survey groups to show how the groups are similar, and where the groups have leadership gaps.

Summary of data collection. The MLQ survey's use in healthcare leadership research in six identified cases for the literature review for this study showed the MLQ format as a trustworthy and reliable research platform. The development of the 5x short form resulted from feedback given from researchers over the years to improve the validity and reliability of the MLQ survey format (Bass & Avolio, 2004). Bass and Avolio started the MLQ format with six factors and received feedback that the system required revisions. The authors of the MLQ format conducted further leadership research, which resulted in the MLQ 5R format, another method debated among researchers (Bass & Avolio, 2004). After further research and revisions, Bass and Avolio completed and tested the MLQ 5x rater in 1999. The MLQ 5x form study results showed improved identification of leadership behaviors compared to the six-factor model and, as a result, is unchanged from the 1999 validation testing (Bass & Avolio, 2004).

Data Analysis

Once data collection from the population and sample for the study occurred, the information were analyzed to produce results based on variables within the research and comparison to the hypotheses and research questions for the study. This section explored the variables in the study and how analysis of the data occurs.

Variables used in the study. This study includes three types of variables: independent, intervening, and dependent variables. Creswell (2014) defined independent variables as "those that (probably) cause, influence, or affect outcomes." The independent variables for this study were the leader type, traditional business, and clinical leader and facilities management leaders. Creswell (2014) defined intervening variables as variables that "stand between the independent and dependent variables, and they mediate the effects of the independent variables on the dependent variables." Intervening dependent variables are the three measured leadership behavior characteristics identified in the MLQ format, including transformational, transactional, and passive-avoidant leadership traits.

An additional intervening dependent variable is the outcomes of leadership, which shows the level of extra-effort, effectiveness, and satisfaction with the leadership the group possesses. Creswell (2014) defined dependent variables as variables that directly depend on the independent variables, and the outcomes influence independent variables. Dependent variables for this study existed within the MLQ survey format in the three profile areas: transformational, transactional, and passive-avoidant leadership traits. Each of these traits has specific questions that relate to the area of focus. The compiled scores received show the tendency for the person surveyed to display the assigned leadership trait. A discussion of all dependent variables and the related questions are in the following section.

Table 1

Variables

Variable	Name	Variable Type	Questions	Identifier
Executive type	Traditional Leader	Independent		
	Facilities Management Leader	Independent		
Leadership Type	Transformational	Interval		
	Idealized Attributes	Dependent	10, 18, 21, 25	IA
	Idealized Behaviors	Dependent	6, 14, 23, 34	IB
	Inspirational Motivation	Dependent	9, 13, 26, 36	IM
	Intellectual Stimulation	Dependent	2, 8, 30, 32	IS
	Individual Consideration	Dependent	15, 19, 29, 31	IC
	Transactional Leadership	Interval		
	Contingent Reward	Dependent	1, 11, 16, 35	CR
	Management-by-exception Active	Dependent	4, 22, 24, 27	MBEA
	Passive-Avoidant	Interval		
	Management-by-exception passive	Dependent	3, 12, 17, 20	MBEP
	Laissez-Faire	Dependent	5, 7, 28, 33	LF
	Outcomes of Leadership	Interval		
	Extra Effort	Dependent	39, 42, 44	EE
	Effectiveness	Dependent	37, 40, 43, 45	EFF
	Satisfaction with Leadership	Dependent	38, 41	SL

Hypotheses 1. Transformational Leadership. According to Bass and Avolio (2004), Transformational leaders influence followers to see a vision of what is essential and guide them to change their environment to make the vision a reality. Transformational leadership is one of the intervening dependent variables with five dependent variables attached. Each of the dependent variables has specific survey questions connected to the variable to measure the amount of influence the dependent variable has on the independent variable set.

Idealized attributes and behaviors. Idealized attributes comprise actions shown by a leader, including pride, going beyond self-interests, building respect, and displaying confidence (Bass & Avolio, 2004). Measurement of these attributes occurs in the survey in questions 10, 18,

21, and 25 of the MLQ 5X survey. Idealized behaviors are shown by discussing what is most important, instilling a strong sense of purpose, considering the consequences of decisions, and instilling collective importance on the vision (Bass & Avolio, 2004). The measurement of these attributes occurs in questions 6, 14, 23, and 34 of the MLQ 5X survey.

Inspirational motivation, intellectual stimulation, and individual consideration. Inspirational motivation includes behaviors such as optimism for the future, discuss the needs to accomplish, articulate the future, and to express confidence around the goals at hand (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 9, 13, 26, and 36 of the MLQ 5X survey. Intellectual Stimulation includes characteristics such as re-examining assumptions to ensure they are correct, seeking different perspectives on issues, looking at problems from varied angles and looking at new ways to complete goals. Measurement of these attributes occurs in questions 2, 8, 30, and 32 of the MLQ 5X survey. Individual consideration occurs when leaders coach and mentor, treat others as individuals, understand the differing needs of followers, and develop the strengths of followers (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 15, 19, 29, and 31 of the MLQ 5X survey.

Hypotheses 2. Transactional leadership. Transactional leadership occurs when the leader focuses on corrective and constructive transactions with followers (Bass & Avolio, 2004). Transactional leadership occurs by defining the expectations of followers to achieve a specific result and the method to get to the established expectations. The dependent variables for transactional leadership include the following.

Contingent reward and management-by-exception: Active. Contingent reward occurs when leaders clarify expectations and recognize the work achieved once the goals have been completed (Bass & Avolio, 2004). Measurement of these attributes occurs in questions one,

eleven, sixteen, and thirty-five of the MLQ 5X survey. Management-by-exception active occurs when leaders focus on mistakes, concentrate on failures, keep track of errors, and only focus on when standards are not met (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 4, 22, 24, and 27 of the MLQ 5X survey.

Hypotheses 3: Passive-avoidant leadership. Passive-avoidant leadership works to avoid creating a defined aim and agreement on how to complete work by followers and does not clarify any form of expectation for followers (Bass & Avolio, 2004). The dependent variables for passive-avoidance leadership included the following.

