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Strategies Healthcare Leaders use for Leadership Development

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This is to certify that the doctoral study by

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2015

Abstract

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MBA, University of Phoenix, 2012

BA, Eckerd College, 2009

Doctoral Study Submitted in Partial Fulfillment

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Abstract

Education and training of potential leaders are essential, and chief executive officers (CEOs) need to identify effective leadership development (LD) programs that foster successful leaders within the healthcare industry. The purpose of this multiple, exploratory case study was to explore LD strategies used by CEOs in hospitals in Central Florida, United States. The overarching research question investigated what executable LD strategies healthcare leaders needed to ensure sustainable growth and successful leaders. The human capital theory and the concepts of emotional intelligence and spiritual leadership guided this study. A purposive sample of 8 CEOs participated in semistructured face-to-face interviews to elicit information on their strategies of creating and maintaining LD programs. A review of organizational documents, as well as member checking of initial interview transcripts, helped to strengthen the credibility of final interpretations. Data were tracked and organized with the assistance of qualitative data analysis software which was used to transcribe and analyze the data. The resulting themes include strategies CEOs use for LD, challenges CEOs face in LD programs, environment of care, generational leadership, and benefits of LD. Study recommendations offered strategies for creating LD programs in the healthcare industry. These findings demonstrate the necessity for effective LD programs and may influence social change by uncovering strategies for LD within the healthcare industry and help CEOs understand LD strategies for implementation within their organizations.

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Dedication

I dedicate this study to my dear husband who has walked beside me each day in spirit guiding me through this journey and to my wonderful daughter who has supported me constantly and makes me so proud. My parents who walk with my husband, all of whom I miss desperately, but I will see them again, this I know.

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Section 1: Foundation of Study

Background of the Problem

The education and training of potential leaders is essential, and chief executive officers (CEOs) need to identify effective leadership development (LD) programs that foster successful leaders within the healthcare industry. Experienced executive leadership is a critical element of success in a constantly and rapidly evolving healthcare environment (McAlearney, 2010). Lack of a stable leadership structure within healthcare organizations may hinder company growth and reduce average human capital, which in turn, may influence economic growth (Schober & Winter-Ebmer, 2011).

Creating an effective LD strategy is not a simple process for most CEOs, as many factors enter into the equation. For instance, demographics, cultural influences, and organizational structure all affect a LD program. Identification of both hard and soft skills required for the executive position helps accentuate the development of employees (Laker & Powell, 2011). For instance, hard skills are skills needed to operate equipment, data entry, etc., and soft skills are desired traits and attitudes for new leaders. Training and education programs also need the support of the employees within the organization to be sustainable and attractive to those potential leaders. Grandy and Holton (2013) suggested that in order for LD to be successful LD should be a collaborative effort between the CEO, senior management, and the employees. According to Gentry, Eckert, Munusamy, Stawiski, and Martin (2014), limited information is available concerning the effectiveness of LD, and its correlation to actual work performance.

Further research into LD programs is necessary to determine what does work in these programs and to establish a benchmark for industry leaders.

Problem Statement

Healthcare leaders are struggling to generate and maintain professional leaders in a complex and changing environment (Hechanova & Cementina-Olpoc, 2013). Organizational investment in LD programs is critical; however, business leaders typically devote less than 10% of their time to LD programs for potential leaders within the organization (Winn, 2014). The general business problem is that some healthcare leaders do not have LD programs to prepare individuals for future leadership positions. The specific business problem is that some healthcare leaders lack strategies for LD

Purpose Statement

The purpose of this qualitative, exploratory, multiple case study was to ascertain what strategies healthcare leaders need for LD. The population included eight CEOs from eight different hospitals within a 75 miles radius of St. Petersburg, Florida. To triangulate the data, I reviewed company documents to explore information about LD programs. Each participant shared her or his success strategies related to LD via semistructured interviews. It is expected that the results will provide recommendations to leaders regarding strategies to develop improved leadership development plans. The inclusion of leadership training strategies could lead to the development of training programs that would influence healthcare organizations, thereby leading to a more productive and profitable environment. Positive implications for social change included the potential to influence healthcare leaders by providing new information on creative

strategies, thereby demonstrating how LD programs can improve work performance and employee satisfaction. Satisfied employees become long-term employees; this not only reduces executive turnover but also ultimately increases the quality of patient care.

Nature of the Study

Qualitative methods explore real-life behavior, allowing participants to voice their opinions (Isaac, Griffin & Carnes, 2010; Chenail 2011; Crocker et al. 2014). Qualitative researchers gather information through qualitative methods such as interviews, personal observations, and discussions (Cox, 2012). The qualitative method and case study design were appropriate for this study focus because the goal was to explore strategies from the perspective of the senior healthcare leaders. Because the study did not test hypotheses nor collect numerical data, quantitative research approach was not used. (Hoare & Hoe, 2013; Upjohn, Attwood, Lerotholi, Pfeiffer, & Verheyen, 2013)..

A multiple exploratory case study was the most appropriate design for the study because it afforded a comprehensive exploration strategy, one that allowed the researcher to explore a particular phenomenon in its environment (Yin, 2013). A case study explores, describes, and explains a business practice based on policies, protocol, and organizational processes (Hotho & Champion, 2011). In this case study, open-ended interviews described LD programs that senior leaders employed to cultivate senior executives from within their organization. It was expected that using a case study design to observe human behavior and its relationship to hierarchical structure, in a professional

and business environment, would lead to a greater understanding of the intricacies of the participants' perceptions.

Research Question

The overarching research question was: What strategies do healthcare leaders use for LD?

Interview Questions

Interview questions play a crucial role in qualitative case studies. Yin (2014) recommended interviewers apply listening skills and follow the interview protocol. The following questions were used in this study:

1. How do you provide leadership training, either internally and/or externally for your employees?
2. If leadership development is an elective activity, how do you motivate employees to participate?
3. What type of training (e.g. knowledge, and skills) is included in your leadership development program?
4. How do you accommodate generational differences in your leadership development program?
5. What obstacles do you face in establishing a leadership development program?
6. In your opinion, how does leadership development training benefit the organization?

7. In your opinion, how does leadership development training benefit the employees?
8. Was the percentage of your 2014 budget devoted to leadership development adequate to serve your organization's needs? Why or why not?
9. Is there any additional information you would like to share?

Conceptual Framework

The conceptual framework is a tool to aid scholars in comprehending a particular problem and they help define the unique factors of the problem (Bordage, 2009). The dominant theory serving as the conceptual framework for the research study was human capital theory (Schultz, 1961) because training and education of human beings are the crux of the theory as described by Schultz. Supporting theories about LD are spiritual leadership (Sweeney & Fry, 2012) and emotional intelligence (Goleman, 2006; Sadri, 2012). Because the healthcare industry is predominantly comprised of caregivers exploration of these theories and their relationship to developing successful leaders in a healthcare setting was appropriate for this study.

Schultz (1961) first introduced the human capital theory which suggested that education imparts useful knowledge and skills. Spiritual leadership focuses on human values, inspirational and motivational leadership through hope, faith, and vision to create a highly motivated, committed, and productive workforce (Sweeney & Fry 2012). The idea of emotional intelligence (EI) has produced growing interest since the beginning of the 21st century, particularly among those involved in developing leadership training. Supporters of EI have argued that it may be more important than intellectual intelligence

(IQ) in calculating leadership success (Goleman, 2006; Sadri, 2012). The exploration of human capital theory, spiritual leadership, and emotional intelligence provided a deeper understanding of the problem as stated and helped in the analysis of the study findings.

Operational Definitions

Emotional intelligence: Emotional intelligence is the ability to understand, control and manage emotions (Sadri, 2012).

Hard skills: Hard skills are teaching of physical skills in the workplace, for example, using a computer for data entry (Laker & Powell, 2011).

Human capital theory: Human capital theory is the education and training provided to increase skills and produce effective leaders (Schultz, 1961).

Spiritual leadership: Spiritual leadership is the application of spiritual values and principles to the workplace (Sweeney & Fry, 2012).

Transformational leadership: Transformational leadership is a process by which leaders initiate significant positive changes in individuals, groups, teams, and organizations. Leaders possess the ability to motivate and inspire followers to go beyond their self-interests for a collective goal (Warrick, 2011).

Soft skills: Soft skills are intangible skills needed for career advancements, such as an excellent attitude and strong reasoning skills (Laker & Powell, 2011).

Stereotypes: Stereotyping is the inference that male and female possess attributes that correspond to their behavior (Koenig, Eagly, Mitchell, & Ristikari, 2011).

Assumptions, Limitations, and Delimitations

Assumptions, limitations, and delimitations are crucial to scholars endeavoring to produce solid research worthy of review by peers. The assumptions comprise facts assumed to be correct based on the researcher's belief. The limitations are potential weaknesses during the administration of the study. Delimitations are characteristics that define the scope and boundaries of the study.

Assumptions

Assumptions are those areas within the study presumed correct, but which are beyond the control of the researcher. There were two primary assumptions for this qualitative, exploratory, multiple case study. One of the assumptions of this study was that participants had knowledge and perceptions regarding LD programs and would respond honestly to the interview question. A second key assumption was that participants would be available in a timely manner.

Limitations

The limitations, as outlined below, constitute the weaknesses of the study and the impediments experienced while conducting the study. My experience and bias as a female healthcare manager could have influenced the results. To mitigate bias and maintain objectivity, I set aside, or bracketed (Husserl 1981), my personal views. I limited this study to a purposive sample of eight CEOs from eight different hospitals within a 75 miles radius of St. Petersburg, Florida.

Delimitations

Delimitations are the characteristics of the study that limit the scope and define the boundaries of the study. For example, the problem as stated represented a delimitation, as it describes the study, limiting the research to certain parameters and influencing the findings. In the same manner, the research question also delimited the study, as did the interview questions. The focus of the study was the experiences of eight CEOs (with 5 years' experience), from eight different hospitals, within 75 miles of St. Petersburg. . Time presented another delimitation as a study conducted over a particular period is a snapshot and is dependent on conditions occurring during that period.

Significance of the Study

Contribution to Business Practice

Findings from the study could provide LD strategies for those healthcare leaders seeking to create successful executives. The modern workforce continues to grow, and contemporary organizational leaders must prepare for this growth. External environmental pressures force business leaders to move with the times and look to a strong leadership structure to maintain their competitive edge (Latham, 2014). LD can create successful leaders, as well as improve business practices. Also, effective training programs can become a conduit for employees to increase their motivation and self-efficacy (Akhtar, Ali, Sadaqat, & Hafeez, 2011; Mosahab, Mahamad, & Ramayah, 2011). Creating effective LD programs within the organization not only enables the aspiring leader to explore his or her full potential but also enhances the culture around them (Coget, 2011). Creating a strong leadership team should boost the bottom line and

increase creativity, profitability, and productivity (Johns, 2013). Building a more competitive and innovative leadership team is a prudent business decision, improving communication, and may ultimately result in better patient outcomes.

Implications for Social Change

Although the emphasis of the study remained in the healthcare industry, providing strategies to senior leaders to attract and retain top executives are important for all employers, irrespective of the business. Leaders of the healthcare industry will be better prepared to advance employees into the upper echelon of leadership.

Increasing the body of knowledge—not only for healthcare leaders but also for aspiring executives—on strategies that employees need to reach executive positions may help them to be more successful. This, in turn, increases their ability to influence or even alter lives. Valuable information on innovative strategies or new leadership models revealed in the findings of the study may reach other scholars, and graduate business students. Additionally, conducting the study may have increased awareness of LD programs in the healthcare industry, thus influencing social change through increased knowledge of LD strategies.

A Review of the Professional and Academic Literature

The purpose of a literature review is to provide background on the study, in order to understand available information about the topic and avoid unexpectedly repeating research. The intent of the study was to explore strategies CEOs employ to develop successful professional leaders, in particular, whether healthcare leaders have sufficient

information on LD programs for aspiring executives. For this doctoral study, the research question was: What strategies do healthcare leaders use for LD?

This review of the literature includes a detailed discussion using professional and academic literature to examine possible research themes. Also discussed is the selection process that determined candidate selection criteria for development programs, various leadership styles, LD programs, and incentives. Also, what leadership qualities successful executives exhibited that produced the optimum financial and relational results.

The following databases were used: Business Source Complete, PsycINFO, SAGE Premier, Academic Search Complete, Google Scholar, and Business Premier. The literature review contains 126 resources, of which 94% were published within the last 5 years, and 86% were peer reviewed.

Discerning the characteristics and traits connected with successful senior leaders from historical perspectives, speculative information, and evidence-based leadership theories are relevant in revealing which competencies healthcare leaders expect from top executives in the healthcare industry. The following key terms were used: *leadership styles, executive recruitment, emotional intelligence, spiritual leadership, mentoring, stereotype, human capital, diversity, conflict management, communication, hard and soft skills, development programs, training programs, transformational leadership, education, healthcare, health care.*

Introduction

The gathering of knowledge and learning new skills are a regular process for humans but seldom do employers realize the benefit of investing in their employees. As early as 1776, when Adam Smith espoused his theories on wage differentials, economists have debated his premise that people are a vital component of an organization; without whom the wheels of industry would slowly stop (Schultz, 1961). Human capital is a collection of resources of a group of people, either individually or collectively, to include knowledge, skills, experience, and training (Schober & Winter-Ebmer, 2011). These resources utilized within an organization create a form of wealth which can be combined to accomplish the goals of an organization**.**

Successful leaders tend to be more empathetic and display spiritual leadership tendencies, tapping into their emotional side more frequently (Sweeney and Fry, 2012). Emotional intelligence (EI) is the capacity to monitor one's own and other people's emotions. In addition to being able to differentiate between varying emotions and group them accordingly, and to use the sensitive information to guide rationale and actions (Sadri, 2012; Quader, 2011).

The healthcare industry focuses on treating people by providing preventive, rehabilitative, and palliative care. A major issue within such organizations is a lack of LD programs for potential senior executives, leading to an imbalance in the leadership structure. Building a strong leadership team to influence business operations is vital to healthcare organizations. In a new age of socially skilled, patient-focused care, leaders look for guidance to help manage their organization that decreases healthcare

incongruences (Dotson, & Nuru-Jeter, 2012). The increase of interdisciplinary patient care teams gives credence to the development of senior executives who can identify with the diverse employee population.

Human Capital Theory

Human capital, which encompasses individual characteristics, usually acquired via education, training, and work experience are important to healthcare organizational leaders (Dotson & Nuru-Jeter, 2012). The failure to recognize individual resources as a form of capital within an organization has led to the notion that labor is merely physical work requiring little or no skills or education (Schultz, 1961). Lack of training for employees may result in failure of new organizations seeking to grow within the market. Rauch and Rijsdijk, (2013) reported results of a longitudinal study performed over a 12-year period to understand the role of human capital in growth or failure of an organization. The findings revealed little correlation between the two, in contrast to Unger Rauch, Frese, and Rosenbusch (2011) who discovered a significant relationship, between human capital and success. The conflicting opinions would thus warrant further research into the role of human capital investment in industry.

Economists have evaded human capital in the belief that profit is not forthcoming from the investment in people. Shultz (1961) and Becker (1993) disputed this notion and collectively agreed that investment in human beings, not only increased profit but also increased self-worth. According to Schultz, those individuals who invest in their future expand their horizons and improve their welfare. Education and training are a prerequisite in the 21st-century work environment, and economic growth is

contingent on the effort of human beings. Thus, it is logical for business leaders to invest in those workers seeking to advance within an organization.

The expense of learning the job is a vital element of net profit for organizations. According to Becker (1993), individual incomes vary according to the extent of investment in human capital. The assumption is that investment in human capital creates in the labor force an indispensable skill base, which in turn creates economic growth. Human capital arises out of any program able to raise individual worker productivity, such as training, education or LD.

In the context of the healthcare industry, human capital is an investment in patient care, which is paramount within the industry. Yepes-Baldó, Romeo and Berger (2013) distributed a survey to 902 nurses to analyze their perceptions as indicators of human capital quality in healthcare. To ensure validity and reliability, a panel of 10 experts in human resources assessment in healthcare organizations analyzed the survey content. The judges agreed the survey content was appropriate and added 13 criterions related to commitment and identification. The findings revealed low responses in job development and opportunity, and motivation. Thus, indicating the healthcare sector would benefit from improving the quality of human capital for their staff (Yepes-Baldó et al., 2013). Therefore, it would behoove senior leaders to evaluate LD programs to improve worker satisfaction and ultimately patient care.

Strategic plans to include LD programs, company growth, and anticipated direction should be part of the leadership mandate for healthcare organizations. Becker (1993) separated human capital into two distinct categories, namely, general and

specific. General human capital is the individual's investment in their future and well-being including healthy living, learning away from the job and self-improvement. On the other hand, specific human capital is the focus on improving efficiency in the workplace, training and education and involvement in development programs within the organization. Investment in human capital should begin at the recruitment stage if CEOs are seeking to develop a strong leadership team (Ployhart, Nyberg, Reilly, & Maltarich, 2014).

In the 1970s and 1980s, recruitment processes were not very sophisticated, and lengthy interviewing processes wore down the senior executives in their search for the perfect candidate. Statistical discrimination (age, gender, education) was a tool used in the 1970s to wean out those candidates considered unsuitable (Bonoli & Hinrichs, 2012). The process often reduced the talent pool, leaving senior leaders with fewer candidates, thus, making the recruitment process precarious and expensive. Additionally, there was no guarantee the employee selected for promotion would remain with the company for an extended period. To reduce executive turnover, it behooves senior leaders to identify specific characteristics that are indicators of successful senior executives.

To identify a suitable participant for a LD program a thorough analysis of the job duties, performance expectations, attributes, and characteristics of the potential candidate is critical (Bottger & Barsoux, 2012). When developing a strong leadership team, it is essential for an organization to have a solid strategy to include an objective assessment process for all potential leaders. Most successful organizations have a strong

strategic plan for growth and future direction. To improve executive retention, informing the candidate as to the strategic orientation of the company is essential (Bottger & Barsoux, 2012). If a prospective employee is unaware of the strategic direction of the company, it is difficult to assess their capability, which, in turn, may raise several issues.

A properly prepared job description (JD) can be used by CEOs as a tool in the assessment process, specifying what the organization is seeking in a senior executive. Selecting the wrong participant can be very expensive for an organization regarding both time and money (Gilmore & Turner, 2010). Stybel (2010) stated that the use of job descriptions might not be the ideal tool for recruitment. Stybel said that using JDs to recruit leaders may create a bias towards hiring leaders because of wishing to have, rather than a need, for an effective leader. As a supplement to the JD, Stybel suggested CEOs use a Leadership Mandate (LM). The mandate is an internal document for use by senior management and outlines how the hiring authority advances in locating strategic goals of the organization in order to secure the perfect candidate for the position. Another approach to recruitment may provide an alternative method that could help secure the ideal candidate. Wells and Hejna, (2009) suggested that to develop leadership talent five primary areas are essential:

1. Key competencies - an assessment of skills needed to perform the job.
2. A detailed job design outlining specific goals and objectives for the executive position as advertised.
3. Recruitment and development.
4. Retention and training.

5. Regular leadership evaluations and performance assessment.

Considering these five elements in conjunction with the JD being the overall strategy for hiring successful candidates, Wells et al. argued CEOs should expend more effort to develop a senior executive. Gilmore and Turner (2010) suggested that alternatives such as better selection processes, accurate job screening, and a better orientation process for new executives improve the success of the senior leadership team. According to Gilmore et al., because of lack of onboarding support, new executives often resign within three years. Therefore, an effective LD program is essential for organizations wishing to reduce this turnover.

To allay the expense of executive turnover, the majority of organizations in their search for executives, employ an external recruiting firm whose primary responsibility is to locate the ideal candidate. These recruiters obviously have a stake in securing the perfect fit for their client as their livelihood depends on their success (Tienari, Meriläinen, Holgersson, & Bendl, 2013). According to Tienari et al., this is where the problem begins with female executive placement. Recruiters or consultants assume power in defining selection criteria and assess candidates based on these standards. During this process, the consultant emphasizes the importance of the disposition and chemistry between the candidate and the client. As a result, the customer's assumptions of male and female skills will marry with the consultant and carry weight in the executive search, thus influencing the process and result. Tienari et al. (2013) reported that male consultants are dominant in these recruiting organizations because of the assumption that males are aggressive and assertive, compared to their female

counterparts. Additionally, it is probable both the client and the consultant are male, consequently, perhaps inadvertently, leading to gender bias.

The increase in education in LD has changed the direction of many organizations, veering away from bureaucratic and toward common thinking. Therefore, selection of candidates needs to be in alignment with an egalitarian approach. According to Hovden, Kvande, and Rasmussen (2011) businesses needed to digress from the concentration on distinct traits and study the practices that create power inconsistencies between males and females in organizations.

Leadership Development

Training healthcare professionals in leadership effectiveness and management is a primary component of healthcare organizations. The difficulty arises from the evaluation of LD programs and scholars of leadership have scrutinized these programs for several years (Daniels et al., 2013). Daniels et al. evaluated a leadership development LD model of a pilot program introduced in a healthcare system for one year. The healthcare system had employed a transtheoretical model (assessment of an individual's willingness to change and provide strategies to promote the change). Including but not limited to, status quo, leadership preparation, action-based leadership, and ongoing evaluation.

Upon examination of the goals of the system and analysis of the LD model Daniels et al. presented an adaptation of the model. Using data from multiple sources (interviews, course evaluations, and journal entries) Daniels et al. found that short-term benefits existed in relation to reflection and a willingness to participate from potential

leaders. However, more time may be necessary to support ongoing consistency in LD. The consensus being a LD model is a useful tool for healthcare leaders to promote sustainable organizational change.

The success of an organization is dependent upon their workforce, particularly leaders who possess the skills to cope with the ever changing global environment. According to Gentry, Eckert, Munusamy, Stawiski, and Martin (2013), LD is a critical component to the success of an organization. To comprehend the expectations and desires of potential executives participating in LD programs, from a global perspective, Gentry et al. explored the challenges participants face in LD programs. Using a mixed method Gentry et al. analyzed the perceptions of 763 participants in LD programs from seven countries. The primary goal being to ascertain what leadership competencies the participants believed were critical to the success of the organization and what challenges the participants faced. The findings revealed challenges potential leaders face are universal, (inspiring, effectiveness, employee development, team leading, guiding change) and consistent with each country. The top leadership competencies recognized included team leading, change management, and resourcefulness. Therefore, to establish a successful LD program, teaching potential leaders to overcome the challenges and enhance the competencies as described, is beneficial. In essence, LD programs are a global initiative that may create successful leaders in all industries.

Creating a LD program within an organization can cause tension for business leaders. Jarvis, Gulati, McCririck, and Simpson (2013) explored some of the tensions that occur which can initiate the necessity of meticulous administration in the design

and implementation of a program. Drawing upon the complexity theory that seeks to understand how organizations adapt to their environment Jarvis et al. evaluated participants from senior management positions in healthcare organizations. The purpose was to ascertain the challenges of evaluating a LD program. According to Jarvis et al. the complexity theory, particularly complex responsive processes of relating (CRPR), aid in the comprehension of tension and explore the necessity of reducing participants frustration.

Of primary concern with the organization was the effect LD programs had on return on investment and provided justification to key stakeholders. Jarvis et al. suggested that communication and research and development strategies are essential components of creating effective LD programs. The CRPR theory that promotes conversation with participants and stakeholders highlights tensions, and the potential for aspiring leaders to realize their value to the organization. In essence, a thorough discussion and preparation of a LD program will ultimately produce a return on investment and a satisfied workforce.

Healthcare is an industry that continually evolves and, as such, the need for strong leadership is critical. These constant shifts present unique challenges to executive leaders in part due to the complexity of these systems, and yet understanding of LD is quite limited. McAlearney (2010), gathered data through a national survey of CEOs and supplemental interviews and set out to study LD programs in this industry. The results revealed that approximately fifty percent of those surveyed had existing programs.

According to McDonagh and Paris (2012), LD programs are crucial to keeping pace with the challenging industry of healthcare.

Changes in demographics of the healthcare workforce, an expanding global economy, and consumer needs necessitate companies to embrace an increasingly interprofessional talent pool, particularly if they intend to remain competitive and recruit the ideal candidate (Dotson & Nuru-Jeter, 2012). The 2008 election race in the United States highlighted the question of gender and ethnicity in leadership; a white woman and a biracial man, both in competition for two of the highest offices in the country. The 2008 election campaign promoted numerous discussions throughout the country (Eagly & Chin, 2010); before that point scholars of leadership had conveniently skirted the issue of diversity of leaders and followers. Eagly et al. argued that the joining of the two bodies of theory and research (diversity and leadership) enriches both domains of experience. In addition to providing guidelines for enhancing leadership in modern organizations and nations.

It is imperative in today's social environment that healthcare companies embrace the business case for LD and work toward social change that empowers leaders. McDonagh and Paris (2012) stated that although women have a significant impact on healthcare, the upper echelon positions eluded them. The change had to start at the senior leadership level. Offering benefits such as flexible work schedules, leadership training, mentoring programs, and development of female networks may spark a change in the trend.

Generational Leadership Development

The 21st-century American workforce is extremely diverse with several generations interacting with one another in a leading or subordinate capacity. According to the generational cohort theory, various traits and loyalties remain consistent in generational cohorts and each generation is distinct. Each cohort is sharing birth years, similar life experiences, traditional values and shared historical and social environment. Such similarities are influencing individuals in their personal and business lives (Gentry, Griggs, Deal & Mondore, 2011). For the first time, four generations are collaborating in organizations: traditionals (1925-1942), baby boomers (1943-1960), Generation X (1961-1981), and Millenials (1981-2002) (Taylor & Stein, 2014).

Gentry, Griggs, Deal and Mondore (2011) investigated generational leaders from three of the four cohorts (Baby Boomers, Generation X, and Millennials). Gentry et al. sought to determine if leaders from various generational cohorts view certain leadership styles and traits more important than others. Their study comprised of two parts: Firstly, examination of what managers from different generations believe are desired leadership practices that contribute to the success of the organization. Secondly, to identify whether managers from the different generations follow those leadership practices. According to Gentry et al., when a gap appears between the practices leaders endorse and the skill levels of those leaders, a need for LD arises. The purpose of the study was to help organizational leaders better align training and development programs with the needs of employees. The results revealed that leaders from these generational cohorts tended to view similar leadership practices more relevant than others. However, Gentry et al. did

note slight variations in perceptions of leadership, perhaps because of the expectation that generations are substantially different to one another.

Salahuddin (2011) researched generational differences and their influence on leadership styles and successful businesses. Focusing on two particular styles, namely transformational and participative, Salahuddin conducted a quantitative study using interviews with leaders and employees from each generational cohort to determine the differences and influences on organizational success. Each of the individual cohorts was discussed, and interview responses indicated similarities between the generations. Gentry, Griggs, Deal and Mondore (2011), indicated favorability of certain leadership practices across generations with the inference that generational differences had little effect on leadership. Whereas Salahuddin believed that generational differences did influence leadership styles and can affect business success.

Developing relationships between leaders and subordinates is crucial in any organization, particularly when the leader is several years younger than their subordinates. Murphy (2012) discussed reverse mentoring, and stated it was an opportunity for business leaders to facilitate cross-generational sharing of information and skills. Technology has developed substantially since the 1980s and, as such, the younger generations may have an advantage over the older generations (Murphy). Therefore, cross-generational mentoring fosters not only learning but also LD of Millennial employees, who are critical to the ongoing success of organizations.

LD in an organization where generational cohorts thrive, such as the healthcare industry, may profit from mentoring programs aimed at creating a bridge between

generations. According to Corner (2014), mentoring is emerging as a popular strategy for LD for two primary reasons: cost effectiveness and strategic effectiveness. A formal mentoring program consisting of a strong plan and well defined goals might enhance the leadership team and close the generational gap that may exist.

Mentoring

Programs such as mentoring, training, flexible working rotations and LD programs for leaders in the healthcare industry may add to the attraction of the industry for potential leaders. A female dominated industry, such as healthcare, may benefit from leaders who can identify with female subordinates, providing role models and mentors for aspiring executives (Price & Howard, 2011). Mentoring is an essential leadership skill. In addition to managing and motivating people, mentors help mentees learn and develop into competent leaders.

Mentoring, a collaborative approach between experienced senior leaders and subordinates creates a learning environment for both parties. The strategic direction of the organization, understanding of employee accountability and the sharing of knowledge creates an alignment between the organization and their employees (Tahir, Said, Daud, Vazhathodi & Khan, 2015). Of course, the success of a mentoring program is dependent upon the leadership skills of the mentors, thus substantiating the case for LD programs within organizations.

However, time constraints may prove difficult for some mentors. It would be beneficial to business leaders to include a mentoring program for the strategic development of aspiring leaders. Tahir et al. targeted 300 school leaders, to include

those leaders with less than five years of experience, and distributed surveys to the group for quantitative analysis. Results revealed mentoring programs were an important component of LD, as mentees believed the collaborative approach to leadership enhanced individual skills and knowledge, thus creating a highly committed workforce and balanced leadership team.

Minority populations, such as Latinas, women, African Americans, and Hispanics may benefit from LD programs with the primary focus on mentoring. San Miguel and Kim (2015), using a phenomenological method explored the lived career and mentoring experiences of several successful scientists and engineers. Exploration of cross-gender mentoring also included in the study, as according to Miguel and Kim, a shortage of female engineers exists in the scientific community. To enable a harmonious working relationship mentees typically connect with mentors of similar culture and background thus, cross-gender mentoring is rare. Semistructured interviews with successful leaders revealed that each participant had, at one time in their career, a mentor-to-mentee relationship and attributed their success to this relationship. In essence, a mentoring relationship can contribute to the success of aspiring leaders, and mentoring programs are worthy of consideration by business leaders.

Spiritual Leadership

Leadership training coupled with the development of strong leadership characteristics is a challenge for any business. Spiritual leadership is a belief that focuses on inspirational and motivational leadership, based on humanitarian values ultimately to create a highly motivated, committed, and productive workforce (Sweeney & Fry,

2012). A developmental model to ascertain how leaders integrated their values, beliefs and self-identity to build strong character growth is a necessary exercise for those companies wishing to hire competent leaders. Sweeney et al. examined how the spiritual leadership model can develop character in the workplace. Suggestions for theory, research, and character development appeared to be the mainstay of spiritual leadership. Spiritual leadership taps into the fundamental needs of both the leader and follower, fostering high levels of company loyalty, financial responsibility, and social responsibility (Sweeney & Fry, 2012). In essence, leaders strong in spiritual leadership tend to be more empathetic and display spiritual leadership tendencies, tapping into their emotional side more frequently.

The healthcare industry forms a particular demographic of a culture of caregivers, clinicians, and a similar population. Ali and Ali (2011) investigated the effect demographics had on the behavior of spiritual leadership defined by four demographic areas: (age, education, experience, most recent experience). Using a quantitative method, a collection of data via a self-administered survey, comprised of two sections, namely demographics and information about spiritual leadership (vision, hope, altruistic love).

Dissemination of 1,000 questionnaires to targeted employees resulted in an analysis of 456 completed questionnaires. Results of the research indicated that the increase in work experience and total duration had an adverse influence on a spiritual leader’s behavior of hope and altruistic love as defined by Sweeney and Fry (2012). It would appear that despite the different influences affecting employee actions, various

demographic effects cause employees to behave differently towards their leader's spiritual behavior.

Crossman, (2010) discussed how spiritual leadership related to other value-based theories such as transformational, servant and the emerging environmental leadership and reviewed scholars' literature about spiritual leadership. Crossman offered a unique contribution emphasizing and clarifying the relationship between spiritual leadership and other value based leadership theories. In contrast to Sweeney and Fry (2012) who attributed spiritual leadership to the strength of character and did not claim an affiliation between spiritual leadership and value based leadership.