Management-by-exception: Passive and laissez-faire. Behaviors displayed by management-by-exception (passive) leadership includes doing not intervene with serious issues, waiting for failures to occur, waiting for chronic problems to form before taking action (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 3, 12, 17, and 20 of the MLQ 5X survey. Behaviors displayed by leaders possessing a Laissez-faire leadership style include avoiding involvement, absent when needed, avoid decision-making, and provide delayed responses when needed (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 5, 7, 28, and 33 of the MLQ 5X survey.

Hypothesis 4: Self-perception of outcomes of leadership. The MLQ format provides a fourth intervening dependent variable with the results of the leadership portion of the survey. The questions related to this section pertain to the transactional and transformational leadership attributes and rate the person surveyed on how impactful the leadership provided is on followers and the organization. The dependent variables for outcomes of leadership include extra-effort, effectiveness, and satisfaction with leadership (Bass & Avolio, 2004).

Extra-effort, effectiveness, and satisfaction with leadership. Leaders who rate themselves as providing extra-effort see themselves getting others to do more than expected, increasing desire to achieve, developing a willingness to try harder (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 39, 42, and 44. Leaders who rate themselves as useful believe they are meeting the needs of the job, representing the job to higher levels of the organization, meeting requirements of the organization lead their group (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 37, 40, 43, and 45 of the MLQ 5X survey. Leaders who rate themselves as having a high-level of satisfaction performing leadership believe it satisfies them with the method of administration showed and are confident with working with others (Bass & Avolio, 2004). Measurement of these attributes occurs in questions 38 and 41 of the MLQ 5X survey. The following graph represents all the variables described in the study, along with the variables and the questions that each of the variables posed within the survey materials

Scores. This study used the summed score process to analyze the survey responses. According to Creswell (2012), the summed score is the scores from an individual grouped by the variable and totaled together. This study will complete summed scoring for the questions that correlate for each variable listed in the table above and then compiled by the dependent variable groups. The scores of traditional business and clinical healthcare leader group and the healthcare facilities management leader group compare to show the similarities and differences between each group's scores. For example, the idealized attributes dependent variable comprise questions 10, 18, 21, and 25. All participants will answer these questions, and then all answers for both groups combine for an accumulated mean group score. The scores compared to each dependent variable group show any significant difference between the two independent variable groups.

The t-test allows for the descriptive statistical testing of all four dependent variables through the related hypothesis. According to Siegle (2019), the use of t-test statistical analysis allows for the comparison of the mean of two groups score to show a statistical variation or lack of accepting or reject the hypothesis null set. All four independent variables have a hypothesis for this study, including a null set showing no statistical difference. Using a t-test provides a proper evaluation of each dependent variable compared to both independent variables for a conclusion on all four research questions. The scores from each group for each hypothesis; studies are analyzed to create a mean score, standard deviation, and total scores for each hypothesis.

To compare the two independent variable groups, and each dependent variable, the t-test creates a two-tailed p value. If the p value given is greater than the alpha set for this study at .05 the null is accepted, and no statistical significance occurs. For a p value of less than .05, the null set rejects, and the statistical significance of the difference is acknowledged. The correlating research and hypothesis questions are below.

Creswell (2012) defined power as a means to gauge the probability in quantitative research correctly, rejecting the null hypothesis when it is false. Failure to reject the null hypothesis when false is also considered a Type II error in statistical analysis (Creswell, 2012). Power for each of the results for this study ensures a reduced potential for type II errors. Research questions and hypothesis for transformational leadership include:

Q1: To what extent does leadership style vary by leadership type regarding transformational leadership style?

H10: There is no difference between leadership types regarding the transformational leadership style.

H7a: There was a difference between leadership types regarding the transformational leadership style.

Research questions and hypothesis for transactional leadership include:

Q2: To what extent does leadership style vary by leadership type regarding transactional leadership style?

H20: There is no difference between leadership types regarding the transactional leadership style.

H2a. There was a difference between leadership types regarding the transactional leadership style.

Research questions and hypothesis for passive-avoidant leadership include:

Q3: To what extent does leadership style vary by leadership type regarding passive-avoidant leadership style?

H30: There is no difference between leadership types regarding passive-avoidant leadership style.

H3a: There is a difference between leadership types regarding passive-avoidant leadership style.

Research questions and hypothesis for self-perceptions of the outcomes of leadership include:

Q4: To what extent does leadership type vary regarding self-perceptions of the outcomes of leadership?

H40: There is no difference between leadership types regarding the self-perceptions of the outcomes of leadership.

H4a There is a difference between leadership types regarding self-perceptions of the outcomes of leadership style

Summary of data analysis. The variables used in the study identify the leadership group, the types of leadership studied, as well as the attributes of each kind of leadership. Utilizing the summed score process allows for consistent evaluation of the two participant group's scores through the analysis process. Evaluating the scores through the t-test process provides a means to assess the scores to ensure if a difference exists at a statistically significant level, or if the null set is accepted or rejected for the hypotheses.

Reliability and Validity

The tool used for academic study must ensure reliable and valid results. Evaluation of the research tool provides a determination of the fit for academic research as well as the appropriateness for the study under consideration. To ensure the MLQ 5X form is the proper evaluation tool for this study, examining the reliability and validity of the tool occurs.

Reliability. The Multi-Factorial Leadership Questionnaire 5X self-rater version developed in 1999 by Bass and Avolio set out to improve previous versions of the MLQ format and address concerns presented by the academic world. To test the academic fit of the MLQ 5X format for academic leadership research purposes, Bass and Avolio (2004) examined the reliability and validity of the form against four other collective leadership research conceptual models. Both the initial and replication samples showed the 5X six-factor model to produce the best overall fit for academic research in the areas of transformational, transactional, and passive-avoidant leadership styles (Bass & Avolio, 2004). The results of the normative sample fit indices produced in 1999 appear below in the figure.