Emotional Intelligence

Emotional intelligence (EI) is a concept that has been revived since the beginning of the 21st century, especially those leaders seeking to develop leadership training in their organizations. Successful leaders usually possess high degrees of emotional intelligence (EI) based on the assumption that leaders possess the emotional fortitude and empathy to develop relationships with subordinates. Proponents of EI suggested it might be more important than intellectual intelligence (IQ) in calculating leadership success (Sadri, 2012). Collaboration between leaders and other individuals is critical; an element of this collaboration involves social relations that bring to the forefront emotional awareness and emotional regulation thus affecting the quality of these collaborations (Quader, 2011). Jorfi, Fauzy Bin Yaccob, Shah, and Rezaian (2012) stated EI was a crucial factor in determining the success in life and psychological well-being of managers and employees interactions in their work environment. Sadri (2012)

reported that leaders high in EI can identify, evaluate, forecast, and manage emotions in such a way that allows leaders to work with and motivate subordinates.

Sadri (2012) reviewed the literature on the concept of emotional intelligence (EI) with a view to making recommendations for incorporating EI into LD programs. Sadri divided his analysis into four separate sections to understand the correlation between EI and leadership. The two most cited models of EI (the ability to recognize emotion in others and act accordingly and the ability to control personal emotions to achieve an objective) were the focus of his first section. Section two comprised a synopsis of the arguments for and against EI and part three researched the relationship between leadership and EI. The final section illustrated how the components of EI integrated with contemporary LD practices and suggested methods for developing EI competencies among managers and leaders (Sadri, 2012). An inclusion of an EI assessment in the selection of potential candidates for LD may benefit CEOs and aid in their selection process for potential executives.

A quantitative assessment of EI may substantiate the consensus that women possess higher degrees of EI. Jorfi et al., (2012) explored EI by conducting a survey using participants from both managers and employees in educational establishments. Cronbach alpha formula assessed the validity of the questionnaire; the result of 80% was acceptable. Seven authorities at the average at 89% announced the consistency of the questionnaire. The results indicated that the female component of the universities' managers and employees were more emotionally intelligent. Thus, concluding that communication effectiveness has a positive relationship with job satisfaction.

In conclusion, EI although a relatively new theory under examination in the business world, it does seem to indicate those individuals higher in emotional intelligence display strong leadership skills. Identifying with their peers and subordinates in a more compassionate manner. The secret of emotional intelligence is to be able to hone those skills in a productive way. Thus demonstrating that EI is a definite asset to a strong leader and the healthcare industry that is people orientated will benefit from leaders high in EI.

Elsesser et al. used a mixed method study to perform comparative studies of hypothetical perceptions of female versus male leaders with actual leaders. It appeared the perception of the real leaders was higher than the theoretical study suggested. Elsesser et al. examined the perceptions of actual subordinates to ascertain not only ratings of their relationship with their leader but also attitudes to male and female leaders in general. The results suggested that the perceptions of participants vary considerably between hypothetical leaders and certain leaders, which supported the role congruity theory.

Stereotypes

On a daily basis, people witness the behaviors of boys and girls, males and females, and these observations promote gender stereotypes because of the inference that males and females possess attributes that correspond to their behavior. Men and women participate in different behaviors to such an extent that they occupy opposite social roles (Wood & Eagly, 2012). For example, there are more women in the domestic

role and occupations such as teacher and nurse, and more men in occupations such as soldier, firefighter, and leader.

Stereotypical assumptions have also formed the basis for leadership evaluation for several years. Stereotyping also plays a role in the workforce, and may influence leaders seeking to develop potential senior executives (Ayman and Korabik 2010; Koenig, Eagly, Mitchell, & Ristikari, 2011). Rationalizations stem from the stereotypical assumptions that certain attributes are not conducive to successful leadership, to notions that influential leaders are agentic and display masculine traits. However, a major concern for corporations, when dealing with stereotypes, is the effects stereotypical assumptions may have on leadership (Koenig, Eagly, Mitchell, & Ristikari, 2011). Ayman and Korabik (2010) reported that one of the primary limitations to achieve equality and autonomy in the management, are the deep-seated negative perceptions and stereotypical assumptions that prevail in management culture.

Leadership studies have focused on behaviors and styles and have not considered the effect of diversity and culture in the command structure. This lack of research may lead to limited information for those organizations seeking to increase diversity in their leadership structure (Ayman & Korabik, 2010). Wood and Eagly (2012) pointed out that research, that indicated men and women sometimes undertake gender atypical activities, suggested a variable psychology that is not strictly segregated by gender. According to Wood et al., males and females can be both perceptive and assertive, given an environment that is conducive to their particular behavior and related support structure. The analysis seems to suggest that theoretically based stereotypical assumptions pervade

the business world and warrants the necessity for further research to clarify these assumptions.

Theoretical perspectives abound in literature, and stereotypical assumptions are not unique. Ayman et al. (2010) discussed three different theoretical perspectives that inspire the analysis of leadership (intrapsychic, social structure, and interpersonal). Intrapsychic examines the leaders' traits; for example, masculinity, emotionality, identity, and the role, irrespective of the gender to ascertain how these traits ultimately affect outcomes and behavior. The social structure emphasizes the expectation of social roles for males and females, with the view that male and female normative roles affect their behavior and outcomes. The interpersonal perspective incorporates the elements of the other two and concentrates on personal relationships between leaders and subordinates. In conclusion, the results indicated that traits of leaders are not universal, but they do have an influence on leader perceptions by subordinates and peers.

Stereotypical assumptions can also apply to physical appearance. Braun, Peus, and Frey (2012) stated that stereotypical assumptions elicited purely by appearance, ultimately resulted in a greater imbalance in leadership. LD programs that include corporate diversity programs may be beneficial to alleviate stereotypical assumptions within an organization (Barsh & Yee, 2011). Leadership styles of men and women were the focus of Chin's (2011) study. Chin stated a transformation of leadership views to include diversity models and introduction of transformational and collaborative leadership styles is necessary to develop successful leaders. It would appear, based on research, that stereotypical assumptions, although associated with gender separation

should not only remain in the confines of gender but also be an integral component of strategic LD.

Leadership Styles

Researchers have studied leadership theories almost to the point of exhaustion, and theoretical evaluation of particular theories is abundant in scholarly journals and textbooks for schools and universities. According to Derue, Nahrgang, Wellman, and Humphrey (2011), research on leadership, dating back to the late 1800s, explored hereditary traits to ascertain what distinguished effective leaders from ineffective leaders. Derue et al. criticized former scholars who had created new theories and had given little thought to validating existing theories; promulgating this exhaustive inquiry has led to confusion in the business world and lack of theoretical integrations.

For example, a study of transformational versus transactional leadership may result in a transformational paradigm within the leadership theorem, and as such, focus on a single model may not produce optimum results. Warrick (2011) argued that businesses need transformational leaders to keep up with the fast-paced, dynamic world of business. Derue et al. (2011) who employed a meta analytic approach, discovered that although transformational leaders possess the characteristics necessary to motivate employees, these leaders might not be as high on skills required to lead. Thus, making a case for additional research into an integrated approach to leadership theories, to include behavior in addition to traits. Derue et al.'s opinion is in contrast to Warrick, who advocated that companies need to develop specific LD programs aimed at enhancing transformational leadership skills to create a more efficient leadership team.

Conventionally, healthcare has regarded the development of the skills and proficiencies of individual leaders as the solution to creating an effective team. However, according to the National Center for Healthcare Leadership (NCHL) leader development that focuses on developing individual skills is not synonymous with LD. Effective leaders are those that motivate teams to improve performance to produce the organizational breakthroughs required in today's healthcare environment (Garman & Lemak, 2011).

As previously mentioned, the healthcare industry is evolving. McAlearney (2010), and Arya (2012) examined transformational change within healthcare and how, to achieve this change, companies needed to explore innovative strategies and designs to be successful. In professionally orientated services, such as healthcare, leaders must not only be technically proficient but also have the vision to establish a truly flexible and visionary business. While, at the same time, have the flexibility to adjust as the concept continues to evolve. Cultural and diversity growth must be part of the transformation, and exceptional leaders must be cognizant of this fact.

In industries that comprise of a female dominated workforce, such as healthcare, it may be beneficial to introduce more training in transformational LD because of the assumed nature of the transformational style of leadership. Women tend to display a transformational style of leadership. Burns (2003) brought the transformational leadership theory to the forefront of leadership studies. Transformational leaders gain the trust, and confidence of the subordinates while establishing a shared vision and serving as role models. Additionally, these leaders provide inspiration, intellectual

stimulation and rely on individualized consideration (Burns, 2003; McDonagh, Bobrowski, Hoss, Paris, & Schulte, 2014). As female leaders tend to be participatory and motivational, the transformational leadership attributes closely align with female characteristics.

To demystify the literature, Derue et al. (2011) created an integrative trait-behavioral model of leadership effectiveness and examined the relationship of characteristics and behaviors across four criteria, to understand what way leadership traits affected performance. The results indicated actions, rather than traits, tended to explain more of the variance in effectiveness, thus revealing the necessity for an integrative model that created a balance between behavior and traits.

The multifactor leadership theory (MLT) developed by Bass in 1985 (Hargis, Watt & Piotrowski, 2011) has been used both empirically and theoretically since that time. Three key leadership behaviors: transformational, transactional and laissez-faire (non-leadership) comprise MLT, and Hargis et al. (2011) examined leadership, using the MLT as a core theory for analyzes. A meta-analysis is gathering results from varying data to compare and contrast results to arrive at a conclusion. Utilization of a meta-analysis system and two types of analyzes were prepared using data supplied by various studies (relative weight and dominance analyzes). The first data set comprised of a survey conducted in 2003 consisting of platoon leaders and their subordinates that examined the influence of transformational versus transactional leadership on team outcomes. Data set two reported on a study conducted in 1995, using a sample of nurses, to discover how the two leadership behaviors affected employee effectiveness and

willingness to go the extra mile to complete the task. These data sets were appropriate because of the diverse nature of the samples.

Brief synopses of various leadership behaviors were part of the study, but the main intent was to examine leadership factors in relation to outcomes and performance of an employee, for example, team cohesion and efficiency. Results revealed that a transformational leadership behavior is vital for cohesion, and transactional leadership is more prominent where actual task performance is necessary (Hargis et al., 2011). Discussed and included in the study were implications and taxonomy to guide LD. Distinct leadership behaviors ranging from transactional to transformational styles exist in the leadership forum.

Proponents of the transformational style of leadership suggested that transformational behaviors increase motivation, thus leading to increased loyalty and improved performance (Selcer, 2012). Iqbal, Inayat, Ijaz, and Zahid (2012) claimed transformational and transactional leadership styles appeared to be the most important, purely because more research existed and argued other leadership styles need further study. This conflicting research is indicative of a need for further research into leadership to highlight successful attributes of effective leaders.

An examination of the social climate of strong leaders may begin to explain the quagmire of leadership theories. Schyns, Kiefer, Kerschreiter, and Tymon (2011) argued that leadership was more than just proficiencies and characteristics. Moreover, in fact, leadership was more of a social process, stating self-awareness is an integral part of LD, and social awareness is an aspect of interpersonal competence. Schyns et al. examined

implicit leadership theories (ILTs) specifically geared to the social determination and self-awareness. The implications for leadership training with a particular focus on leader identities within a leadership group were essential to the success of any development program.

Although empirical data highlights the effect transformational leaders have on their subordinates, leadership studies remain scarce on the value placement of transformational leaders and their potential influence on effective leadership outcomes. Groves and LaRocca (2011) questioned the transformational leadership models that have governed leadership research since the 1980s. Using a values-centered leadership design, focusing on organizational values Groves et al. gathered information from 122 company leaders and 458 of their subordinates. The intent of the findings was to determine if transformational leadership did indeed have an influence on business outcomes. The results revealed that leader stakeholder values and follower value congruence achieved significant yet limited roles in elucidating the degree to which transformational leadership generates important leadership consequences.

The healthcare industry is not alone in their leadership quandary. In an ever changing environment, consisting of information technology and increasing pressure from consumers Hechanova and Cementina-Olpoc (2013) were curious as to the effect a transformational leadership style had on organizational change. Because their operations and management may comprise a diverse group of leaders and skill sets Hechanova et al. performed a comparative study of two entirely different entities (academic and business). Hechanova et al. limited their study to entities that had changed within five

years; the hypothesis being there would be significant differences between academic and business organizations in transformational leadership. The results revealed academia claimed better leadership support for changes, in contrast to participants in the company environment. Academic participants also reported their leaders challenged status-quo and displayed typical transformational leadership styles, inspiring and motivating their subordinates. In conclusion, educational leaders created a more harmonious environment for their subordinates, thus instilling commitment and less resistance to change.

To determine if a transformational leadership style was a hindrance to an executive Ayman, Korabik, and Morris (2009) performed a study consisting of groups of existing leaders (58 male, 51 female). Each leader teamed with a subordinate who were instructed to complete a self report on transformational leadership on each of their leaders. Ayman et al. used gender as a moderator to address the influence of stereotyping on those leaders that exhibited a transformational style of leadership, and to ascertain the correlation between transformational leadership and productivity. The results revealed that male subordinates viewed their female leaders in much less favorable light than female leaders with female subordinates, thus demonstrating that a transformational leadership style was not popular with male subordinates, who seemed to favor the transactional style of leadership.

A transactional style of leadership employs the use of reward and coercion to reach an objective. A transactional leader increases their influence through hierarchal structures using their position of authority to motivate subordinates. Eisner (2013), used a qualitative design and analyzed the results of 80 interviews with senior mixed gender

executives. The intent of which was to determine if males did indeed display a transactional style of leadership, as speculated by the literature used for research. The results of the study revealed that 95% of the male executives interviewed displayed a transactional style of leadership. According to Eisner (2013), women (93%) employ the transformational leadership style based on personal power while men use the position based power to display a transactional leadership style. Contemporary managers could use results of this survey as a base for evaluations of their staff.

Followership

A strong leader displays skills admired by team members, who, in turn, want to emulate these skills and follow their example. Scholars labeled these subordinates as followers (a person who willingly offers full support to the leader by being an active participant). In 2011 followership became a recognized construct that benefitted leadership research (Baker, Mathis, and Stites-Doe, 2011). The hypotheses focus centered on whether followers were inclined to mimic leader characteristics in individual quests to become leaders. A study performed in healthcare organizations validated the hypotheses and revealed followers adopted leadership characteristics, embraced change, and are innovative. The followers strived to improve performance, so they too became successful (Baker et al., 2011). The hypotheses tested focused on embracing change, doing the job, challenging the process, enabling others, and working with others. Support for three of the hypotheses and minor support for the remaining two determined that in the practice of being a good follower, followers also seem to share characteristics mutual to successful leaders. Therefore, the result suggested a possible overlap between

leader and follower roles assumption. Followers that embrace change, not afraid to think outside the box and who, in turn, will become successful leaders were the mainstay of the study.

A charismatic leader can have a positive influence on their followers, often providing inspiration purely because of the strength of character and presence. Whether charismatic leaders communicate antisocial or self-interest goals, is dependent, to some extent, on their personality (Humphreys, Zhao, Ingram, Gladstone, & Basham, 2010). Leaders who use their charisma to establish a personal relationship with their subordinates for personal gain may result in a failed project or business collapse. On the other hand, leaders who use their charisma to empower followers often attain positive organizational outcomes (Humphreys et al., 2010). To examine this supposition, Sosik, Chun and Zhu (2014) used a quantitative process model and gathered survey data from 667 subordinates of leaders from 13 different industries. Results revealed that leader narcissism played a significant role in the relationship between leader charisma and follower psychological empowerment. Thus, providing empirical support for self-concept based theories of charismatic leadership.

Transition and Summary

The information presented in the literature review on LD programs used by senior leaders could prove useful to leaders in the healthcare industry. The central research question of this research study determined what information healthcare executives need to create LD programs for aspiring leaders. I intended to achieve this objective through interviews and data collection. The findings of the study may present

healthcare leaders with a guide to reducing executive turnover and improve leadership skills within their organizations. Exploring leadership theories as described in the conceptual framework enriched the depth of the study, and provided a framework for future researchers.

Section 1 contains a discussion of the background, the problem and purpose statement and the research method. Section 2 of this study includes the methodology chosen in examining this research question. The section begins with a review of the purpose of the research and the role of the researcher. Secondly, a discussion of the methods of gaining access to the participants and the measures to ensure the ethical protection of the participants. A description of the research method and design, as well as clarification of the research method and design selected, is also included in section 2. Also incorporated is descriptions of the population and sampling method, to include explanations of characteristics relevant to the current research study. The final discussion included data collection and analysis, their reliability and validity, the collection techniques, and the analysis methods employed.

Section 3 presents the results of the research study. Also, included in Section 3 are the applications of the results to the professional practice as well as the implications for social change. The final section includes a reflection of the completed study, recommendations for further research and development, ending summary, and conclusions.

Section 2: The Project

Section 2 provides a restatement of the purpose of the study and contains a discussion of the research methods and the resources used for the study. This section offers a discussion on the chosen participants, research method and design, population and sampling, and reliability and validity. Section 2 also includes a discussion of the data collection tools and techniques used.

Purpose Statement

The purpose of this qualitative, exploratory, multiple case study was to explore the strategies healthcare leaders use for LD. The population comprised eight CEOs from eight different hospitals within a 75 miles radius of St. Petersburg, Florida. Each participant shared her or his success strategies about LD via semistructured interviews. The results are expected to provide recommendations to leaders about strategies to develop improved LD plans. The inclusion of leadership training strategies might lead to the development of training programs that may have positive implications for healthcare organizations, thereby leading to a more productive and profitable environment. The implication for positive social change is the opportunity to influence healthcare leaders by providing new information on creative strategies, thereby demonstrating how LD programs can improve work performance and employee satisfaction.

Role of the Researcher

As a female manager within the healthcare industry, the study remained in the industry as I have a familiarity with policies and procedures. Although I work in a hospital within the geographical area, I did not conduct interviews in my place of work.

It is the responsibility of the researcher to remain impartial in data collection (Tomkins & Eatough, 2013). Therefore, I had no personal connection to the participants, thus helping to mitigate any personal bias (Chenail, 2011). I identified potential bias and set aside my views using the bracketing technique described by Husserl (1981) who recommended researchers bracket specific assumptions. For example, my experience as a female manager in the healthcare industry could result in individual bias. Thus, to mitigate this I bracketed any personal perceptions in my notes during interviews and my anaylsis of data.

The interview protocol outlined the steps I followed in the data collection stage and provided me with a guide, which in this case, was a semistructured face-to-face interview method (De Ceunynck, Kusumastuti, Hannes, Janssens, & Wets, 2013). I used it to gain an understanding of the problem. Semistructured interviews are more flexible and allow an open discussion between interviewer and interviewee (Crocker et al., 2014). I recorded all interviews to ensure accurate and efficient communication. The face-to-face approach of qualitative methodology, as recommended by Yin (2014), is advantageous, especially when interviewing participants, and yielded a complete understanding of the research problem. To assure reliability and validity of the case study as advised by Guba (1981), rigorous examination of the LD strategies and several data collection procedures were necessary. I collected secondary data from documents that pertained to LD strategies and profitability as they applied to the study (Yin, 2014). Using secondary data in combination with interviews provided methodological triangulation (Bekhet & Zauszniewski, 2012). Member checking by way of discussion

of the transcribed interviews with participants contributed to the validity of the findings. My primary responsibility as a researcher in this qualitative study included data collection, organization of triangulation material, determination of themes, and presentation of the findings (Collins & Cooper, 2014). The ultimate goal being to review, analyze the data and offer results and recommendations in Section 3.

Ethics plays a crucial role in any research study. I complied with ethical guidelines as prescribed in the Belmont Report published by The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (Akhavan, Ramezan, & Moghaddam, 2013; Educational Development Center, 2009). The report summarizes ethical principles as prescribed by the National Commission and provides a guide for researchers, identifying three principles relevant to research involving human subjects (boundaries between practice and research, fundamental ethical principles, and applications). Additionally, acknowledging interpersonal and moral dimensions serves to improve quality and more discerning results (McDermid, Peters, Jackson, & Daly, 2014). Thus, ethics play an important part in the role of any academic researcher and must be thoughtful and well prepared before any study.

Participants

The participants of the study comprised of healthcare leaders with developed strategies for LD. Consisting of a purposive sampling of eight CEOs, from eight different hospitals, within a 75 miles radius of St. Petersburg, Florida provided data. To gain access to the participants, I used all mediums available, email, telephone, and United States Mail. For my initial approach, I dispatched an invitation to my participants

(Appendix A) and followed up with a phone call and email. It is important I establish a rapport with my participants and working as a female manager in healthcare provided me with a clearer understanding of the environment. Purposive sampling was appropriate for this target population. Purposive sampling has a specific intent and involves sampling persons with expertise or superior knowledge in a specialized area (Crocker et al. 2014; Williams, Burton & Rycroft-Maone 2013). Each participant met the selection criteria of a minimum of five years' related work experience, direct involvement in the senior leadership role, and development of a successful leadership program. All of the data, to include digital data, stored on a USB drive, gathered from participant interviews is in a secure lock box that will remain in my possession for 5 years as per Walden University Institutional Review Board (IRB) regulations. I will destroy all data after a 5-year period (the USB drive will be deleted).

As advised by Yin (2014), each participant was asked to sign an informed consent form, which outlined the purpose of the study, and confidentiality rules. Participants had an opportunity to review the transcript before publishing and finally the option to withdraw if desired. The consent form included a notice to the participant about the purpose of the study and the intent to comply with the confidentiality agreement I attested to before the interview. Open communication with my participants promotes trust and honest answers to questions posed by myself. The initial approach to the participants was via US mail, telephone or email, and the project explained before consent. I must be cognizant of the potential relationship between the participants and myself and, as such, the initial approach remained objective, as suggested by Haahr,

Norlyk, and Hall (2013). The interviews were scheduled to accommodate the participants and were approximately 30-45 minutes in duration.

Research Method and Design

The qualitative exploratory multiple case study was appropriate for the study. The study concentrated on the strategies employed by CEOs to create effective LD programs within their hospitals. This qualitative exploratory multiple case study is designed to explore the perceptions and lived experiences of CEOs in the healthcare industry. Discussion of the research method, research design and relevance are the focus of the following sections.

Method

A quantitative study explores empirical data and presents statistical information to the reader to substantiate findings. As a quantitative method relies on statistical data, the study may not provide the lived experiences of the participants (Hoare & Hoe 2013; Upjohn, Attwood, Lerotholi, Pfeiffer, & Verheyen, 2013; Yin, 2014). The lack of explanation of the quantitative method will not be constructive as the objective is to gain an indepth understanding of the phenomenon. A mixed method study, using a combination of qualitative and quantitative methodologies, may offer more substantive data and enhance the validity of findings (Goldman et al. 2015; Lunde, Heggen, & Strand, 2013; Venkatesh, Brown, & Bala, 2013). However, the mixed method approach has to give equal merit to both qualitative and quantitative, and the statistical component of the quantitative approach may diminish the depth of explanation and understanding of the phenomenon of this study.

The qualitative research method describes different individuals' perspectives to develop a shared meaning. A qualitative method interprets and provides a description of purpose to gain a deeper understanding of the topic (Chenail 2011; Crocker et al. 2014; Isaac, Griffin & Carnes, 2010). Because a holistic understanding is the objective, a qualitative method will offer a broader and deeper perspective on the phenomenon. The interpretation of the qualitative method translates into gathering information through inductive qualitative methods such as interviews, personal observations, and discussions (Edward & Welch, 2011). Additionally qualitative research offers an individual perspective concerning a phenomenon to accomplish group values (Trotter, 2012). Case studies are a form of inquiry that does not need to depend exclusively on ethnographic or participant-observer information, as ethnographies typically require a length of time in observation and focuses on detail (Yin, 2013). These methods are especially useful for emphasizing the experiences and perceptions of individuals and challenging structural or normative assumptions.

The goal of this qualitative, exploratory, multiple case study was to interview 8 CEOs, from 8 different hospitals, within a 75 miles radius of St. Petersburg, Florida. The findings of the study could be generalizable to CEOs in other hospitals located in Florida with more than five years' experience who are seeking to launch a LD program. The objective being to discover strategies these leaders used for LD in their organization. Personal interviews is recognized as a method of collecting data in qualitative research and as such data received, are a reputable source of information (Chenail, 2011; Haahr,

Norlyk & Hall, 2014). The face-to-face approach of qualitative methodology is advantageous, helping to create a complete understanding of the research problem.

Research Design

I employed a case study research design to support data gathering instruments and data analysis. The research design will depend on the understanding and analysis of data collection and the ability to explore several personal perceptions, which, in this case, is CEOs in the healthcare industry. The interview process is useful in helping to understand the social phenomenon of the participant's responses (Chenail 2011; Upjohn, Attwood, Lerotholi, Pfeiffer, & Verheyen, 2013; Yin, 2014). The participants in this study responded to questions concerning their lived experiences as senior leaders in the healthcare industry. The case study research design comprised of research instruments to include a review of LD strategies, procedures, annual financial reports, curriculum vitae of executives, and interviews with CEOs involved in the process. The research design will enable the collection of the required data to support the doctoral study's conclusion.

I considered a case study design the most appropriate design to understand the problem as stated. A case study research design allowed me to collect evidence to explore a focused research subject. It is also necessary to achieve data saturation, as it is a crucial scientific concept in the organization and content of qualitative research (Walker, 2012). Qualitative studies are used to explore perceptions and lived experiences of individuals to obtain a more comprehensive understanding of business practices such as the LD strategies explored in this study. A quantitative study examines statistical data and presents this data in tables, graphs and numerical formulas to validate

their conclusions (Upjohn, Attwood, Lerotholi, Pfeiffer, & Verheyen, 2013). Using a case study design to observe human behavior and its relationship to business procedures, in a professional and business environment, may lead to a greater understanding of the intricacies of the participant's perceptions.

Upon review of other research designs, to include quantitative and phenomenological design, I considered the case study most appropriate to provide a complete understanding of the business practice under exploration. Ethnographic studies require a lengthy time in the field and concentrate on detail, and the narrative approach focuses on a single individual's experience (Yin, 214). Neither of which method supported the intent of the study. Case studies are a form of inquiry that do not need to depend exclusively on ethnographic or participant-observer information, as ethnographies frequently require a length of time in observation and focuses on detail (Yin, 2014). Case studies explore and analyze a particular case within an environment to provide a better understanding of the case (Pastore, Carr- Chellman, & Lohmann, 2011).

Narrative research focuses on information gathered in the field. Such as stories, autobiography, journals, letters, conversations, personal items, and memories to comprehend the way people develop meaning in their lives (Gockel, 2013). The narrative approach usually relates to lived experiences of an individual while an ethnographic study furnishes a rational approach to identifying and understanding the behavior within a particular context (Robinson, 2013). The phenomenological approach concentrates on clarification of meaning and individual lived experiences to increase knowledge of the phenomenon. The grounded theory focuses on specific social activity

that could develop new areas for future research (Finlay, 2012; Kenny & Fourie 2014; O'Reilly, Paper, & Marx, 2012). A case study was suitable for this study as opposed to other designs, such as narrative, ethnography, phenomenological, and grounded theory. The case study design was appropriate for this study, as it will provide the researcher a greater insight into the perceptions and life experiences of the study participants on LD.

Population and Sampling

A purposive sampling is appropriate to support the qualitative research design and semistructured interviews. The purposive sampling strategy will consist of screening and selecting the participants involved in executive leadership in the healthcare industry. In addition to selecting the participants, the purposive sampling strategy will support the ability to choose the suitable participant proficiency to contribute to the doctoral study. Purposive sampling consists of personnel who represent the hospital executive staff and who possess the necessary experience and expertise in their chosen field. The sample, comprised of eight CEOs, from eight different hospitals, and was selected from hospitals located within a 75 miles radius of St Petersburg, Florida. Participants had to meet the selection criteria of a minimum of five years in their position to guarantee their background and profile, which supported the research design and purpose. Data saturation is also a crucial methodological concept in the organization and content of qualitative research (Walker, 2012). The research participants were appropriate for this doctoral study as they provided the information needed. Qualifications of the interviewees for suitability were the sampling criterion for the study.

Convenience sampling consists of the selection of participants conveniently located for the researcher and, in this case, because of the specificity of the participants it will not be appropriate to use this method of sampling. Random sampling will not be suitable as a specialist group of participants is required for the study.

Ethical Research

Ethical concerns may surface on occasion during the research process. According to Yin (2014) the integrity of research is not only procedural. The principles for ethical research should include, but are not limited to, focus on the participants, stakeholders, and peers. Ethics should always be responsive to the situation and flexible throughout the research process.

A component of ethical research is to ensure all steps taken comply with the organization's policies and put in place before participant interaction. In addition, participant names were kept confidential. Walden's IRB granted approval to conduct research for this doctoral study (approval # 08-14-15-0356958). Each participant received an invitation that included an informed consent form (Appendix A) and the option to withdraw from the study. Appendices B and C addressed confidentiality, interview questions and interview protocol. One-on-one semistructured interviews are beneficial for researchers as more detailed responses can be given by participants and are a reputable source for gathering data **(**Haahr, Norlyk & Hall, 2014). In addition, all interviews were digitally recorded and transcribed verbatim for analysis.

Participants did not receive incentives other than receipt of a copy of the study's results, approved by Walden University. A locked file or safe deposit box will store all

data from each participant's interview for 5 years, per requirements of the IRB. At the end of this period, all hard and soft copies of the data will be destroyed by way of shredding for both media and documentation.

Data Collection

Data Collection Instruments

As the interviewer conducting semistructured face-to-face interviews, I served as the primary data collection instrument. The validity of the qualitative data is dependent on the ability of the interviewer to produce data focused on the topic of interest within the time allotted for discussion (Hurst et al. 2015). In addition, the credibility of the research is not only reliant on the implementation of procedures but also on the self-awareness of the researcher (Houghton, Casey, Shaw, & Murphy, 2013). According to Chenail (2011), the researcher is the key instrument in the collection of data because the interaction between participant and interviewer facilitates valuable information regarding life experience. Yin (2014) suggested the interview process (Appendix C) establishes a connection between interviewer and participant and motivates the interviewee to provide detailed answers. A qualitative researcher plays a more complex role in research, because of personal interaction with participants, compared to the quantitative researcher (Graebner, Martin & Roundy, 2012). The data collection instruments consisted of an audio tape recorder, notebooks, and writing implements. Observing mannerisms and facial expressions enhanced the resultant theming and breakdown of the data (Ioannidis et al., 2013). Because NVivo 10, is the ideal vehicle for qualitative analysis I used it to analyze audio recordings and interviews.

Finally, the notebook and pen or pencil were used to take interview notes as the interview progressed. These instruments ensured transcriptions are reliable and can be validated by the interviewees. The participants were asked to answer eight interview questions and an additional open-ended question that invites the participant to mention any other relevant matters not covered in the previous eight questions. Additional data collection sources include archival data, financial reports, and employee statistics that add to the richness of the study.

Data Collection Technique

Face-to-face, semistructured interviews with each participant provided the data, and each interview was recorded and transcribed. Interviews are an appropriate method for collecting data and establishing rapport in a case study format (Yin, 2014). The semistructured interviews were 30 – 45 minutes in length with male and female executives in the healthcare industry. Personal interviews are a method of collecting data in qualitative research **(**Haahr, Norlyk & Hall, 2014; Potter, Mills, Cawthorn, Donovan & Blazeby, 2014). The interview protocol provided a guide to the interviewee, which in this case, was a semistructured face-to-face interview method (De Ceunynck, Kusumastuti, Hannes, Janssens, & Wets, 2013). I explained the procedure to the participant to include the type of interview, the general format, and the ultimate objective. The participant was already aware of the length of the interview as described in the invitation (Appendix A) and the interview protocol outlined in Appendix C. Upon satisfaction from both parties the interview questions, previously outlined, followed a predetermined interview format, based on the findings of the literature review and my

individual experience. Alpha and numerical codes allocated to the participant, per organization and department to ensure the confidentiality of the participants. Other collection techniques also include member checking (transcript interpretation with participants).