Table 6. 1999 Normative Sample Fit Indices of MLQ Validation Models: Replication

Model	χ^2	Df	GFI	AGFI	RMSEA	NNFI	CFI
Null Model	19967.23 20494.28 21288.01 20131.44	496					
Model 1: One factor	6634.23 7050.53 6901.42 6341.43	464	.71 .70 .72 .73	.67 .66 .68 .69	.093 .096 .094 .091	.66 .65 .67 .68	.68 .67 .69 .70
Model 2: Three factors - Transformational, MBE and Passive	3237.13 3409.94 3456.11 2936.41	461	.86 .86 .86 .88	.84 .84 .84 .86	.063 .064 .064 .059	.85 .84 .84 .86	.86 .85 .86 .87
Model 3: Four factors – High and Low Transformational, MBE and Passive	2930.07 3096.91 3208.68 2788.68	458	.88 .87 .87 .88	.86 .85 .85 .87	.059 .061 .062 .058	.86 .86 .86 .87	.87 .87 .87 .88
Model 4: Six-factors – Target Model	2259.50 2519.34 2625.00 2263.11	449	.91 .90 .90 .91	.89 .88 .88 .89	.051 .055 .056 .052	.90 .89 .88 .90	.91 .90 .90 .91

[A] Replications with four independent samples; sample size 1,534, 1,550, 1,573 and 1,520 respectively
[B] The fit indices for each of the four replications are reproduced in this table.

Figure 1. Normative Sample Fit Indices of MLQ Validation Models. Replication. Copyright © 1995 by Bernard Bass & Bruce J. Avolio. All rights reserved in all media. Published by Mind Garden, Inc. www.mindgarden.com

Validity. The results of the 1999 normative and replication studies of the MLQ 5X six-factor leadership questionnaire concluded that for a small sample set of leadership studies with homogenous study groups, the MLQ 5X survey was a secure fit for academic research (Bass & Avolio, 2004). The addition of the six-factor model improvements allows for a deeper understanding of the leadership dynamics present within the study group (Bass & Avolio, 2004). The MLQ 5X six-factor survey is still an accepted, reliable, and valid leadership research tool, providing a strong foundation for this academic study of healthcare leadership styles in traditional and facilities management leaders.

Summary of reliability and validity. The use of a tested model, such as the MLQ 5X survey format, allows for a reliable and valid means of data collection for the use in this study.

The MLQ 5X form results are reliable and valid when paired with the populations, samples, and overall objectives to evaluate the leadership trait differences between the two healthcare leadership groups represented in this study.

Transition and Summary of Section 2

Using the MLQ 5X survey format to study leadership differences between traditional business and clinical healthcare leaders and healthcare facilities, management leaders provide a reliable format for this research. Using members of the ACHE and ASHE groups for homogenous sampling offers a study group access that assures proper participant experience and subject focus to support this research. Analysis of the results of the surveyed participants occurs in Section 3 to determine what leadership style differences are present between the two survey groups.

Section 3: Application to Professional Practice and Implications for Change

This section covers the conduction of the academic study as well as the outcomes related to the hypotheses. A discussion of the results from the hypotheses related to business practice follows the findings. This section will conclude with a review of the overall study with recommendations for further research in the area of healthcare leadership.

Overview of the Study

This study reviewed the leadership style differences between traditional business and clinical healthcare leaders compared to healthcare facilities management leaders. The study aimed to identify potential gaps in leadership style that could create complications related to communication between leaders representing the two areas. The traditional healthcare business and clinical leader group consisted of members of the American College of Healthcare Executives (ACHE). The healthcare facilities management group comprised of members from the American Society of Healthcare Engineers (ASHE). The study began using the MindGarden Transform survey-hosting platform on January 6, 2020, and concluded on February 9, 2020, with both groups achieving the desired number of survey responses, 66 from the ACHE group, and 65 from the ASHE group.

Completion of the survey occurred on the MLQ 5X form, which reviews the level of transformational, transactional, passive-avoidant, and the outcomes of leadership. The extraction of a mean score for each of the leadership styles for all elements of the leadership style occurred as well as the deviation for each area to complete a t-test verification of the hypotheses. Rejection of the null hypotheses occurred for transformational leadership and outcomes of leadership. Acceptance of the null hypotheses occurred for transactional and passive-avoidant leadership. Both transformational leadership and results of leadership were higher for the ACHE

group concerning the ASHE mean scores. For both the ACHE and ASHE group, the level of transactional and passive-avoidant leadership showed no statistical difference between the two groups.

Presentation of the Findings

Hypotheses 1. Transformational leadership. Transformational leadership reviewed the IIA, IIB, IM, IS, and IC functions of transformational leadership, as shown in Table 1, Variables.

Bass and Avolio (2004) stated transformational leaders strive to achieve higher levels of performance through improved development and innovation through proactive leadership. All 66 ACHE participants and 65 ASHE participants answered the appropriate questions for the survey. A mean score of 3.5 for ACHE and 3.2 for ASHE represented the transformational leadership scores for each group. Transformational leadership was the highest level of leadership represented for both groups for all areas studied. Table 2 represents transformational area responses.

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The research question and hypotheses for transformational leadership include:

Q1: To what extent does leadership style vary by leadership type regarding transformational leadership style?

H10: There is no difference between leadership types regarding the transformational leadership style.

H7a: There was a difference between leadership types regarding the transformational leadership style.

The standard deviation for participant answers for ACHE was 0.46, and for ASHE was 0.5 for the transformational related questions. A two-tailed *t* test using the mean score, sample size, and standard deviation provided a p value of 0.000499664. With the p value being below the acceptance points, rejection of the H10 hypothesis occurred, showing a higher level of transformational leadership present in the ACHE group. With a power of 0.8103, the probability of a type II error of falsely rejecting the hypothesis is minimal.

Table 2

Transformational Leadership

Transformational	Mean Score	Sample Size	Standard Deviation	p value	Accept/ Reject	Power
ACHE	3.5	66	0.46	0.0004997	Reject	0.8103
ASHE	3.2	65	0.5			

Hypotheses 2. Transactional leadership. Transactional leadership reviewed the CR and MBEA traits of transactional leadership, as shown in Table 1 Variables. Bass and Avolio (2004) explained how transactional leaders use definitions of expectations to promote a reward system based on the actions of others. A mean score of 2.55 for ACHE and 2.45 for ASHE represented the transformational leadership scores for each group. Transactional leadership was the second-highest level of leadership traits described for both groups. Table 3 depicts all transactional area responses.