I did not conduct a pilot study due to the size of the population for the study. It is my intent to share my interpretation of the interview with participants so each participant can critically review and suggest changes accordingly. Using secondary data such as archival data, financial reports, employee statistics, collected from the hospital administration staff, in combination with interviews provided methodological triangulation for the study (Bekhet & Zauszniewski, 2012).

Data Organization Techniques

The preparation for data organization begins before conducting interviews by ensuring that the instruments and materials perform as expected (Potter, Mills, Cawthorn, Donovan & Blazeby, 2014). Semistructured interviews provide data, gathered by way of audio recording, video recording, notebook, and pencil and are an ideal vehicle for a qualitative exploratory case study **(**Haahr, Norlyk & Hall, 2014). I tracked and organized the data of this study with the assistance of computer-assisted qualitative data analysis software (CAQDAS) designed to transcribe and analyze the data. A secure filing box in my possession contains all data, hard and soft materials, and will be destroyed after five years of the study's completion.

Data Analysis Technique

Technique

Semistructured interviews with eight CEOs, from eight different hospitals, within 75 miles of St Petersburg, Florida, furnished the information for the study. Using secondary data such as mission statements, financial reports, biographical data, employee statistics, and so forth, in combination with interviews provided methodological triangulation for the study. Triangulation adds to the richness of the research and helps establish credibility (Bekhet & Zauszniewski, 2012; Fielding, 2012). A digital record and a literal transcription of each interview served as the basis for transferring the data to the software designed to aid in the data analysis of qualitative research, as recommended by Yin (2014). The participants' responses addressed the research question of this study and the interview questions.

Analysis

Software tools correctly programmed to assist scholars are an excellent accompaniment for researchers when interviews are complete, and the data is ready for analysis. Computer-assisted qualitative data analysis software (CAQDAS) for researchers is scarcer than software used for quantitative studies (Leech & Onwuegbuzie, 2011). An example found in CAQDAS tools is that researchers can import the transcribed interview data, to include archival data, financial data, statistics (method triangulation), and transcription interpretation (member checking) into the software qualitative research analysis (Onwuegbuzie, Leech, & Collins, 2012). I uploaded all digital data and verbatim interview transcription into NVivo to analyze for

substantiation. The primary asset of these CAQDAS programs is the expectation that after performing data analysis the user has access to results.

I employed NVivo® 10, software specifically designed for analysis of qualitative data. NVivo®10 qualitative data analysis software, sorts words and phrases to develop themes, subthemes, categories, and tags using word recognition and auto-coding functions (James, 2012). Categorization of findings by theme coding ensures thorough data analysis as stated by Leech and Onwuegbuzie (2011). In essence, after gathering of all transcription interview data, member checking interpretation data, and digital data, CAQDAS tools can be used to import, analyze, and codify the data for this study to identify commonalities in the data provided by participants.

Coding

To maintain participant confidentiality, the individual names of the participants had standard initials, and the hospitals numbered. For example CEO1-10 for CEOs, H1 –H10 for the hospitals. Following the transcription stage, each transcribed interview had the participants' substitute names for upload into the selected CAQDAS (NVivo®10) tool for this study. Once the data analysis process was complete, and the thematic coding produced, the process of analyzing and answering the research question helped in recognizing the preferred strategies for creating a successful LD program.

Reliability and Validity

Validity and reliability are two elements that any qualitative researcher should be concerned about while planning a study, evaluating results and assessing the quality of the study. Quantitative researchers rely on experimental methods and empirical data to

test hypotheses. Therefore, the terms reliability and validity are usually synonymous with quantitative research (Thomas & Magilvy, 2011). Qualitative research, on the other hand, although bound by the same elements, depends more on four constructs outlined by Guba (1981). Credibility (qualitative analog to internal validity), transferability (qualitative analog to external validity/generalizability), dependability (qualitative analog to reliability), and confirmability (objectivity). The purpose of qualitative research is to obtain an understanding of a particular phenomenon by delving into the topic by way of interviews, observations and analysis of data. Thus, the four constructs described by Guba (1981) represent qualitative equivalents of the terms reliability and validity. According to Yin (2014), four tests establish the quality of case studies: construct validity, internal validity, external validity, and reliability.

Reliability

Reliability is the ability of others to repeat a study and achieve similar results (Zikmund & Babin, 2012). In the qualitative investigation, dependability is analogous to reliability. To eliminate doubt and increase credibility, maintaining consistency throughout the study is critical, from the initial stage to the conclusion (Svensson & Doumas, 2013). To keep this consistency; the interview questions are an important contribution as these are significant to assure reliability. Proper transcription of interview data is critical and, as suggested by Gordon (2012), recording of all interviews ensured the accuracy and reliability. To this end, to avoid the personal bias of participant or the researcher, the objectivity of the questions is vital.

The objective of reliability is to reduce errors and bias. A future researcher who conducts the same study and achieves similar results meets the requirements for reliability (Yin, 2014). In other words, the later researcher must repeat the same research study, and not merely replicate the results of a different study. The optimum approach to ensuring reliability is to conduct research based on the premise of a study audit that must pass inspection (Yin, 2014).

Follow up member checking interviews with the participants added to the richness of data and achievement of saturation. To achieve methodological triangulation, I collected data from multiple sources (Bekhet & Zauszniewski, 2012). To include mission statements, financial reports, employee CVs, and a demonstrated record of successful LD programs. Describing the interview protocol described in Appendix C also contributed to the rigor of the study, thus providing a clear outline and solid procedures so a fellow researcher has a complete understanding and, in principle, be able to follow the same steps to arrive at the same conclusion.

Validity

The theory of validity is to confirm the credibility and trustworthiness of the research as presented in the study (Chenail, 2011). Construct validity is the connection of research theory with the research measurements and the legitimacy within (Drost, 2011). Construct validity, reported by Yin (2014), is achieved via data collection using diverse evidence sources, such as documentation, archives, semistructured interviews, and observation. In relation to documentation, it is important that any documents used corroborate and strengthen evidence presented. I used published annual reports,

community statements, mission statements, biographical information and LD tracks to validate the data. Quantitative data that is precise creates another dimension to the study and may also provide credibility and support the research findings.

The CEOs selected for the study had expertise in the area of LD programs, thus providing the researcher with credible information to analyze data and discuss the findings. Targeting senior leaders with expert knowledge of the research problem as stated was a logical course when seeking data saturation (O'Reilly & Parker, 2012). Data saturation is a crucial methodological concept in the organization and content of qualitative research (Walker, 2012).

I discussed my interpretation of transcripts from the initial interviews with the participants. Second interviews contribute to member checking for the richness of data and achievement of saturation. To achieve methodological triangulation, I collected data from multiple sources. To include mission statements, financial reports, CEO biographical information, and a demonstrated record of successful LD programs. Interviews targeted at a particular population that, in this case, is eight CEOs, from eight different hospitals, within a 75 miles radius of St. Petersburg, FL. Interview transcriptions are essential for data analysis and clarification of findings of a case study (Gordon, 2012). The strength of these interviews is reliant upon the questions posed and the clarity of the responses. Because interviews are the mainstay of the study, it is important my questions be carefully articulated to avoid individual bias. All interviews were recorded and National Institute of Health (NIH) recommendations and ethical guidelines adhered to for protection of participants.

According to Yin (2014), internal validity is a primary concern with exploratory case studies, as a researcher is intent on clarifying a how and why event. Concluding an incorrect causal relationship threatens the validity of the study, making it crucial that I am certain to examine data from the study carefully. According to Thomas and Magilvy (2011), internal validity and credibility are similar. Each component seeks to reinforce presented data to be sure of accuracy and interpretation of human experience so that people with similar experiences can easily identify with the result.

Establishing a rapport with interviewees is critical to creating an honest and open discussion. Member checking, achieved by asking the participants to review summaries and interpretation of their transcripts for accuracy, is a primary component in qualitative studies (Thomas & Magilvy, 2011), and provides quality control for the researcher. Additionally, member-checking aids in accuracy and credibility of the recording of the participant's interview (Harper & Cole, 2012). I shared my interpretation of their interviews with each of the participants so they could critically review and share other comments if any. The interviewee confirmed either that the summaries did or did not reflect their views, feelings, and experiences. If the interviewee affirms the accuracy and completeness of researcher interpretation, then the study will achieve credibility.

The research question posed directly influences the strategies used to achieve transferability. In qualitative exploration, the extent to which a researcher's study findings have applicability in another context defines transferability (analogous to external validity) of the findings (Thomas & Magilvy, 2011). To accomplish transferability, I gave complete details as to the type of industry, geographic location,

and the population. As suggested by Guba (1981), transferability criteria could permit new researchers with an interest in LD programs, to transfer the findings into other research contexts.

Summary and Transition

In this qualitative, exploratory multiple case study, I explored the lived experiences of CEOs, who have created leadership development strategies and been involved in decision making process. I collected responses to the interview question, transcribed the interview data, uploaded the data to the qualitative analytic software program, NVivo® 10, and identified themes. Section 2 contained detailed information on (a) participants, (b) research method and design, (c) population and sampling, and (d) ethical research. I described how I implemented the data collection, data analysis, and conceptual framework to explore my participant's acumen regarding strategies and decision processes for LD programs. I categorized participants' responses into themes to identify what strategies the participants are implementing to create and maintain LD programs.

Section 3 will provide an overview of the study, discuss the presentation of the findings, applications to professional practice, and the implications for social change. It will also provide recommendations for action and further research, reflections, and the study's summary and conclusions.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative exploratory multiple case study was to explore what strategies healthcare leaders need for LD. Section 3 presents the findings, review of applications to professional practices, implications for social change, and recommendations for further study. I compared the findings and the research question to illustrate the relationship of the findings to the literature and the conceptual framework. The emergent themes derived from the data and triangulation data formed the recommendations for further study. My reflections, summary, and study conclusions complete Section 3.

Presentation of the Findings

The business problem in this research study was that some CEOs lacked strategies for LD. I conducted face-to-face interviews with eight participants. I scheduled and conducted all semistructured interviews in the private office of each participant and interviews did not last more than sixty minutes. I used a purposeful sampling method and open-ended questions. The objective of each question was to elicit pertinent information from the participants about his or her experience.

To triangulate and confirm the data from the face-to-face semistructured interviews, I reviewed LD organizational programs, financial data, mission statements, individual participants' background and experience, and other business records regarding LD strategies. Following analysis of these data, five main themes emerged:

1. Strategies CEOs used for LD

2. Environment of Care (culture, philosophy, and environment)

3. Challenges CEOs' face in implementing and maintaining LD programs.

4. Generational Leadership

5. Organizational and Employee Benefits

I imported the raw data from the interviews into NVivo® 10 for qualitative analysis. The result confirmed the five themes I identified in my manual assessment, and identified sub-themes that aligned with the literature review, namely, selection criteria, mentoring, communication, conflict management, and motivation.

The conceptual framework for this research project was the human capital theory, supported by spiritual leadership, and emotional intelligence. One hundred percent of the data received from participants supported the human capital theory, in that they believed education and training to be at the crux of LD. Assessment tools and individual statements from participants also supported spiritual leadership and emotional intelligence. The human capital theory first introduced by Schultz (1961) who believed that education and training of human beings imparted knowledge and skills that enhanced productivity and created effective leaders. Spiritual leadership derived from servant leadership, a theory first espoused by Robert Greenleaf in 1977 and championed by Louis Fry in 2003 who applied it to business management. Sweeney and Fry (2012) implied individuals high in spiritual leadership demonstrated excellent leadership skills. Emotional intelligence is the ability to harness one's emotions in a productive manner by becoming more rational and able to empathize with others (Goleman, 2006, Sadri, 2012). Within this study, I compared the frameworks with the findings to gain an in-

depth comprehension of the effectiveness of strategies, barriers, and other critical factors that influence LD programs within the organizations.

Thirteen CEOs of hospitals within the geographic region of 75 miles radius of St. Petersburg, FL received invitations and eight responded. After the eighth interview, I observed a data saturation point and realized that no new concepts and/or information were emerging. Data saturation is a crucial methodological concept in the organization and content of qualitative research (Walker, 2012). A case study research design explores, describes, and explains a business practice based on policies, protocol, and organizational processes (Hotho & Champion, 2011). A case study approach served as an effective way to explore a phenomenon in a real-life setting.

The overarching research question for the study was: What strategies do healthcare leaders use for LD?

I used face-to-face, semistructured interviews to gain an understanding of strategies the participants used to create LD programs and asked my participants the following questions:

Question 1: *How do you provide leadership training, either internally and/or externally for your employees*? The objective of this question was to ascertain from the participants whether there was an LD program in place and if so, in what format for example, internally or externally.

Question 2: *If LD is an elective activity, how do you motivate employees to participate?* Motivational factors are significant in creating successful LD

programs, and my intent for using this question was to discover the methods each participant believed to be effective in their organization.

Question 3: *What type of training (e.g. knowledge and skills) is included in your LD program?* This question aligned with question one as training is a component of LD. Table 1 illustrates types of training each participant utilized in their facility.

Question 4: *How do you accommodate generational differences in your LD program?* The objective of using this question was to ascertain from my participants whether generational cohorts influenced the LD Programs.

Question 5: *What obstacles do you face in establishing a LD program?* An important factor in creation and participation in LD and the intent of asking this question was to collect information from the participants as to their perceived challenges.

Question 6: *In your opinion, how does LD training benefit the organization?* Participants stated their opinion as to how LD programs benefitted their organization.

Question 7: *In your opinion, how does LD training benefit the employees?* Participants stated their opinion as to how LD programs benefitted their employees.

Question 8: Was the percentage of your 2014 budget devoted to LD adequate to serve your organization's needs? Why or why not? The objective of asking

this question was to ascertain from participants whether their financial allocation was sufficient for LD and training.

Question 9: *Is there any additional information you would like to share?* This question allowed participants to add any additional information they believed was pertinent to the study. No new themes emerged from the data collected from this question.

To triangulate data, I collected LD program outlines from each of the participant's facilities (Table 1), which also substantiated the themes identified in my data analysis. According to Day, Fleenor, Atwater, Sturm, and McKee (2014), the development of effective leaders and leadership behavior is a primary concern in organizations of all types. LD programs are a critical component of any organization, and 100% of participants had established an LD program within their organization.

LD Programs. Hospital 1 **(**H1) is part of a health system, which included 12 hospitals, all within 75 miles radius of St. Petersburg, FL. To be eligible for the LD program offered at H1, each employee has to meet the following criteria:

1. Receive a nomination from their immediate supervisor.
2. Complete an assessment to measure their leadership skills.

As mentioned earlier CEO1 utilized assessment tools to determine qualifications of potential leaders, and although reluctant to share all assessment models used, he did state the DISC survey was a primary instrument. CEO2 and CEO8 also stated they utilized the DISC survey in their organizations, and CEO8 stated she requested her leadership team to complete a survey annually.

There are three tracks of leadership offered within H1; (a) aspiring leader, (b) emerging leader, and (c) experienced leader track (Table 1). CEO1 believed continuous improvement and professional growth were essential components of H1's quality culture. H1's LD program aims to develop the leaders needed to fill future positions by creating a talent pipeline that begins with the aspiring leader track and continues through the assessment and development of executive leaders. H2 has two main tracks of LD: (a) Stepping with PRIDE– designed to identify individuals from diverse backgrounds who wish to grow and display leadership potential. Each candidate selected receives a broad spectrum of developmental experiences under the guidance of a mentor, (b) Competency Development for Leaders - comprised of eight modules encompassing aspects of personal and professional development.

Additional triangulation data collected pertaining to LD tracks for each facility also revealed educational and experience criteria potential leaders needed to advance through the tracks. Each CEO stated a Bachelor's-prepared candidate was required for a managerial position with a Masters or above for Director or senior executive. CEO1 stated if a candidate for development did not possess educational degrees, they had the opportunity to acquire their degree while training and H1 offered a tuition reimbursement program for those candidates.

Table 1

LD Programs per facility

Hosp.	Type	Modules	Key Audience
H1	Aspiring	Communication, managing conflict, diversity and managing change EQ assessment.	Team members who show leadership potential but have no management experience
	Emerging	coaching, managing change, and conflict, supporting strategic planning and understanding process improvement tools	Newly hired or promoted individuals who have not yet reached the position of manager.
	Experienced	Four core classes and three electives	Managers & Above
H2	SWP	Enhance self-development skills, mentoring, personalized development & education, increase system understanding, increase visibility	individuals from diverse backgrounds who display leadership skills
	Modules 1-8	Promote personal & professional leadership. Video conferencing, group work, didactic sessions, practical assignments	Supervisor or Manager
H3	GSGH	interviewing selection, hiring, procedures, and basics of finance	New Managers
	Sphere 1	Ongoing LD	Managers & Above
	Sphere 2	Understanding organizational culture	All Leaders
H4	Offsite LD	2 or 3-day retreat for periodic skills building and didactic lectures, continuing through the year.	Directors and above
	Onsite	Local version as above	Managers
	Onsite	Communication, Diversity and managing change.	Frontline employees
H5	Onsite University	Building Trust, Coaching & Developing, Critical Thinking & Decision Making, High Impact Communication, Professional development,	Managers & Above
		On-boarding, retaining staff, customer focus, building trust, critical thinking, coaching & developing others	New Leaders
H6	Level 1	Orientation: EQ assessment, fundamental approach to leadership, illustrate techniques to influence behavioral change, Practice skills, customer service	Supervisor or Manager
	Level 2	Influence	Manager & Above
	Level 3	Strategic	Manager & Above
H7	Offsite LD	Structured program - work with mentor, team building skills, and LD	Directors and above
	Onsite	Continuing LD, Mentoring, ongoing crucial conversations, how to develop a strong team	Supervisor or Manager
H8	Onsite meeting	LD - conflict management, customer service, communication, mentoring	Managers & Above
	Quarterly Corporate	Webinars, unified training across the network	Managers & Above

Source: LD program information supplied by participants and executive staff at member checking conferences.

Demographic Characteristics of the Participants

To triangulate data, I collected biographical data on each of my participants (Table 2). CEO1 has served seven years in his present position, with a total of 25 years in senior leadership roles. CEO2 has served three years in her current organization and has been a senior leader for a total of 16 years. CEO3 has served 22 years as a senior leader, her last 8 years at Hospital 3 (H3). CEO4 has served as president in Hospital 4 (H4) for three years, having joined H4 as senior director four years previously. CEO4 has a total of 16 years in senior leadership positions. CEO5 has served as CEO of Hospital 5 (H5) for 22 years. CEO6 has served a total of 25 years in senior leadership and joined Hospital 6 (H6) 13 years ago. CEO7 has served in her present position for four years, having served a total of 32 years in senior leadership positions. CEO8 has served in her current position for three years and has a total tenure of 11 years in senior leadership. Table 2 graphically illustrates the cumulative total and the percentage of employees who participate in LD programs each year, and Figure 1 illustrates the gender classifications of the participants.

Table 2

Demographic Characteristics of Study Participants

	Gender	Exp. (years)	No. emp.	Annual participants	%
CEO1	Male	22	1500	75	5
CEO2	Female	16	3800	190	5
CEO3	Female	25	500	30	6
CEO4	Male	16	3160	160	5
CEO5	Male	22	1800	90	5
CEO6	Male	25	2000	100	5
CEO7	Female	32	700	50	7
CEO8	Female	11	325	25	8

Source: Biographies and employee information received from human resource personnel

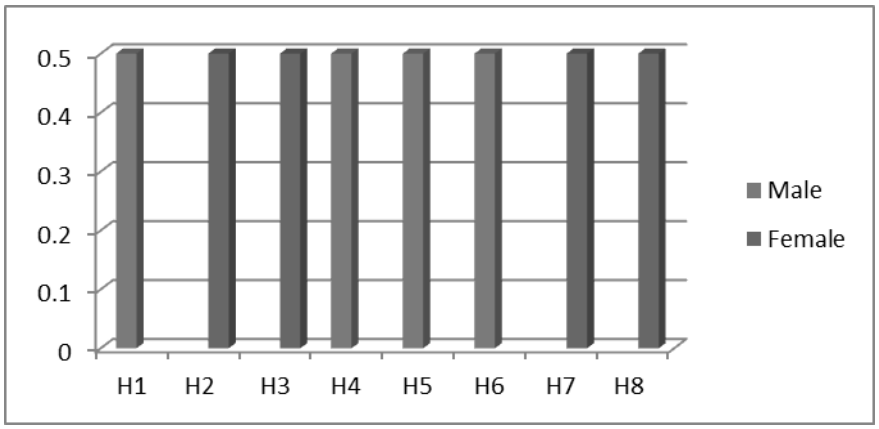

Figure 1: Gender classification of study participants

Emergent Theme 1: Strategies CEOs Use for LD

The first main theme as previously stated is strategies CEOs leaders use for LD programs. According to McDonagh and Paris (2012), LD programs are essential to the constantly evolving industry of healthcare. Participant responses to interview questions number one, two, and three indicated the basic strategies leaders used by CEOs. Within the first main theme, there are five sub-themes as identified through participant responses, within company records, and then confirmed by current research: (a)

selection criteria, (b) mentoring, (c) communication, (d) conflict management, and (e) motivation.

Questions 1, 2, and 3 concentrated on strategies each of the CEOs used in their facilities and discussed how CEOs motivated employees to participate in such programs. The participants from the interviews produced factors that helped determine the strategies healthcare leaders used to create effective LD programs. Although each of the CEOs was guided by corporate mandates and had standardized LD programs established within their organization (Table 1), each CEO had developed internal strategies to ensure participation by employees in their LD programs.

Question 1: *How do you provide leadership training, either internally and/or externally for your employees*?

Internal training was dominant in the organizations (96%), with the remaining 4% incorporating training from corporate headquarters located out of the State of Florida. A network of hospitals throughout the country guides each of the hospitals who participated in my study and corporate offices continues to mandate programs throughout the network. Each of the CEOs abides by corporate regulations, procedures, protocols, and so forth. However, each organization has the flexibility to adapt the programs to align with the unique culture/environment of the organization, the intent being to complement the corporate requirement. CEO1 stated his personal philosophy guided the LD programs within his hospital and stated he had no difficulty remaining in compliance with corporate guidelines.

As a supplement to internal training and geared to the objectives of each organization 100% of the participants have a Web-based management system (WBMS) in their organizations. A WBMS is an online education resource that allows educational officers within the facilities to design and develop courses for their employees. Orientation modules, development modules, and regulatory training are all included. CEO1 claimed there had been an enormous shift from face-to-face education to computer-based online learning, and although he preferred the former, he understood the necessity of a flexible learning structure. CEO3 stated she had a chief learning officer who is an expert in WBMS and designs educational programs for her staff. H2, H4, H5, H7, and H8 employed human resources personnel to accommodate the staff and monitor the compliance of employees.

Selection criteria. Three of the participants (37.5%) stated that they used assessment tools as part of the selection criteria. CEO1 did state that the DISC survey was a primary instrument. DISC is a behavior assessment tool based on the DISC theory of psychologist William Moulton Marston (1964), which focuses on four different behavioral traits: dominance, inducement, submission, and compliance (DISC). CEO2 and CEO8 also stated they utilized the DISC survey in their organizations, and CEO8 stated she requested her leadership team to complete a survey annually. According to Gray (2014), there are several assessment tools available to senior leaders and each is dependent upon the type of organization. Gray stated assessments are the first step in developing LD initiatives within any organization.

CEO1 stated his leadership team was primarily responsible for selecting candidates for LD. He did, however, occasionally observes employees in the hallways and often suggested an employee who displayed skills to the unit leaders. He stated an employee who helped a patient or visitor, or did not ignore trash in the hall is worthy of consideration for development. Those individuals considered for recruitment who displayed traits such as helping others, problem-solving, and a positive attitude had priority. Sweeney and Fry (2012) suggested individuals who possessed high levels of spiritual leadership are excellent leaders; this surmization is aligned with the research and conceptual framework. An opinion supported by CEO8, who suggested she selected candidates based on her personal observation and believed spiritual leadership was an important trait for potential leaders. CEO6 stated the traits of a bad leader were easily identifiable, and he believed that one could learn as much by observing poor leaders as opposed to those leaders displaying strong leadership traits. CEO7 believed there were certain innate skills, such as confidence and assertiveness that were inherent and she looks for those skills in employees for LD.

Mentoring. Mentoring, a collaborative approach between experienced senior leaders and subordinates creates a learning environment for both parties. San Miguel and Kim (2015) believed minority populations, to include women and ethnic groups, would benefit from a mentor/mentee relationship. The strategic direction of the organization, understanding of employee accountability, and the sharing of knowledge creates an alignment between the organization and their employees (Tahir, Said, Daud, Vazhathodi & Khan, 2015). Of course, the success of a mentoring program is dependent upon the

leadership skills of the mentors, thus reinforcing the case for LD programs within organizations.

The female CEOs (2, 3, 7, and 8) had formal mentoring included in their LD programs, in comparison to the male CEOs. Who, although they agreed a mentor promoted individual learning, their LD programs did not formalize mentoring. CEO2 considered mentoring a crucial component of leadership training and had a formalized program where any level of an employee could attend coaching and mentoring training to become a coach or mentor. The employee registers with an online educational program specific to coaching and mentoring to track their progress. Once an employee has completed 25 hours of training, they qualify as a resident in coaching and mentoring. An employee qualifies as a fellow after 50 hours, which credentials and certifies that employee. CEO2 added that the H2 health system has a national program Graduate Health Administration Training Program (GHAT), and she is a preceptor in that program. For instance, an individual enrolled in a Masters in Health Administration or similar field can intern in H2 for one year and CEO2 coaches that individual.

CEO8 stated if a front line employee approaches her with a request to shadow her for a period, she is willing to accommodate the request and encourages mentoring in her leadership team. CEO7 included a mentoring program in her onsite continuing LD programs and believed it to be an essential element of the program. CEO3 encouraged mentoring in her facility and had an open-door policy for all of her employees. Of the male CEOs, CEO5 personally mentored employees and stated education is becoming a

priority in the H5 system as the changing environment of healthcare has created the need for knowledgeable leaders (McAlearney, 2010).

Communication. Communication is a key component of the LD tracks as illustrated in Table 1. CEO1 stated technology had transformed communication in the workplace; texting and messages notified team members instantly of meetings or emergencies. He stated it used to be time-consuming to contact team members to determine their availability for a late weekend shift, involving a base coordinator calling each person. Team members now receive group texts and can respond instantaneously, thus improving efficiency and reducing downtime. CEO4 also believed technology was influencing communication. CEO7 and CEO8 emphasized the need for efficient communications, using modules in their leadership track to address crucial conversations, peer-to-peer conversations, and basic managerial training to include presentational skills and team building. According to Grandy and Holton (2013), informal and formal communications play a critical role in LD programs. Figure 2 illustrates how communication influences organizational behavior and is crucial for successful LD programs.

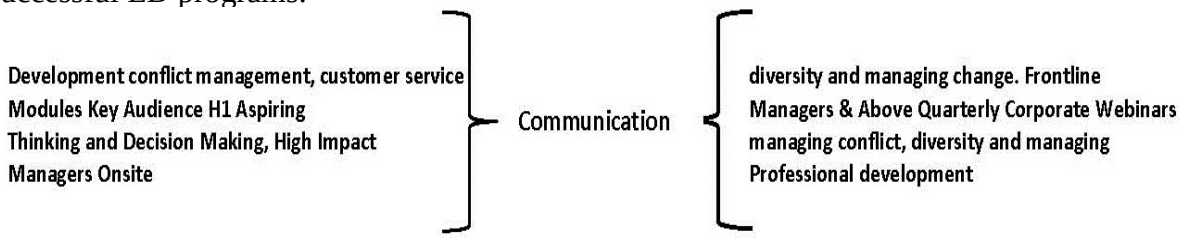

Figure 2. Components of LD influenced by communication.

Conflict management. A component of LD training is dealing with conflict, and each of the tracks outlined in Table 1 indicates conflict management and effective

communication as essential elements of the training. Multidisciplinary teams working together, each of whom with a different personality and different style, will eventually lead to conflict within the group. Therefore, training in conflict management is essential for a team. Individuals high in emotional intelligence tend to have strong communication skills, which align with the literature, and according to Batool (2013), those leaders can manage conflict more effectively. According to Grandy and Holton (2013), before LD can be effective, managers need to have the skills and knowledge, to include conflict management, to perform an assortment of management tasks.

Each participant in my study agreed conflict management must be a component of basic leadership training. CEO2 stated that conflict management training went hand in hand with understanding one's personality and individual leadership style, which aligns with the conceptual framework. CEO8 stated communication and conflict management were included in her ongoing LD.

Question 2*: If LD is an elective activity, how do you motivate employees to participate?*

Motivation. Motivation is an essential component of LD strategy, for without the commitment and the desire of the employees to become a leader, LD programs are pointless. Most leaders believe that employee motivation has a direct correlation with employee performance and commitment (Vallerand, 2012). Each of the participants concurred with this opinion and had their unique way of motivating their employees.

CEO1 expected his leaders to complete the LD program within his facility, regardless of their stature. He firmly believed that all employees needed to participate in LD, to advance within the organization. As mentioned earlier CEO1 utilized assessment

tools to determine strengths or weaknesses of aspiring leaders. Assessments include, but are not limited to, leadership skills, individual personality style, and traits. The healthcare industry, according to CEO1, because of the sheer nature of the industry, comprised individuals who were passionate and as such, emotional intelligence was included in assessments. This supposition aligned with the conceptual framework and literature review as denoted by Goleman (2006) and Sadri (2012).

CEO1 believed that individual assessments provided H1 senior leaders a priority list of classes that matched individual needs of the aspiring leader. He also stated there is a core management of classes that every manager has to take, illustrated in Table 1. CEO2 believed that leaders who had participated in LD programs provided motivation to other employees within the organization by word of mouth and sharing of knowledge. Participants were encouraged to thank their team members for being readily available to take on extra responsibility while he or she was part of an LD program.

Although leaders strive for continuous growth, some leaders fail to recognize that individuals also strive for continuous personal growth (Chamberlin, 2010). Additionally, Chamberlin believed growth and development of individuals create motivation in the workforce. Competent leadership may close the gap between employee motivation and job performance by initiating strategies that enhance human capital, thus aligning with the literature review and conceptual framework. Each participant's primary focus is on quality patient care, community involvement, and corporate accountability. Triangulated data, which includes individual facility mission statements, provides the impetus to implement programs and incentives. In conclusion, the

participants stated their LD programs closely aligned with the mission and values of each facility.

Annual performance evaluations also allowed employees to share their goals with their leaders. Each of the participants stated assessments and evaluations were mandatory within their organizations. In addition, CEO3 stated each employee in H3 had a mid-year development conversation that supplemented the annual evaluation. CEO3 believed allowing employees to discuss their aspirations with direct leaders, not only reinforced relationships but also reduced turnover with staff. Da Silva and Shinyashiki (2014) noted that annual appraisals are critical to building relationships and retaining staff.

Emergent Theme 2: Environment of Care (culture, philosophy, environment)

Healthcare personnel have a common goal, and that is patient care. Each of the participants shared these suppositions and responses were consistent with a shared culture across facilities. This similarity suggests the education and training programs referenced by the participants were successful in creating a cultural understanding in each organization. McAlearney (2010) stated the healthcare environment is evolving rapidly, and it is vital that quality of care does not suffer. As supported in the literature review, a new age of patient-focused care is forcing leaders to increase training with the intent of reducing healthcare incongruences (Dotson, & Nuru-Jeter, 2012). A significant element of patient care is establishing an environment that supports a workforce that is diverse and multi-cultural. Therefore, it is critical the environment of care is a component of LD in a healthcare organization. Each of the CEOs stressed the

importance of culture and environment (Table 3) within their facility, which they believed formed the basis for LD.