The research question and hypotheses for transactional leadership include:

Q2: To what extent does leadership style vary by leadership type regarding transactional leadership style?

H20: There is no difference between leadership types regarding the transactional leadership style.

H2a. There was a difference between leadership types regarding the transactional leadership style.

The standard deviation for participant answers for ACHE was 0.7 and for ASHE was 0.7 for the transactional related questions. A two-tailed *t* test using the mean score, sample size, and standard deviation provided a p value of 0.415143. Acceptance of hypothesis H20 resulted in showing no statistically significant difference between the ACHE and ASHE groups related to transactional leadership traits. With a power of 0.8106, the probability of a type II error is minimal.

Table 3

Transactional Leadership

Transactional	Mean Score	Sample Size	Standard Deviation	p value	Accept/ Reject	Power
ACHE	2.55	66	0.7	0.415143	Accept	0.8106
ASHE	2.45	65	0.7			

Hypotheses 3. Passive-avoidant leadership. Passive-avoidant leadership reviewed the MBEP and LF traits of transactional leadership, as shown in Table 1. Bass and Avolio (2004) described the negative effect of passive-avoidant leadership due to the sufficient lack of leadership presented by these traits. A mean score of 0.55 for ACHE and 0.50 for ASHE represented the passive-avoidant leadership scores for each group. Passive-avoidant leadership traits were the lowest level of leadership traits expressed for both groups. Table 4 depicts all passive-avoidant trait responses.

Research question and hypotheses for passive-avoidant leadership include:

Q3: To what extent does leadership style vary by leadership type regarding passive-avoidant leadership style?

H30: There is no difference between leadership types regarding passive-avoidant leadership style.

H3a: There is a difference between leadership types regarding passive-avoidant leadership style.

The standard deviation for participant answers for ACHE was 0.6 and for ASHE was 0.5 for the passive avoidant related questions. A two-tailed t-test using the mean score, sample size, and standard deviation provided a p value of 0.6051. Acceptance of hypothesis H30 resulted in showing no statistically significant difference between the ACHE and ASHE groups related to passive-avoidant leadership traits. With a power of 0.8109, the probability of a type II error is minimal.

Table 4

Passive-Avoidant Leadership

Passive-avoidant	Mean Score	Sample Size	Standard Deviation	p value	Accept/ Reject	Power
ACHE	0.55	66	0.6	0.6051	Accept	0.8109
ASHE	0.5	65	0.5			

Hypotheses 4. Self-perception of outcomes. Self-perception of outcomes for leadership reviewed the EE, EFF, and SAT traits of self-perception of results, as shown in Table 1 Variables. Bass and Avolio (2004) stated that the ability of a leader to provide higher outcomes of leadership, the transformational leadership traits offer the best results. A mean score of 3.5 for ACHE and 3.3 for ASHE represented the self-perception of outcomes scores for each group. The self-perception of outcomes was the same level of response with transformational leadership

levels for the ACHE group and higher than transformational level responses (3.2 for transformational) for the ASHE group. Table 5 depicts all the self-perception of outcomes responses.

Research question and hypotheses for self-perceptions of the outcomes of leadership include:

Q4: To what extent does leadership type vary regarding self-perceptions of the outcomes of leadership?

H40: There is no difference between leadership types regarding the self-perceptions of the outcomes of leadership.

H4a There is a difference between leadership types regarding self-perceptions of the outcomes of leadership style.

The standard deviation for participant answers for ACHE was 0.46, and for ASHE was 0.53 for the self-perception of outcomes related questions. A two-tailed *t* test using the mean score, sample size, and standard deviation provided a p value of 0.0227934. Rejection of hypothesis H40 resulted in showing statistically higher self-perception of outcomes for the ACHE group. With a power of 0.81, the probability of a type II error of falsely rejecting the hypothesis is minimal.

Table 5

Outcomes of Leadership

Outcomes of Leadership	Mean Score	Sample Size	Standard Deviation	p value	Accept/ Reject	Power
ACHE	3.5	66	0.46	0.0227934	Reject	0.81
ASHE	3.3	65	0.53			

Demographic information for participants. Collection of demographic information occurred during the survey process to evaluate the participant age, gender, education level, years

in current position, area of leadership, leadership level, and hospital bed count. The demographic information provides additional background information that uncovers potential areas for discrepancies within the data results.

Age and gender. Participants had the option to answer questions related to age and gender or decline to respond as the items with no requirement to move forward with the survey process by answering these two questions. Answers showed that the ACHE participants were younger, overall having a higher level of participation with participants under the age of 50. The majority of ASHE participants were in the over-50 age brackets. The ACHE group also showed an even spread of participants between male and female respondents. The ASHE group was predominantly male, with only six of the 65 participants being women. Figure 2 shows the distribution of participant responses related to age and gender.

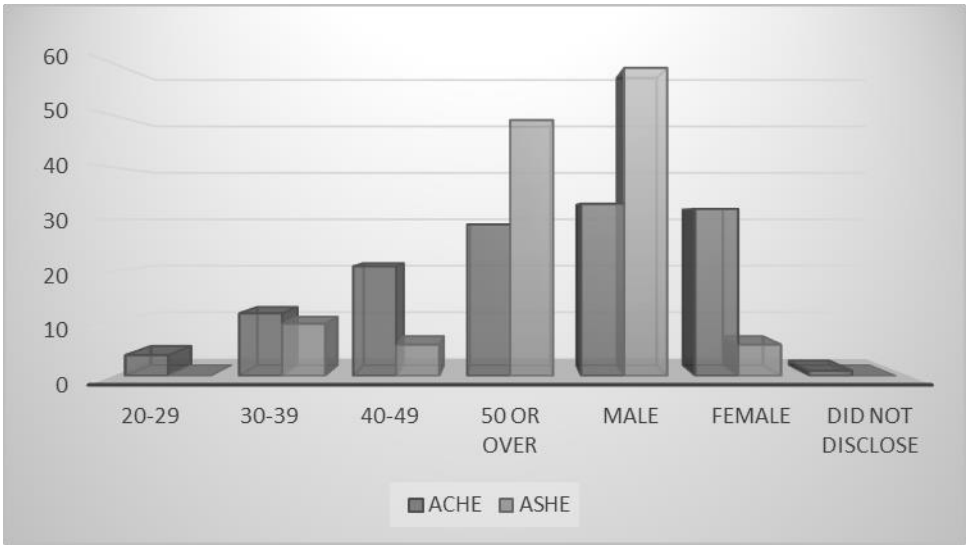

Figure 2. Participant age and gender.

Education level. Participants for both survey groups provided answers related to the degree level obtained. The ACHE group showed a higher level of education, with the majority of participants responding with graduate and post-graduate level education. The ASHE group responded with the majority of education at the bachelor level or below.

Figure 3 shows the responses to the education level for both groups.

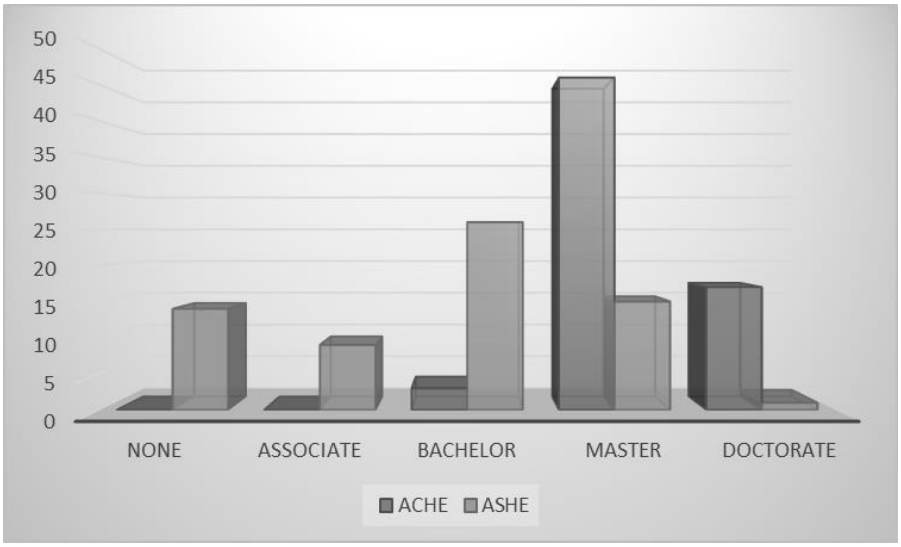

Figure 3. Education level.

Years in position. Participants provided responses related to the number of years in the current position held. ACHE member responses showed the number of years in their current position to be less than 10 years. ASHE members showed a fuller spread; however, the majority of respondents showed over 21 years in the current status. Figure 4 shows the distribution of responses for both participant groups.

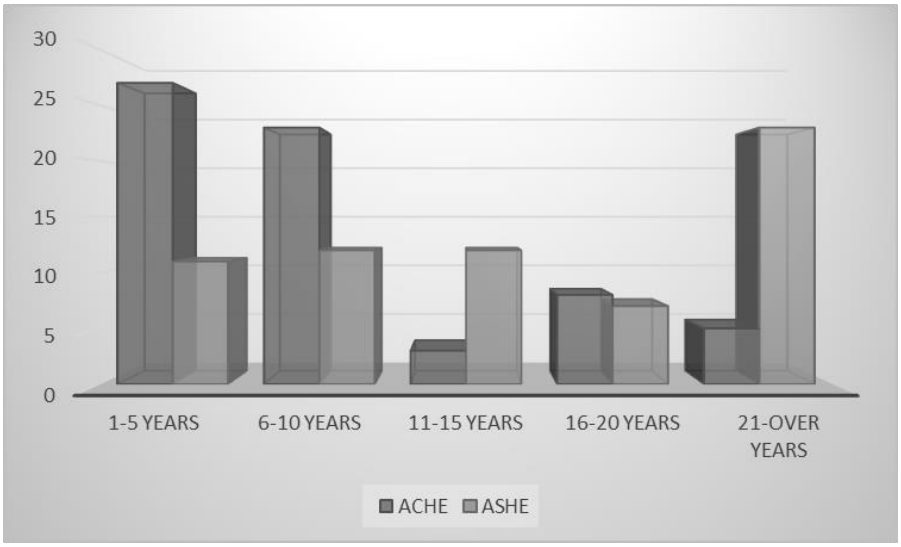

Figure 4. Years in position.

Area of leadership. Since this study searched for responses from specific areas of leadership, a control demographic question ensured proper distribution of survey responses. The ACHE participants showed a distribution of one-third of clinical leaders and two-thirds of business leaders. The distribution of responses corresponds appropriately with the areas of leadership intended for representation within the ACHE participant group. The ASHE group responses were all for facilities management leadership with one exception, which answered for business leadership. The ASHE responses correspond appropriately to the expected type of leadership representation for this group. Figure 5 represents the participant responses related to the kind of leadership representation in this study.

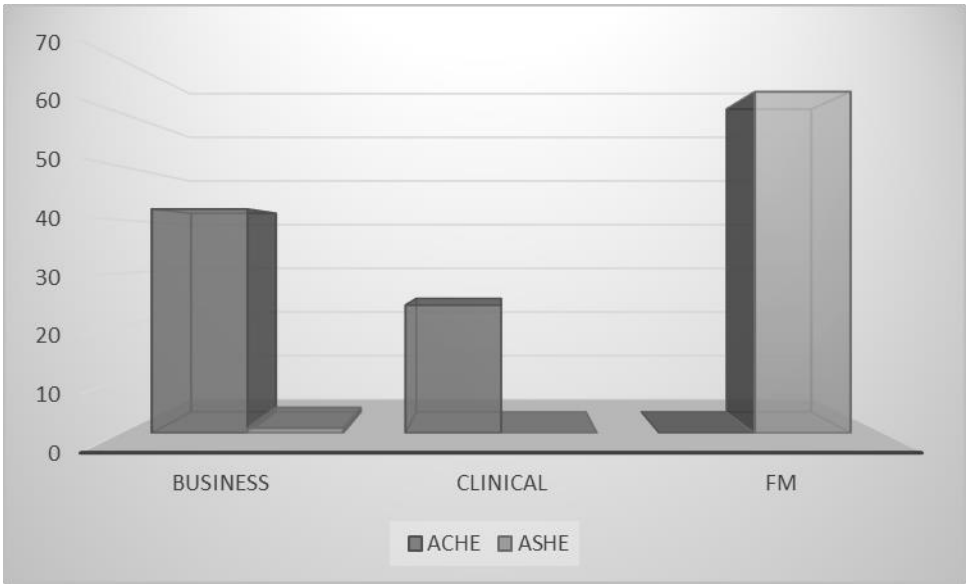

Figure 5. Area of leadership.

Leadership level. Participants provided responses related to the leadership level they represented within their organizations. The ACHE group participants showed a higher level of leadership achievement within their organizations, holding a higher number of senior executive and vice president roles than the ASHE group. The ASHE group showed a majority of

participants holding a director level within their organizations. Figure 6 represents the participant responses related to positions held.

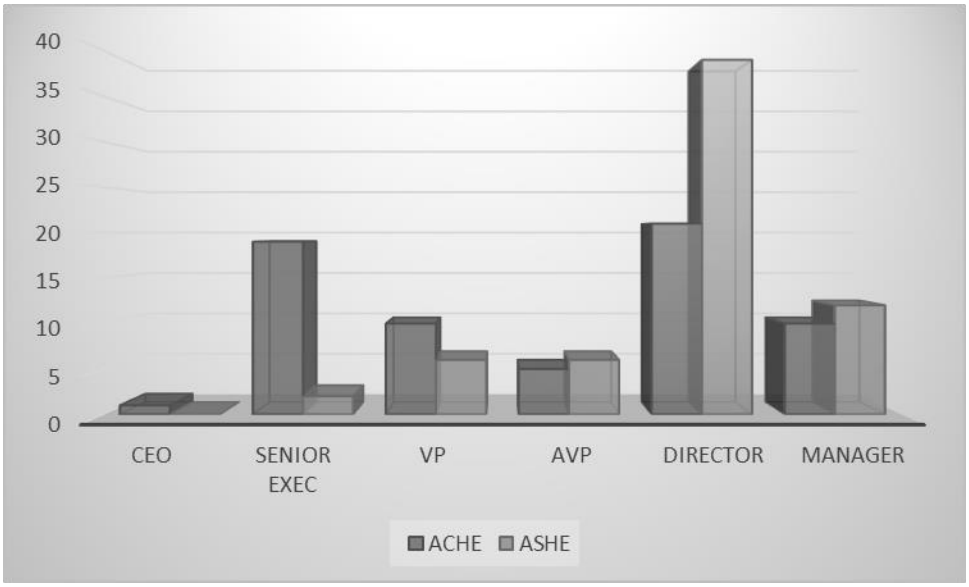

Figure 6. Level of leadership.

Hospital size. Participants identified the number of hospital beds for their organization to show what correlation the size of the organization might represent within-participant responses. The participants for both ACHE and ASHE showed an even distribution between the two groups, with nearly half of both groups representing organizations with bed counts above 500. Figure 7 shows the participant response distribution related to bed count for their organizations.

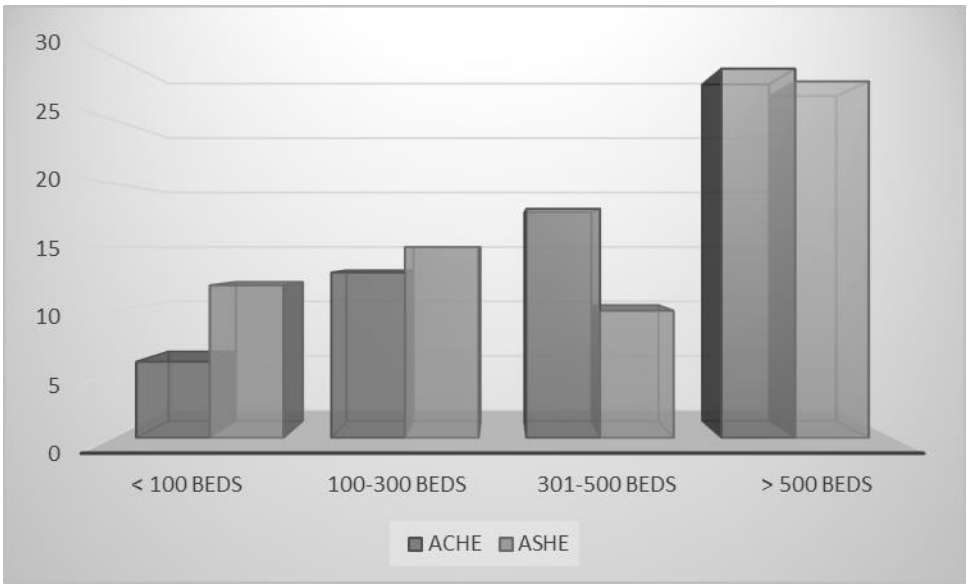

Figure 7. Hospital size by bed count.

Relationship of hypotheses to research questions. The research questions for each of the areas of leadership included in the academic study related to the possibility of difference in leadership styles between the two participating leadership groups. Of the four questions presented for the study, two of the questions yielded results that show variation between the groups. Transformational leadership traits and self-perceptions of outcomes for leadership were statistically higher for the ACHE group compared to the ASHE participants. The areas of transactional and passive-avoidant leadership traits showed no statistical difference between the two study groups. The results provide conclusive answers to all four research questions related to the leadership style differences for both groups of participants.

Summary of the findings. The casual-comparative study of leadership style differences between participants from ACHE and ASHE showed the ACHE group with higher levels of transformational leadership traits and a higher level of self-perceptions of outcomes concerning the leadership the participants provide in their roles. Demographically, the primary differences between the participant groups related to the age, gender, education level, and position held

within the organization. The demographic results showed the ACHE group, which ranked higher in transformational leadership and self-perception of outcomes, also had a younger, more diverse group of participants with higher levels of education and holding more senior-level positions within the organization.

Relationship of findings to research framework. The MLQ 5X survey format through MindGarden performed as expected and provided results consistent with the normative studies conducted by Bass and Avolio (2004). The standard variation for both groups was low, providing results leading to conclusive results without concern for vast degrees of difference between the group participants. The lack of abnormal results within this study provides reliable results with a definitive outcome to further the knowledge base surrounding healthcare leadership styles. Evaluation of all dependent variables identified confirmed the validity of the results through low deviation within the study group. Participation for both groups occurred over a reasonable amount of time and yielded the goal of 130 total participants split evenly between both groups.

Relationship of findings to anticipated themes. A study of the academic literature for the leadership traits studies in this research showed the presence of transformational and transactional having the highest level and most desirable attributes for healthcare leadership. Passive-avoidant leadership traits showed the potential for negative impacts on organizations and were the least desirable trait in healthcare leadership. The results for this study confirmed transformational and transactional leadership as the strongest attributes within both the ACHE and ASHE participants. Passive-avoidant leadership traits were significantly lower than both transformational and transactional leadership traits within the study groups, as anticipated from the literature review.

Relationship of findings to the literature. The academic literature for healthcare leadership traits showed the use of the MLQ 5X form as a valid tool for leadership study in healthcare occupations. This study confirmed the validity of use for the MLQ 5X format and provided a sound measurement for two independent groups of healthcare leaders to compare. Researchers such as Harris and Mayo (2018) and Jambawo (2018) found that transformational leadership was the most desirable leadership traits to provide the best patient care possible. The findings for this study found both the ACHE and ASHE groups possessed high levels of transformational leadership traits. Smith (2015) found transactional leadership traits were among the most predominant in traditional healthcare leaders. This study found transactional leadership was the second-highest level of leadership found for both groups. Stare et al. (2013) found passive-avoidant leadership traits provide negative impacts to the healthcare environment. The findings for this study showed the ACHE and ASHE groups possessed low levels of passive-avoidant leadership traits.

Applications to Professional Practice

The study results show an opportunity present to improve the level of transformational leadership and self-perception of outcomes for leadership within the healthcare facilities management group. The correlation between traditional business and clinical leaders have a higher level of transformational leadership, along with a higher level of self-perception of outcomes for leadership should not be ignored. The results for traditional leaders show higher levels of transformational leadership traits improve the self-perception of leadership outcomes. Both transactional and passive-avoidant leadership traits for both groups were statistically similar and aligned with research suggestions for levels within the groups' responses. Applying

the knowledge learned from the study of healthcare leadership traits between these groups would potentially improve the outcomes of patients treated in healthcare organizations.

Transformational leadership. With both study groups showing high marks for transformational leadership, the outlook for patient care shows promising for today's healthcare environment. Smith (2015) stated the presence of transformational leadership in healthcare results in improved patient outcomes. The outcome of this study showed higher levels of transformational leadership traits present in the ACHE participant group. Even with a strong result for transformational leadership traits in healthcare facilities management leaders, the potential exists to improve the level of transformational presence in healthcare facilities management leaders. Improving the level of transformational leadership for healthcare facilities management leaders would assist the overall organization in reaching patient care goals.

Transactional and passive-avoidant leadership. The presence of transactional and passive-avoidant leadership in both study groups showed no statistical difference between the group's results. Transactional leadership showed to be lower in both study groups compared to transformational leadership traits. Hargis et al. (2011) found transactional leadership traits less desirable than transformational qualities, which produced a result lacking a clear overall vision for the organization. The presence of passive-avoidant leadership traits in both groups was significantly lower than both transformational and transactional leadership trait levels. Stare et al. (2013) found with the introduction of passive-avoidant leadership traits, stress levels for healthcare workers increased, and patient care results suffered. The presence of low passive-avoidant characteristics is encouraging and shows a proper alignment with active leadership for both study groups.

Self-perception of outcomes for leadership. Both study groups provided results with strong indications that the participants understood the impact of the leadership provided on the organization and those the groups lead. The traditional business and clinical leadership group showed a higher level of this self-perception of outcomes, however, which includes improvement opportunities with the healthcare facilities management group. Self-perception of outcomes relates to the ability to see the results of the leadership provided. Due to the possibility of reduced organizational visibility within the healthcare facility management leaders, this outcome has merit. Traditional business and clinical leaders possess opportunities for alignment of the corporate vision from the bedside and strategic perspective to impart upon the facilities leaders in the healthcare setting that support the infrastructure of that vision. Alignment of the overall vision for all levels of the organization, including support-services related departments, has the potential to impact the self-perception of outcomes for leadership positively.

Biblical implications. Demonstration of transformational leadership occurred best in biblical practice through the actions of Jesus Christ. Jesus led his followers through a clearly defined message intended to improve the lives of those around him. Jesus faced persecution, prosecution, and death to fulfill the vision. The vision Jesus possessed was to transform humankind. Jesus desired to change the hearts of followers to align with a higher purpose, which ultimately produced a message that still holds thousands of years later. To provide this result, Jesus possessed a clear understanding of the outcomes for his leadership.

Recommendations for Action

The following recommendations intend to lessen the gap between traditional healthcare leaders and healthcare facilities management leaders. Provide leadership training for facilities management leaders to include transformational leadership development. Improved

transformational leadership trait understanding provides increased opportunities for transformational change within the healthcare facilities management field. The leadership training should encourage alignment for facilities management leaders with the strategic objectives of the healthcare organization. Improved organizational alignment within a critical support-services function such as facilities management should provide an environment aimed at providing the best possible care for the patients the healthcare organization serves.

To reduce the gap for facilities management self-perception of leadership outcomes, the organization should define opportunities to showcase the importance of the leadership provided for the facilities management area. Self-perception of outcomes would likely improve if opportunities for the facilities management team to understand how daily actions improve the patient care experience within the organization existed. Development of indicators showing the results of activities provided by facilities management leadership would improve the perception of facilities leaders as well as provide a common foundation between traditional healthcare leadership roles.

Both traditional leaders and facilities management leaders benefit from providing facilities management leadership with additional transformational leadership development opportunities. The staff in the facilities management department would benefit from the leadership development of facilities management leaders by improving the overall department and healthcare organizational vision and the impact the department makes on patient outcomes.

From a demographic perspective, two areas stand out as opportunities for further action. The first opportunity is providing improved opportunities for women in healthcare facilities management fields. The demographic information provided from the ASHE participants showed a clear gap in gender for healthcare facilities management leaders. In contrast, responses for

traditional healthcare roles were closer to even between both men and women. The second opportunity from the demographic perspective was the need for improved education opportunities for healthcare facilities management. The level of education for the traditional healthcare leader group included more participants holding degrees, as well as advanced degrees. Healthcare facilities management participants reported fewer degrees overall and far fewer advanced degrees in the ASHE group. Providing and encouraging continued education opportunities and incentivizing advanced degrees in healthcare facilities management could further lessen the gap between traditional healthcare leaders and healthcare facilities management leaders.

Recommendations for Further Study

The academic knowledge base for leadership study of support-services levels of healthcare leadership is limited. Opportunities exist for further research in the areas of healthcare environmental resources, supply chain, sterile processing, biomedical engineering, food and nutrition services, pharmaceuticals, volunteer leadership, parking and valet services, as well as other support-services related healthcare fields. The research of leadership traits in support-services would provide additional academic and business knowledge for functions of healthcare that impact patients, families, and employees of healthcare organizations.

Reflections

The study comparing traditional business and clinical leadership traits to those of healthcare facilities management leaders surprised the researcher with the areas of similarity between the two leadership groups. The researcher preconceived expectations for more dramatic differences between the two participant groups. However, the outcomes provided an improved perspective on the lack of extreme differences in the traits studied. The increased levels of

transformational characteristics, as well as higher self-perception of outcomes for traditional healthcare leadership roles, did not surprise the researcher. An initial preconceived idea existed in the areas of both transformational and self-perception of outcomes results. The surprise was in the level of healthcare facilities management transformational and self-perception of outcomes results. The researcher expected lower results for the two areas and higher results for both transactional and passive-avoidant styles for facilities management leaders.

The Biblical implication of leadership style differences and self-perception of outcomes for leadership align with the message Peter provided to the Jews and gentiles in 1 Peter. Both groups of ACHE and ASHE participants need to ensure positive results for the patients served within healthcare organizations. Understanding the differences between the two leadership groups provides a framework to improve alignment with strategic objectives for improved outcomes. The goal for both groups of leaders should align with shared skills and an aim to transform the organization's abilities for providing excellent care to all patients.

Summary and Study Conclusions

This casual-comparative quantitative study between traditional business and clinical leaders compared to healthcare facilities management leaders showed the leadership trait differences in transformational, transactional, passive-avoidant, and self-perception of leadership outcomes. Traditional business and clinical leaders showed higher levels of transformational leadership traits and a higher self-perception of outcomes for leadership compared to the healthcare facilities management group. Transformational and passive-avoidant leadership traits were statistically similar for both groups. The findings provide knowledge surrounding the support-services leadership within healthcare organizations that support the business and clinical objectives for healthcare organizations. The opportunity to improve transformational leadership

and self-perception of outcomes for leadership in healthcare facilities management leaders could provide improved patient care results and ensure enriched regulatory complaint healthcare environments.

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Appendix A: Liberty IRB Exemption Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

September 20, 2019

Joshua Ashlock
IRB Exemption 3927.092019: Healthcare Facilities Management Leadership Style Compared to Traditional Healthcare Business and Clinical Leaders

Dear Joshua Ashlock,

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 that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if…the following criteria is met:
>
> > (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

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
Research Ethics Office

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Appendix B: Liberty IRB Stamped Consent Form

CONSENT FORM

Healthcare Facilities Management Leadership Style Compared to Traditional Healthcare Business and Clinical Leaders

Joshua Ashlock
Liberty University
School of Business

You are invited to be in a research study regarding healthcare leadership styles. This study reviews leadership style similarities and differences between traditional business and clinical leaders and healthcare facilities management leaders. You were selected as a possible participant because of your membership with either ASHE or ACHE and your role as a leader in healthcare facilities management or a leader in business and clinical healthcare. Please read this form and ask any questions you may have before agreeing to be in the study.

Joshua Ashlock, a doctoral candidate in the School of Business at Liberty University, is conducting this study.

Background Information: The purpose of this study is to better understand the leadership styles present in healthcare leadership.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Take an online survey consisting of a short demographic survey, which will take approximately three minutes, and a forty-five question survey, which will take approximately fifteen minutes.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

Benefits: Participants should not expect to receive a direct benefit from participating in this study. The primary potential benefit to society is to improve the academic understanding of the present leadership styles in healthcare leadership.

Compensation: Participants will not be compensated for participating in this study.

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Your email address will be requested by MindGarden as part of your participation, but your survey responses will be completely anonymous to the researcher, and no personal, identifying information will be provided to the researcher.
- The data will be stored on a password and encryption protected computer with no personal identifiers attached to the data. The data will be kept for three years and then erased.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you

The Liberty University Institutional
Review Board has approved
this document for use from
9/20/2019 to --
Protocol # 3927.092019

decide to participate, you are free to not answer any question or withdraw at any time, prior to submitting the survey, without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Contacts and Questions: The researcher conducting this study is Joshua Ashlock. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact him at jpashlock@liberty.edu. You may also contact the researcher's faculty chair, Dr. Keith Mathis, at dkmathis2@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

Appendix C: Mind Garden Copyright Letter

mind garden

www.mindgarden.com

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Multifactor Leadership Questionnaire

The three sample items only from this instrument as specified below may be included in your thesis or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument may not be included or reproduced at any time in any other published material. Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

Citation of the instrument must include the applicable copyright statement listed below.
Sample Items:

As a leader ….

I talk optimistically about the future.
I spend time teaching and coaching.
I avoid making decisions.

The person I am rating….

Talks optimistically about the future.
Spends time teaching and coaching.
Avoids making decisions

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com