Mission statements and promotional information collected from managerial personnel emphasized the importance of the environment of care in each of the facilities. CEO7 believed a healthy leader creates a distinctive culture in their individual unit that contributes to the overall culture of the organization. CEO1 firmly believed that employees who did not understand the culture and philosophy of H1 would not advance and may not remain with the organization. CEO2 stated culture, quality and environment were crucial elements within H2 (Table 3). According to CEO1, financials is not an outcome because H1's philosophy focuses on quality and supporting the culture and environment. Creating effective LD programs not only enable aspiring leaders to explore their full potential but also enhance the culture in the organization (Coget, 2011). H1 stated an aspiring leader who was already familiar with the internal workings of the organization and understood the philosophy and culture of the system would find it easier to transition into a leadership position.

CEO2 and CEO3 agreed the mission and values of the facility created a desire in their employees to advance within the organization, thus promoting active participation in LD programs. CEO7 believed employees received inspiration from the culture and environment of the organization and her personal investment in her employees. According to Chamberlin (2010), organizational culture, job type, and reward systems for motivating employees affect individual performance. Table 3 illustrates the importance of culture, environment, and philosophy in each facility.

Table 3

Environment of Care: Participants' Themes and Supporting Statements

Theme	Participants' supporting statements
Culture	It's important me that you understand my culture as much as I understand you are a good leader (CEO1).
	But it's more important that culturally I can train you in all the business pieces but if you don't have my culture, I don't have a chance (CEO2)
Environment	We have here a healthy work environment that they can create that people in their departments feel comfortable coming to them with issues (CEO7)
	That also gets out to the community; it gets out to the environment that if you are part of our system, you are part of something (CEO1)
Philosophy	All of our LD is based on our quality philosophy (CEO1)
	I had to put my leadership philosophy in place which is tied to the corporate leadership philosophy… (CEO2)

Emergent Theme 3: Challenges CEOs face in LD Programs

The changing environment of healthcare creates a constant challenge for hospitals who are striving to be fruitful and profitable. MacPhee, Chang, Lee, and Spiri (2013), stated the expanding health community requires competent leaders. The need for effective leaders is prevalent within the industry, and the participants mirrored these concerns. The healthcare workplace continues to confront a variety of challenges from regulatory compliance to establishing multidisciplinary teams as denoted by MacPhee et al. (2013). Jarvis, Gulati, McCririck, and Simpson (2013) stated creating an effective LD program could cause tension for leaders, creating a snowball effect for subordinates, and lowering morale. Therefore, organizations need to commit to the strategic development

of team members' knowledge and skill base, to keep up with the fast-paced environment.

CEO1 stated the biggest challenge is time in that a new manager who is trying to familiarize themselves with their department and become accustomed to their new position is reluctant to attend LD training. Ongoing LD is a requirement in H1 and often managers are resistant to attend the courses stating they do not have the time. CEO8 concurred with CEO1 that resistance was a challenge and believed all leaders must be committed and accountable for the LD program to succeed. CEO1 added another challenge he encountered was keeping employees engaged in the program. An internal promotion was a smoother transition as the aspiring leader was already familiar with the internal workings of the organization and understood the philosophy and culture of the system. However, dealing with new leaders who believed they already possessed the necessary skills to be a successful leader was problematic.

CEO5 stated that time is a primary challenge for LD but is hopeful online training will mitigate this factor, allowing leaders to concentrate on day-to-day operations. CEO4 stated time is a factor not only for the employee but also for the leader, who has to commit to the program. In addition to the time constraint, CEO3 commented on the influence health reform is having on all health systems in unique ways, particularly LD. She believed the traditional training that has governed LD might diminish in future.

According to CEO3 innovation and creativity has increased since 2013 and leadership demands are changing, and she believed healthcare facilities would need to

restructure and evolve. She stated a challenge arises from employee inertia as change is inevitable and keeping employees engaged is critical. According to Ladegard, and Gjerde, (2014) establishing trust with subordinates is essential, as trust enables engagement of employees. Because committed individuals look for the next opportunity to improve and be solution orientated for their staff, for their departments for themselves. H3 disseminates an annual employee survey, which CEO3 believes monitors the engagement level of the employees.

CEO3 believed the healthcare industry had apathy toward LD. The energy and focus of clinical staff remain in the critical care areas, such as emergency, intensive care or the operating room, and it is difficult to establish an LD program that clinical leaders do not consider urgent. Her challenge is how to make LD a priority in her organization and remain competitive. CEO7 stated in addition to time; LD programs are not only an investment in individuals but also a financial investment, and as a senior leader, she has to be cognizant of this. CEO2 stated that LD was ingrained in the culture of the organization and leaders understood the necessity of continued learning. As previously mentioned, CEO2 believed employee communication was the key to a successful LD program.

CEOs of an organization have a tremendous influence upon their employees, which can lead to the success of failure of an LD program. According to Carmeli, Tishler and Edmondson (2012), it is equally as important to learn from failure as it is from success. Carmeli et al. suggested that leaders who engage in the process of learning from failures (direct experiences) have a tendency to make superior quality strategic

decisions compared to those leaders who do not. Table 4 illustrates examples of supporting statements from my participants relating to this theme.

Table 4

Challenges Leaders Face When Establishing LD Programs

Theme	Participants' supporting statements
Challenges in establishing an LD program	Time, time, time, only time (CEO2).
	It's really getting everyone in a room taking them away from their job and devoting that time to actually giving them leadership training (CEO3).
	Probably the biggest challenge is that in particular a new manager is really really busy ... I'm telling them that once a month they go to a class all day, and it makes it a little more challenging (CEO1).
	Constantly trying to balance that to make sure that we're supporting and developing our leaders and being mindful, and sometimes it's being too busy (CEO7).

The challenges faced by the participants of my study align with my research and literature review. Dotson and Nuru-Jeter (2012) stated that altering demographics of the healthcare workforce, an expanding global economy and consumer needs force organizations to embrace a multidisciplinary talent pool, especially if they plan to remain competitive. According to Jarvis, Gulati, McCririck, and Simpson (2013) creating a LD program within an organization can cause tension for the business leaders. Carefully constructed LD programs may mitigate tension in the upper echelon of leadership, thus supporting the problem as stated.

Each of the participants is guided by corporate mandates and had LD programs in place, which they believed to be adequate for the organizational needs. However, time constraints, employee engagement, and individual investment were challenges each of them faced. According to Kaiser and Curphy (2013), LD is a significant business, costing industries billions of dollars and Kaiser et al. believed there was insufficient evidence to determine, if, in fact, LD programs are a worthy investment. It would behoove senior leaders to monitor these programs, and additional research on the success or failure of LD programs may be warranted.

Question 8: *Was the percentage of your 2014 budget devoted to LD adequate to serve your organization's needs? Why or why not?*

Financial constraints usually govern organizational programs, and senior leaders have to be cognizant of these limitations when strategizing LD programs. According to West, Ramirez & Bernardo (2012) senior healthcare leaders are faced with the daunting task of not only addressing financial challenges but also improving leadership capacity to address the complexities of the modern health system and constant changes that are occurring as a result of innovation and protocols. It would appear, however, each of the participants was not concerned with budget allocations. CEO1 commented that the expenditure for LD was minor in comparison to their overall budget. He believed the budget amount to be approximately a quarter of a billion dollars, and if educational expenses were a million dollars, that is less than quarter of a percent of the overall budget. He stated the payoff for LD was substantial, and expenses have reduced, as well as turnover in the organization, since initiation of LD programs. According to CEO1,

financials is not an outcome because H1's philosophy focuses on quality and supporting the culture and environment.

CEO5 stated there is not a specific line item for LD; H5 has an education unit, and each department has monies allocated to them. He believed funding was adequate and stated H5 has invested more in leadership education since 2010. He stated that education and training had become more of a priority within the organization.

CEO4 stated LD was essential in their organization and although one had to be cognizant of financial expenditure. He believed, based on the size of their budget, that funding was adequate for training and development of leaders. CEO3 stated H3 had a corporate allocation of monies for LD, and she did not know what that allocation was, suffice to say funding was always available for their programs. I researched financial data for each of the hospitals, using data from their corporate office websites and published annual reports. Table 5 is a listing of 2014 budget for each of the organization with a calculation of education spending based on their comments.

In conclusion and in response to question eight as to whether the participants believed their allocation of funds in 2014 was sufficient for their needs, 100% stated yes. Each of them stated the education budget allocated to their organization included LD, tuition reimbursement, and education hours paid to employees, speculating the costs were approximately a quarter-percent of their total allocation.

Table 5

Financial Data per Facility

Facility	Budget (millions)	Education budget (approx.)
H1	10	2.5
H2	6.5	1.625
H3	3.4	0.85
H4	4.5	1.125
H5	4.5	1.125
H6	8.1	2.025
H7	37	9.25
H8	4.9	1.225

Source: Annual financial reports issued by each facility, acquired through corporate search.

In essence, each of the CEOs had little interest in budget or finances and perhaps addressing this question to financial officers within the organization would have presented conflicting information. I recommend future research on financial implications of budgetary constraints for development and training.

Emergent Theme 4: Generational Leadership

As mentioned by CEO8 and according to Taylor and Stein (2014), in 2015 four generations are collaborating in the workforce: traditionals (1925-1942), baby boomers (1943-1960), Generation X (1961-1981), and Millenials (1981-2002). The healthcare industry is not exclusive in that the workforce is extremely diverse with several generations interrelating in a leading or subordinate capacity. According to Gentry, Griggs, Deal and Mondore (2011), various traits and allegiances are uniform in

generational cohorts and each generation is unique. Each cohort is sharing birth years, similar life experiences, traditional values, and shared historical and social environment. Such similarities are influencing individuals in their personal and business lives. Salahuddin (2011) believed generational disparities influenced LD and organizational success. Thus, understanding these cohorts and developing an LD program for aspiring leaders, whether they are Traditionals, Millenials, Generation X or Baby Boomers, is beneficial to healthcare leaders.

CEO7 believed it was important to understand those generational cohorts as she stated each generation had a unique perspective on LD. Therefore, reward and recognition programs geared to the generational leader were an essential component of the program. CEO1 stated he never considered generational cohorts in his LD program. Because leadership is cross-generational and employees comprised of all generations a good leader has to possess the same core competencies, regardless of age or culture. He stated generational training was not a component of H1 LD programs. However, he is cognizant of the individual skill sets and the assessment tools utilized in H1 identifies those characteristics and what type of training is needed, as he mentioned earlier. His perception of generational differences is guided by technology and his assumption of generations. He believed it was the responsibility of his leadership team to recognize the strengths and weaknesses of their subordinates and lead accordingly.

CEO5 stated the vice president in human resources had been encouraging H5 to make accommodations for generational disparities in the workforce. He stated the most dramatic change he had encountered in the new generation of workers was their desire to

move on quickly in their careers, and he believed younger generations (Millennials and Generation X) no longer wanted to remain in a position for 35 years.

One hundred percent of the participants did not make accommodation for generational age differences in their LD programs. CEO4 stated generational age differences, did not influence him as his senior leadership team was mature individuals. However, he did have a sense of the difference in generations and agreed with CEO1 that the responsibility lay with his leadership team to accommodate each generational cohort.

CEO3 believed there was a need for leaders to understand generational cohorts from the perspective of values, work ethics, and loyalty. For instance, in 2016 H3 plans to bring together people whom, although geographically dispersed, share something in common of importance and interest. CEO3 stated that one of the first topics would focus on early careerists to determine their goals and aspirations. The group will comprise of those individuals early in their career who want to be part of a network within the health system. Peer discussions help promote collaboration and problem solving. There also may be topics related to generational interests. CEO3 believed these group conferences would promote diversity, address generational gaps and create new leaders within the system.

CEO5 believed that the H5 LD programs focused on individual learners, not their generational group. He stated he did not give generational training priority in the LD program. He believed each person had their aspirations, and those aspirations were the driving force behind their desire to become a leader, not their generation. CEO2

stated that the teams formed in their facility are not self-identified; the organization seeks to establish multi-disciplinary teams that contain a diverse group of people providing an opportunity for a high functioning team.

The female CEOs (2, 3, 7 & 8) were more open to understanding the generational cohorts in the workforce, in contrast to the male CEOs who did not believe generational disparities had a significant influence on leadership. Despite their recognition of the need to study generational leadership, however, only one of the female CEOs (3) had a concrete plan to include generational discussions in her training program. CEO2 stated generational discussions occurred in her senior leadership team, usually centered on diversity and generational similarities but were not a component of the formal LD program. CEO7 believed there was a need for additional training in generational understanding.

Table 6

Theme and Participants' Supporting Statements

Theme	Participants' supporting statements
Generational leadership	Boy, this something our vice president in human resources has been really educating us on (CEO6). I mean it's a topic of how to manage millennials as compared to boomers, but I don't know if we spend a lot of time (CEO3). I still think that no matter what generation you come from, you are an individual, and you have to focus on that individual of what makes them work (CEO 5).

Emergent Theme 5: Benefits of Leadership Development

The purpose of this study was to explore LD programs within healthcare facilities, specifically hospitals, with the intent of determining strategies CEOs use within their organizations. Questions six and seven focused on the benefits to the organization and the employees. According to Dahinten et al. (2014), LD programs empower employees and increase the perception of organization support and commitment. Thus, an empowered employee is inclined to remain with the organization, reducing turnover and ultimately increasing profitability. As previously discussed, the challenges of LD center primarily on individuals, one CEO (7) mentioned financial investment but did not consider it a primary challenge to LD.

CEO1 believed LD keeps everyone moving in the same direction, aligning individual goals with that of the organization. He believed teaching individuals to function at higher levels ultimately benefits the organization. The main advantage of LD programs is that it develops individuals for the future, and it keeps the organization on

track. Additionally, it prepares the organization for the future and succession planning that accompanies LD ensures a smooth transition from one leader to the next. His opinion is in line with the conceptual framework and literature review and within the constructs of the human capital theory.

According to CEO2 and CEO4, an organization will stagnate without innovative and competent leaders. Biggs, Brough, and Barbour (2014) stated LD programs improve employee attitude and reduce financial costs associated with employee turnover. CEO3 stated long-term investment in LD creates skillful leaders who are more creative and can engage their staff in a more sustained way. CEO6 stated strong leadership in an organization benefits everyone; employees enjoy their job, have better direction and understand the company expectations. Also, CEO2 stated leadership training supports the future direction regardless of position in the organization it is important and value added to the mission. According to CEO7, the majority of employees will leave or stay in an organization, or any industry based on their relationship with their direct supervisor. A successful leader promotes loyalty and reduces turnover, an opinion shared with CEO6. Table 7 illustrates the theme of benefits and supporting statements of LD for organization and employee. Figures 4 and 5 are images from LD Handbooks collected from human resources personnel.

Table 7

Benefits of LD, and Participants' Supporting Statements

Theme	Participants' supporting statements
Benefits of LD	It develops people for the future, and it keeps the organization on the path (CEO5) Well, Number 1 you cannot function unless you have leaders,… you will not have a great organization (CEO4) Consistency If you are working for one manager and you decide to go to another department... the management may be different, but they have a consistent philosophy (CEO1). "The more I can have effective leaders ... the better leaders they can be and the better chance I have of retaining good employees (CEO7) Investment over time in helping leaders be more balanced, less reactionary and more creative (CEO3)

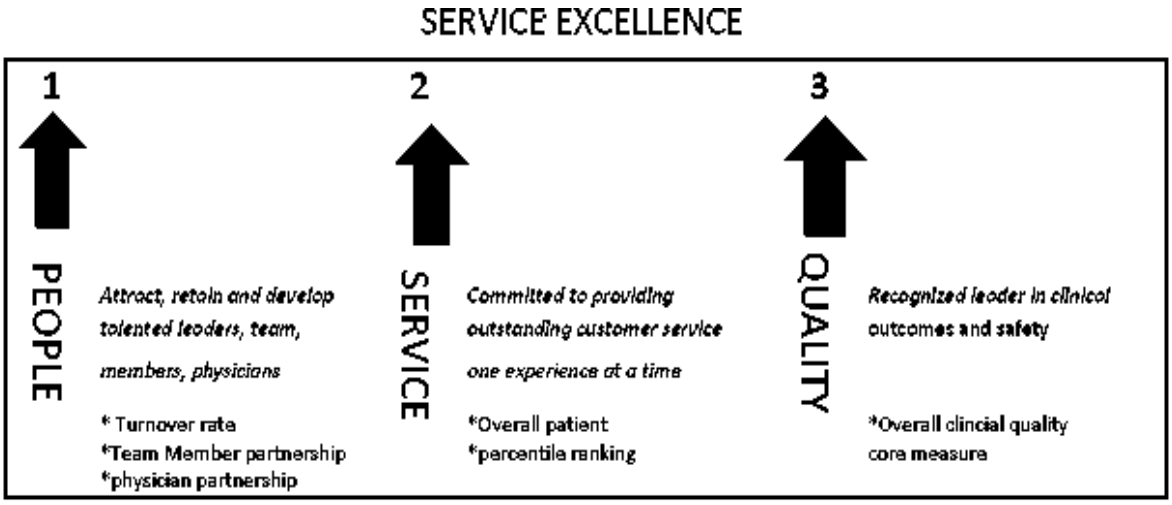

Figure 3. Tenets of LD from LD Handbook © SM.

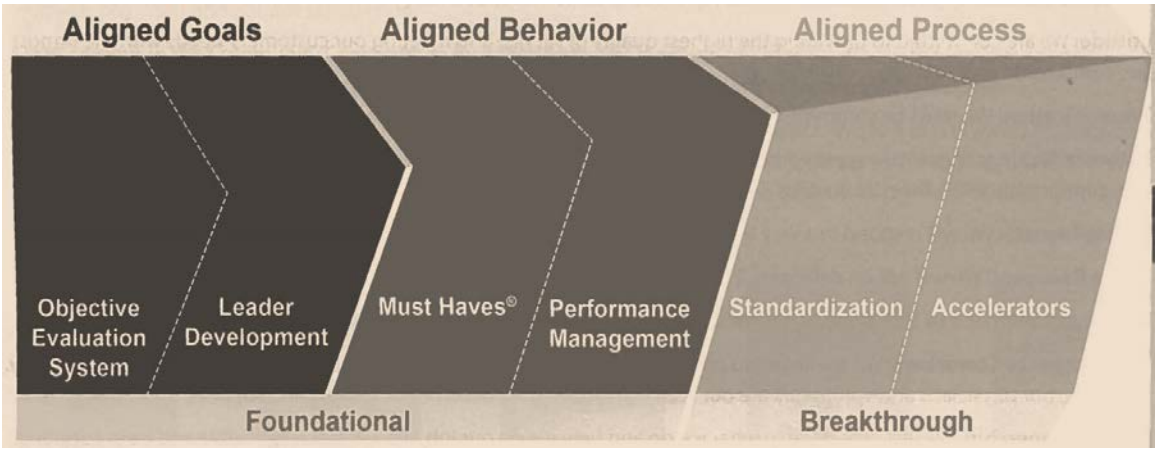

*Figure 4***.** Second Image from LD Handbook alignment goals of LD © SM.

As previously described, each of the facilities has leadership tracks designed to improve leadership and more importantly, as noted by all participants, reduce turnover. These findings confirm previous research (da Silva, & Shinyashiki, 2014). CEO6 stated that lack of a solid leadership structure produces a high turnover of staff and believed that employees usually left their employment because of bad leadership. CEO3 believed bad leadership resulted from apathy and reluctance to change, thus leading to repetition of unhealthy business practices, CEOs 7 and 8 reiterated this opinion. Mahdinezhad Suandi, Bin, Silong, and Omar (2013) speculated that lack of effective leadership causes organizations to falter. Organizations with effective leaders tend to innovate, creatively address challenges and promote high performance from employees.

Conclusion

The consensus of all participants is that LD benefits both the organization and the employees, in terms of employee empowerment, organization profitability, and equilibrium of leadership. Lack of employee engagement, compensation and

opportunities for improvement are factors that influence turnover and affect profits (Bottger & Barsoux, 2012; Tienari, Meriläinen, Holgersson & Bendl, 2013). According to Murphy and Johnson (2011), developing leaders and leadership capacity is crucial to organizations. Daniels et al. (2013) believed an LD program was an important tool for senior leaders to promote sustainable organizational change.

Summary of Findings

The findings of this study demonstrate that LD programs are an essential component of organizational success. Each of the participants had LD programs in place they believed to be successful. CEO1 reported a reduction of turnover in H1 since the initiation of a standardized LD program within his organization, each of the CEOs interviewed by me echoed this sentiment. The conceptual frameworks and research closely aligned with the findings. The healthcare industry is a service industry, focused on quality of care, and as such, leaders that display high emotional intelligence and spiritual leadership excel in the industry. As the findings support training and education of potential leaders, the human capital theory is also pertinent to the research study.

Applications to Professional Practice

This research is meaningful to business practice and indicated LD programs contribute to increased profitability, (as highlighted in Emergent Theme: Benefits of LD) better leaders, stronger communication, and longevity of organizations. Creating effective LD programs not only enable aspiring leaders to explore their full potential but also enhance the culture in the organization (Coget, 2011). Despite the changes in

healthcare reform and external pressures within the healthcare industry, each of the CEOs had maintained consistent LD programs.

Lack of employee engagement, compensation and opportunities for improvement are factors that influence turnover and affect profits (Bottger & Barsoux, 2012; Tienari, Meriläinen, Holgersson & Bendl, 2013). Organizations must recognize that employees are their main asset and cannot afford to lose key performers (da Silva & Shinyashiki 2014). LD programs offer employees the opportunity to advance within their environment, thus, as stated earlier, subsequently reducing turnover.

Healthcare leaders can implement LD programs to achieve a desirable employee outcome. Therefore, it behooves senior leaders to create successful LD programs for employees. The identification of strategies in this study (Table 1) and substantiated by participants illustrate the importance of LD programs. Evaluation programs, motivational factors, mission statements, and value-based programs are strategies implemented within the hospitals and included in this research study.

Healthcare leaders can apply strategies as explored in this research study to implement successful programs within their facility, and open the door to effective communication with their senior leadership teams. As noted by Latham (2014) environmental pressures force business leaders to look at a strong leadership structure to maintain their competitive edge and LD programs can fill the gap. As senior leaders understand the strategies as discussed, the results of the study may aid leaders in developing effective LD programs, which in turn, will retain key professionals within their organizations.

Implications for Social Change

The study may contribute to positive social change in any health systems organization. Providing strategies to senior leaders to attract and retain top executives are important for all organizations. Leaders of the healthcare industry will be better equipped to advance employees into the upper echelon of leadership. The adaptation of the strategies as discussed in the study may also affect social change by influencing healthcare leaders to build a more sustainable and valuable workforce, promoting company profitability and increasing their competitive edge.

Moreover, LD strategies may have a positive effect on the healthcare industry. Investment in human capital creates in the workforce an indispensable skill-base, which in turn stimulates economic growth (Becker, 1993). Human capital stem from any program able to raise individual worker productivity, such as training, education or LD (Ployhart, Nyberg, Reilly & Maltarich, 2014). Researchers could utilize the finding of the study to develop a greater understanding of LD strategies employed in the healthcare industry.

Recommendations for Action

Senior leaders may consider evaluating their strategies against those listed in the first main theme, which are strategies all companies can use to create LD programs. As discussed earlier senior executives need to begin exploring LD strategies to maintain profitability, sustainability, and reduce turnover. If strategies do not exist within the company, managers and supervisors are tasked with developing individual goals within their units, thus creating downtime that affects the overall performance of the

organization. If CEOs decide to implement LD programs within their facility, they should also work with human resources personnel and their leadership team to ensure LD strategies aligns with the objectives of the healthcare system. Senior leaders should also consider the fiscal budget and then allocate funding to support LD strategies.

Findings from this study are important to CEOs, senior leaders, and front-line staff. The application of successful LD programs will benefit not only the organization but also employees and the industry. Moreover, all company stakeholders involved in creating a leadership team form the future profitability of the organization. Understanding the result of this study may be particularly benefitting to the healthcare industry CEOs by revealing the strategies that companies leaders may have in place to create successful leaders and reduce turnover. I will disseminate the results of the study through conferences, scholarly journals, and business journals. Furthermore, I may circulate the findings of this study by way of training and informational seminars regarding LD strategies senior leaders need for training and developing future leaders.

Recommendations for Further Research

The findings from this study warrant additional exploration of LD strategies. Irrespective of the industry, senior leaders need to implement strategies that improve leadership and strengthen their competitive edge. Therefore, researchers should conduct further studies to explore problems not covered in the study and to address delimitations. Also, since this study focused on a particular geographical area (75 miles from St. Petersburg, FL) I recommend exploring LD strategies CEOs need to implement within a different geographic location. I further recommend exploration of LD strategies that

organizations need with a larger sample size or larger organization. Healthcare facilities consist of many specializations, to include private facilities, not-for-profit, and for-profit organizations, and I would suggest conducting a study to compare LD strategies within these types of facilities. A comparison between these business types could reveal strategies more appropriate for the budget allocation and operations for each affiliation.

The findings of this study warrant further exploration to examine strategies related to generational leadership. Each participant stated a strategy to train leaders to understand the generational cohorts did not exist in their LD programs. Thus, concentrating on generational influences on LD programs may be beneficial to leaders. Also, a study focusing on the influence of employee turnover on a company's stability and profitability may benefit senior leaders.

Reflections

Working on this research project presented quite a few challenges to me, and my understanding of the doctoral research grew with each stage of the process. The attention to detail and the academic alignment the research required both challenged and amazed me. I admit to being overwhelmed by the data that emerged during my collection of data, both from interviews and company records. I was impressed by the passion the CEOs displayed and their willingness to participate in the research study. Each of them expressed interest in learning more about LD programs, and we discussed further research in the future. The obvious gap, in my opinion, was a lack of generational training, which surprised me.

The findings of this study affects me personally as a healthcare manager. The results of the study were similar to my experience in LD from an educational perspective. I expected to find similarities in the data but was surprised in the consistency of comments from my participants. The findings from this study exposed me to additional strategies I can incur in the educational department within my organization.

Summary and Study Conclusions

Leaders are a vital component of any organization and development and training is necessary for an industry that is constantly evolving, such as healthcare. Effective strategies to train, develop and retain senior leaders are a necessity if CEOs want to attract and retain talented leaders (Grandy & Holton 2013). After collecting and analyzing data, five main themes emerged from the data: (a) strategies CEOs use for LD, (b) challenges CEOs face in LD programs (c) environment of care, (d) generational leadership, and (d) benefits of LD. The findings indicated that LD programs are vital to the smooth running and success of an organization. Successful leaders contribute to the profitability of an organization, employee engagement and a competitive edge in the industry.

The participants of the study answered semistructured interviews questions pertaining to the problem as stated. In addition to participants answering all questions asked during the interview, I conducted a review of company documents, including LD outlines, mission statements, and financial data. I triangulated data collected through

semistructured interviews and organizational data with current literature to support the findings.

Although each CEO had different structures of LD programs within their organizations, the basic managerial training was consistent, recurrent themes of communication, conflict management and culture were present in each of them, and thus demonstrating LD programs are unique to the culture and environment of each facility. Also consistent were the barriers faced by the CEOs in their implementation of their programs, approximately 80% relating to people, involving time constraints and reticence. In addition, management practices, leadership characteristics, and organization culture also influences LD programs. Therefore, understanding the critical factors, barriers, and LD strategies is also important when determining the need for and developing and implementing LD Programs. Creating an effective LD strategy is not a simple process for most CEOs, as many factors enter into the equation and leaders must consider several factors when addressing needed strategies (Laker & Powell, 2011). As noted in the constructs of human capital theory education and training is vital (Becker, 1993, Schultz, 1961). While having the optimum strategies in place is important for LD, leadership characteristics also play a significant role in the development of leaders. As previously discussed, leaders high in emotional intelligence (Goleman, 2006; Sadri, 2012) and spiritual leadership (Sweeney & Fry, 2012) contribute to the success of the program. CEOs who aim to maintain successful LD programs should consistently motivate, value, encourage and communicate with their employees.

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Appendix A: Invitation to Participate in the Study

<Date>

<Address Block>

Dear

As part of my doctoral study research at Walden University, I would like to invite you to participate in a research study I am conducting. The purpose being to explore the strategies healthcare leaders utilize to create leadership development programs within their organization. I contacted you to participate because you are a CEO in a hospital within 75 miles of St Petersburg, FL. Participation in the research study is voluntary and is confidential.

Please read the enclosed consent form carefully and ask any questions that you may have before acting on the invitation to participate. To achieve the objectives of the research study, your participation depends on satisfying certain criteria in addition to being the CEO of a hospital. To include: (a) hospital leader with hiring and supervisory responsibility, (b) leadership experience for 5 years or more, and (c) participants must be 18 years of age, with no maximum age requirement. If you satisfy these criteria and you would like to participate in this study, please call me at (727) 409-0520 or email at Julie.Hunt@Waldenu.edu to schedule a convenient time for interview.

I anticipate that the total time required for each interview will span no more than one hour. The interviews will be audio recorded, and participants will have the opportunity to review the transcribed interview for accuracy prior to inclusion in the

study. I sincerely appreciate your valuable time and thank you in advance for your cooperation.

Sincerely,

Julie Hunt

Appendix B: Confidentiality Agreement

Name of Signer: Julie Hunt

During the course of my activity in collecting data for this research, namely, strategies that hospital CEOs use for leadership development, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is omitted.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this Agreement will continue after termination of the job that I will perform.
6. I understand that a violation of this agreement will have legal implications.

7. I will only access or use systems or devices I am officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement, and I agree to comply with all the terms and conditions stated above.

Signature: **Julie Hunt** **Date:** _____/_____/_____

Appendix C: Interview Protocol Form

Interview Protocol

Hospital: _____

Interviewee (Name): _____

Interviewer: _____

_____Interview Background

Post Interview Comments or Leads:

_____

Leadership Development Programs

Introductory Protocol

To facilitate note-taking, I would like to audio record our conversations today. This was outlined in the informed consent process. Fundamentally, this document states that: (a) all information is confidential, (b) your participation is voluntary and you may halt the interview at any time if you feel uncomfortable, and (c) I do not intend to inflict any harm. For your information, only I will be privy to the recordings which will be eventually destroyed after they are transcribed. Thank you for agreeing to participate.

I have planned this interview to last no longer than 60 minutes. During this time, I have a few questions that I would like to cover. You should have ample time to answer all questions in as much detail as you wish without fear of interruption.

Introduction

You are being asked to participate in this study because: you are a chief executive officer and have responsibility for developing and maintaining a leadership development (LD) program. You have been employed by the organization for a minimum of 5 years as a CEO. The purpose of my study is to explore the lived experiences of CEOs regarding strategies for LD programs.

Interviewee Background

Interview Questions:

As if recounting an experience for a listener who must recall and convey the event in full detail for others,

1. How do you provide leadership training, either internally and/or externally for your employees?
2. If leadership development is an elective activity, how do you motivate employees to participate?
3. What type of training (e.g. knowledge, and skills) is included in your leadership development program?
4. How do you accommodate generational differences in your leadership development program?
5. What obstacles do you face in establishing a leadership development program?
6. In your opinion, how does leadership development training benefit the organization?
7. In your opinion, how does leadership development training benefit the employees?
8. Was the percentage of your 2014 budget devoted to leadership development adequate to serve your organization's needs? Why or why not?
9. Is there any additional information you would like to share?

Post Interview Comments and/or Observations: