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Associations Between Leadership Style and Employee Resistance to Change in a Healthcare Setting

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2016

Abstract

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MHA, National American University, 2009

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Dissertation Submitted in Partial Fulfillment

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Abstract

Health reform is forcing healthcare administrators to make rapid changes. A tendency to resist change can present problems for these organizations, including the large, not-for-profit Catholic healthcare systems. In order to make positive contributions towards healthcare, it's important to recognize the nature of the organization's involvement to change. The transformational leadership style has been shown to be positively correlated with change however, the relationship among leadership styles, employees' behaviors, and motivation to change are still not well understood and require further study**.** Further, although Oreg's Resistance to Change (RTC) approach has been researched in direct patient care areas, RTC research in non-patient settings is lacking and necessary in delivering the full spectrum of patient care. This study focused on the relationship of transformational leadership to RTC and if the relationships leaders' have with subordinates' influence change. A customized survey that included the Multifactor Leadership Questionnaire, RTC, and Leader Member Exchange (LMX 7) was emailed to 500 random individuals of various ages and races from 3 non-patient areas. Thirty leaders and 133 raters responded. The regression analysis showed a strong correlation between transformational leadership and RTC. Additionally, each of the variables from the LMX 7 section of the survey showed associations indicating the relationship leaders develop with their subordinates and leader transformational scores were positive. This study may contribute to the awareness of RTC and utilizing transformational leadership style to move change in a positive direction for a healthcare setting.

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Dedication

This journey is dedicated to the love of my life, John Matthew Andrew Garcia. Without your words of encouragement and belief in me, I would have never fulfilled my dream. Secondly, to my daughter Mercedes Enjoli Michael Anne Garcia, may I be an inspiration to you always. Never look back and conquer any challenge that may lie in your path.

Acknowledgements

This dissertation process definitely was one of the most challenging journeys I have ever experienced. Many times, I found myself spinning out of control and wanting to quit. Overcoming the obstacles and barriers wouldn't have been possible without my husband and daughter nudging me along. It is definitely a sigh of relief knowing now that I can travel and not have to worry about grabbing my laptop. Yes, Mercedes! I can finally watch you play tennis in hopes that one day you reach your dream of becoming a tennis star. Just remember, nothing is impossible if you believe and have courage.

Throughout my academic journey and during the completion my dissertation, the faculty and university staff never ceased to assist. For that, I would like to say thank you. Finally, to my committee members Dr. Patrick Tschida, Dr. James Dockins, and Dr. Daniel Michael Nwabufo Okenu, I would like to express my deepest appreciation to you all. Despite the barriers both academic and personal, our journey is finally completed. Thank you Dr. Tschida for your encouraging words, "Keep your eye on the prize" I did! Dr. Dockins, thank you for being the expert in the field and offering your time and assistance. Dr. Nwabufo Okenu, thank you for your dedication and reviews of my work. Your fine eye and expertize helped guide the direction of the study. Thank you all from the bottom of my heart. "All things are possible for one who believes" (Mark 9:23).

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Chapter 1: Introduction to the Study

Background

The Old Testament was the first to introduce changes in traditional law which led to the first documentation of organizational change (Burke, 2011). Today, different approaches and theories are used by healthcare organizations to impact change. Change is often feared in healthcare organizations, which makes it even more difficult to occur. With the fast rate of change among healthcare organizations (Burke, 2011), it is important to discover a way to overcome resistance to it. Currently, organizations are at risk of losing an average of $135 million dollars for every $1 billion invested (Langley, Smallman, Tsoukas, & Van de Ven, 2013). For many years, leaders have served to overcome hurdles and lead organizations toward achievements.

Change occurs both in small increments and with leaps and bounds. Change is usually not incremental; it can be nonlinear (Burke, 2011). The health care industry is known for advancements to occur daily; therefore, preparation for change can be complicated at times. Health care usually follows an evolutionary change pattern, which involves organizational strategic planning and careful development; the mission acts as the primary entity making change (Burke, 2011). With change occurring rapidly and with reimbursement driving the healthcare organization to change, a leader's influence remains a factor. According to Al-Swidi (2012), transformational leadership can improve employees' behaviors. There is, however, a gap in the association between a not-for-profit

Catholic healthcare organization, transformational leadership, and the ability to motivate people to change.

Problem Statement

According to Oreg (2003), four underlining factors are correlated with RTC: (a) routine seeking, (b) emotional reaction to imposed change, (c) short term focus, and (d) cognitive rigidity. Many leaders in healthcare face change; they handle it in different ways, using diverse theories. One such theory is called “transformational leadership.” It was founded, in part, by Bass (1999). This type of leadership style has leaders working hand in hand with subordinates to identify the needed change and then creating a vision to guide the change. The founding theorist proposed that transformational leaders exhibited "superior leadership performance" (Bass, 1999, p. 21).

Transformational leadership is commonly practiced in business sectors other than health care, where it has been found to be beneficial. Transformational leadership is also a contributing factor in several vital organizational outcomes when change has been resisted (Seltzer & Bass, 1990). The use of transformational leadership in healthcare departments in a not-for-profit organization is limited. The objective of this research was to acquire a foundation for understanding leadership styles in a not-for-profit Catholic healthcare organization. Many studies on resistance to change have been carried out with those who provide direct care to patients, such as nurses and other care providers. In this study, I will first examine how leaders in indirect departments—information

management, patient financial services, and human resources—manage change. Finally, I investigated whether, in a not-for-profit, Catholic healthcare organization, there was a link between (a) how leadership influences employees' behaviors and (b) motivation to change.

Purpose of the Study

The purpose of this quantitative study determined (a) whether transformational leadership is associated positively with change in a not-for-profit Catholic organization, and (b) whether leadership has an influence on employees' behaviors and motivation to change.

Nature of the Study

Quantitative data from the customized MLQ360 online Mind Garden's Transform™ questionnaire was analyzed using simple descriptive statistics (frequencies, means, and standard deviations). This will enable future researchers to make comparisons by linking leadership characteristics in a not-for-profit Catholic organization at a departmental level and the resistance to change among the employees in each of the three departments. Additionally, few studies focused on (a) the context of employees' reactions to change and (b) leadership styles in a not-for-profit Catholic organization. ANOVA was used to determine if the differences in the sample's average scores were large enough to conclude that the groups' average scores were unequal.

Three questionnaires were administered. (a) The Multifactor Leadership Questionnaire (MLQ) identified the characteristics of a transformational leader. (b) The Leader–Member Exchange (LMX) has been a successful measurement tool among organizational change researchers because of its contributing variables, which are crucial to consider during change. (c) Most healthcare organizations can initiate change, but followers' resistance remains the challenge. Oreg's (2003) 17-item scale, Dispositional Resistance to Change (RTC), was used to measure resistance to change using four factors: (a) routine seeking, (b) emotional reaction, (c) short-term focus, and (d) cognitive rigidity.

Research Questions and Hypotheses

Based on answers to the questionnaires, this project sought to clarify the following questions: (a) How do leaders dictate changes in a healthcare setting, using transformational leadership, when faced with resistance to change? (b) Do leaders' relationships with subordinates influence change in a healthcare organization? The primary independent variable in this study was leadership style and the dependent variable was resistance to change.

This research addressed two hypotheses. First, in order to evaluate the null hypothesis, the alternate hypothesis was considered. For this study, the alternate hypothesis of the population parameter was greater than the claimed in both hypotheses. H_a: $\mu >$. If the null hypothesis is rejected, the alternate hypothesis will be used. In

Research Area 1 (answering the first research question), the instrument analysis, the null hypothesis ($H_0$1) was that there is no difference in the factor structures of the RTC questionnaire and the MLQ. Finally, in Research Area 2 (answering the second research question), the individual respondent level, the null hypothesis ($H_0$2) was that there is no association between leader-follower relationships and leaders' transformational leadership scores.

Theoretical Base

The theoretical framework was based on the Bass transformational leadership theory. Bass's research interests are based on the context in which a leader influences followers (Bass, 1997). Most of the time, followers identify with a leader due to trust, honesty, and loyalty. Bass (1997), however, believed that the leader transforms followers by using transformational characteristics while keeping other motives in mind, such as goals and procedures. Bass identified four aspects to the transformational leadership style: (a) individual consideration, (b) intellectual stimulation, (c) inspiration, and (d) idealized influence.

Previous leadership literature (Bass & Steidlmeier; 1999) suggested that transactional leadership involves contingent reinforcement, where followers are motivated with praise, promise, and rewards. According to Bass and Avolio (2003), transformational leadership is the best style for managing an organization through change. According to Herold et al. (2008), having the ability to connect with followers

personally helps leaders with the motivation to change. And when the change involves significant personal impact, transformational leadership has been shown to be positively related to followers' commitment to change (Herold et al., 2008). The goal of this study was to develop a better understanding of change and the influences that leadership has on its followers.

Definition of Terms

The following terms were defined according to the way they were used in this study.

Change. Change in this study refers to organizational strategic planning and careful development where the mission acts as the primary entity to make the change (Burke, 2011).

Leader. For the purpose of this study leadership is the person who motivates people to work hard to achieve success.

Leader–Member Exchange (LMX). Describes how leaders maintain their position through a series of processes with their members (Graen, & Uhl-Bien, 1995).

Mind Garden. An independent publisher of psychological assessments and instruments.

Resistance to change. An action taken by individuals or groups when they observe that a change is occurring and the change poses as a threat to them

The Multifactor Leadership Questionnaire. A widely used instrument for measuring transformational leader characteristics (Bass & Avolio, 2000).

Transformational leadership. A leadership style focused on the interest of employees to be willing to change when desirable. The employees share the leaders' vision of an ideal organization with a sense of high level for achievement. Employees are valued at an individual level and are willing work for the betterment of the organization (Bass, 1985).

Assumptions

This study was based on a randomized sample of leaders and followers in three departments. The subjects were asked only to provide their race, age, and ethnicity. It was assumed that the participants answered honestly given the anonymity and confidentiality built into the study. In this study, leaders were asked to recognize, understand, and illustrate leadership influence practices during times of change. Thus, it was assumed that the participants were forthcoming and honest in discussing their experiences and perceptions of leadership influencing change phenomena.

Limitations

The following were limitations to the study, which will be further discussed in Chapter 3:

1. Leadership and change management are constantly evolving. Therefore, what is considered true now may not be considered true in years to come.

2. Leadership and management are culturally bounded.
3. External factors can influence leadership.
4. Whenever an instrument is used, the results are based on its reliability and validity.

To address the limitations in this study, the statistical tools were carefully selected and evaluated for reliability and validity. Additionally, to provide an unbiased evaluation, each leader and rater was randomly chosen. Any external factors were not considered in the research however, the environment that this study was delivered was at a work. Each individual had their own link providing confidentiality.

Scope and Delimitations

I purposely chose three different departments for this study. Information management, human resources, and patient financial services to allow a more in-depth understanding of the leadership style involved in these indirect patient care departments. Additionally, I limited the framework to only capture the insights of leadership and followers, but not the perceptions of the stakeholders. Stakeholders may have different operational and change management processes therefore, construing this studies focus and framework. The study was also limited utilizing one leadership theory. which allowed more focus on one leadership style to determine if transformational leadership is best for leading change in a Catholic not-for-profit healthcare organization.

Significance of the Study

Leadership qualities are not acquired genetically, therefore making leadership a learned behavior. The potential findings of this research will contribute to social change in several ways. First, if leadership style is tied to employees' behaviors, such knowledge may improve collaboration among healthcare organizations implementing change. Thus reducing unnecessary costs. Second, few studies have been done on the effects of transformational leadership behaviors in a not-for-profit, Catholic healthcare organization. The results of this study could help leaders understand what leadership style can motivate change in a not-for-profit, Catholic healthcare organization. Third, the relationship between leadership styles, employees behaviors, and motivation to change is not well understood. This study is expected to contribute to the growing knowledge of different leadership styles and change management at a departmental level in a specific type of healthcare organization.

Summary

Transformational leadership is primarily concerned with the capabilities to enact change successfully in an organization. This study incorporated subordinates' relationships with their leaders while keeping in mind individuals' tendency to resist change. Oreg (2003) developed the Resistance to Change Scale to measure an individual's dispositional inclination to resist change. Since healthcare is a constantly changing environment, it is important to understand how leader−follower relationships

contribute to overcoming resistance to change. Additionally, Al-Swidi et al. (2012) indicated that transformational leadership has an optimistic influence on the behaviors of employees. Transformational leadership has been recognized to have a significant effect on the employees' job satisfaction because it enhances employees' perception of empowerment (Al-Swidi et al., 2012). Bass (1985) identified a transformational leadership characteristic that encourages individualized consideration. Transformational leadership deals with inspiring others. This statement can then be questioned: Is there an association between resistance to change and the leadership under which individuals fall in a not-for-profit Catholic healthcare institution?

Chapter 2 provides an extensive review of transformational leadership and organizational change. Millar, Hind, and Magala (2012) suggested that organizational change and implementation are key issues that require a change of thinking; changes in attitudes usually need to start with leadership. The healthcare environment requires individuals to demonstrate transformational behaviors such as consideration, creativity, inspiration, and a sense of meaning.

Chapter 3 identifies this study's research methods; it includes a description of the design, the research population, dataset, and analysis of the data. Chapter 4 provides the results of integrated data gathered from the survey to include 20 questions on transformational leadership based on the results of the MLQ portion. Additionally, the correlating results of MLQ and the RTC which refers to the 17 questions developed by

Oreg (2003) are provided. Finally, in Chapter 4 this research examined the relationship leaders cultivated with followers using 7 questions with LMX theory. Chapter 5 provides the importance of transformational leadership and explores the relationship between leadership style and followers' resistance to change.

Chapter 2: Literature Review

Introduction

The chapter consists of three sections. The first section is the search strategy for the research. The second section provides a description of the theories that support the ideas in the study. The third section provides an extensive review of the research literature that supports transformational leadership and the influence of change. It also includes a discussion of resistance to change and why change poses a challenge in healthcare. At the end, there is a brief summary.

This chapter is divided into three sections: introduction, foundational theories, and review of the literature.

Search Strategy

The literature search focused on the association between leadership and the influence of leadership in healthcare. The following databases were used: CINAHL, PubMED, Google Scholar, PsycINFO, , and EBSCO. There was a vast amount of research on transformational leadership and change, but there was little research on change in not-for-profit Catholic organizations and transformational leadership in healthcare. The following keywords were used: *not-for-profit, nonprofit, Catholic, management in healthcare, healthcare leadership, transformational leadership, change,* and *resistance to change*. The search for literature using these key words provided a vast amount of results. Therefore, research criteria were implemented. The first process of

elimination, involved exclusion of articles that were not in the English language, thereby reducing the search criteria. Articles that could not be translated to English were eliminated. Articles of low scientific rigor were also eliminated. Finally, articles published outside the years 2008 to 2013 were eliminated. Before I considered an article, I reviewed the abstract. Many of the abstracts reviewed online were not available for free or allowed to download the full article. However, the Walden Library was able to provide a link to those articles that were needed for the research.

Review of the Literature

Foundational Theories

History of Bass transformational leadership theory. One primary concern with transformational leadership is the ability to enact change in the organization successfully. Transformational leadership theory evolved from elements preceding the theory. The theory itself incorporates other leadership types such as behavior and trait, situational, charismatic, transactional, and situational leadership (Bass & Bass, 2008). Transformational leadership theory is focused on leadership creating positive change with followers, while assisting with each other's welfare and performing on the interests as a whole (Bass, 1985). James MacGregor Burns was the inventor of transformational leadership first introduced in his book *Leadership* (1978). With this leadership style, the leader must first instill motivation and performance into the group. Unlike transactional leadership that describes a set of specific behaviors, transformational leadership provides

an outlined process in which leaders and followers increase motivation in each other (Berson & Avolio, 2004). Transformational leadership theory is gauged towards values and purpose that provides short term goals while focusing on the needs of a higher precedence.

Bass (1985) took Burns's original theory of transformational leadership and suggested an extension to which a leader is transformational by measuring four components: (a) Intellectual stimulation--transformational leaders inspire followers to be inventive and explore new opportunities to learn, while accomplishing tasks, (b) individualized consideration--transformational leadership deals with the support and inspiration of others; to enhance a caring environment, transformational leaders provide an open communication channel so that individuals feel free to express ideas and each one contributes direction in their own unique manner, (c) inspirational motivation--transformational leaders are able to express a clear vision to others; these leaders are also capable of assisting others to experience the desire and creativeness to reach the organizations expectations, and (d) idealized influence-transformational leaders are considered the role model for followers. This occurs because the transformational leaders warrant the trust and respect of the followers; therefore, the individual emulates the leader and internalizes the ideals. The Bass transformational leadership theory can then be expressed as the influence it has on others. Transformational leaders, Bass suggested (1995), earn respect, trust, and admiration from followers. Another main concept of

Bass's transformational leadership theory is to create positive change with followers while still assisting with each other's interests and then acting on the interest as a whole group. Al-Swidiet et al. (2012) has indicated that transformational leadership does have an optimistic influence on the behaviors of the employees.

Transformational leadership influence of change. According to Bass and Riggio (2006), transformational leaders are:

> those who stimulate and inspire followers to both achieve extraordinary outcomes and, in the process, develop their own leadership capacity. Transformational leaders help followers grow and develop into leaders by responding to individual followers' needs by empowering them and by aligning the objectives and goals of the individual followers, the leader, the group, and the larger organization. (p. 3)

According to leadership expert Riggio (2009), this type of leadership style has been known to have a positive effect on organizational groups. Additionally, Riggio suggested that transformational leaders believe entirely that followers do their best leading members of groups to feel invested and motivated. Riggio further stated that "research evidence clearly shows that groups led by transformational leaders have higher levels of performance and satisfaction than groups led by other types of leaders" (p. 2006, make sure that any quote includes a page number). It is based on these theory concepts that transformational leadership has received greater attention in healthcare and has been

identified as the leadership style that will facilitate change (Herold, Fedor, Caldwell, & Liu, 2008).

Leadership Influences

Leadership is the ability to motivate individual and organizational excellence, while attaining a shared vision and successfully managing change to obtain the organization's successful performance (Karp & Helgo, 2008). It is of no surprise that healthcare organizations large and small may be the considered the most complex in history. Today, healthcare leaders must find a way to adapt to difficult social and political forces (Canyon, 2013) while doing more for less. KPMG, a global network of healthcare professionals, identified four major healthcare stressors that influence leadership. Those influences included reimbursement shrinkage, healthcare professional shortages, continuous requirements to performance and safety indicators, and widespread acts for precision. There must be strong leadership in the healthcare organization as part of the internal processes (McConnell, 2010). According to Koppula (2008), since leaders are most likely to have direct contact and influence over followers, they are most important in influencing followers to stay motivated and engaged. The logical solution then would be to question the competences of healthcare leaders and managers in an environment that is escalated by public demand. As indicated by Griffith (2010), there is an increased demand for healthcare organizations to have more sophisticated capabilities from leaders and managers.

Now the question remains: Have healthcare managers and leaders been keeping up with the changing demands in healthcare? Bryson (2011) conducted research to identify indicators in the organization that not only addressed the specific strategic goals needed but took the research further, identifying behaviors and attitudes needed to bring the organization to success. Managing and establishing conduct through effective leadership encourages positive behaviors and supports reinforcement the of the organization's expectations (Bryson, 2011). Additionally, obtaining a buy-in from the leaders' followers is essential. For organizational commitment, a buy-in is undeniably essential. This provides followers a reason to come to work every day and gives purpose to the assigned job title. This act generates the obligations required to make the desired connections in achieving the organization's visions and meeting the organization's mission (Bryson, 2011). Finally, establishing a commitment from followers is an essential influence needed from organizational leaders. Defining a road map and identifying how "we" are going to get there are just a few things a leader can do to establish a strategic plan.

Change in Healthcare

Healthcare organizations are environments known for constant changes. Whether responding to change, introducing change, or managing change, it is fair to say that healthcare needs to adapt to change. For many, change creates a fearful environment, a source of instability, a demanding atmosphere, and at times, can be stressful (Furst &

Cable, 2008). On the other hand, change provides an exciting ground that is responsible for the existence of many successful healthcare stories. Care of individuals often requires a quick response or solution. Therefore, healthcare organizations frequently view distress in a very constricted, short-term manner and look for a quick solution (Hayati et al., 2014). This situation can result in issues being unclear or the failure to address the core problem. The process usually takes a linear approach, mainly determining if change is necessary and often not displaying the best choice for the solution. Thus, in order to make positive contributions to healthcare, one must recognize the nature of healthcare organization's experience to rapid change (Hayati et al., 2014). In particular, healthcare organizations must become proficient at managing and understanding change.

When change is considered or encouraged, conflict can occur between those who support the current scenario and those who are advocating the change (Millar, Hind, & Magala, 2012). There will always be a struggle between individuals supporting the status quo and individuals encouraging change. Among the promoters of change, there may be struggles as to the degree and the nature of change that is anticipated. The research conducted by Herold et al. (2008), proved that having the ability to personally connect with followers can assist leaders with the motivation to change, which can reduce the conflict. Additionally, transformational leadership has been established as being related to followers' change commitment when the change suggests substantial personal impact (Herold et al., 2008). Healthcare definitely is an area in which change can be slow

regardless of the known reaction to find a quick solution. It has been estimated that over a period of 15 years, knowledge and new treatments start coming into common use (Luxford, Safran, & Delbanco, 2011). Many of the changes occurring in healthcare are promoted, however, over a few months to a few years. Change in healthcare occurs rapidly, and there must be skilled individuals in the processes of change to expedite the occurrence (Luxford et al., 2011).

Change Leadership

The 20th century methodologies of management like Max Weber and Peter Drucker, who have been successful in assisting organizations in change, are no longer sufficient. In order to drive results in a healthcare atmosphere, change requires an innovative direction. In healthcare, what is the difference between management and leadership? For most healthcare organizations, management is a system of individuals and technology working well together (Plachy, 2009). Items such as planning, budgeting, organization of staff, control, and problem solving are just a few duties required from management. Without virtuous management, healthcare organizations are more likely to become complex and chaotic in ways that destroy the organization's existence (Karp & Helgo, 2008). It is vital that healthcare organizations have good management in place. High quality leadership can bring profitability, order, and consistency to the healthcare organization.

Greenleaf (2002) stated that leadership begins with serving. "It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead" (Greenleaf, 2002, p. 33). Leadership is also about handling change. When confronting numerous healthcare changes, it is important that healthcare organizations become more diverse and versatile in handling change. Leaders need to set the tone by creating vision, strategy, communication, direction, motivation, and alignment. Millar, Hind, and Magala, (2012) suggested the systems that are created by leadership are for managers to use in fundamental ways that create opportunities for the individuals involved. Faster technological changes, greater demand in quality management, meeting governmental demands, and changing demographics of the work-force are amongst the many factors that have contributed to the shift in healthcare (Mukhopadhyay & Postolache, 2012). In order to compete effectively in healthcare, major changes are necessary for survival. More changes most certainly demand for more leadership.

Organizational culture is the product of leaders that set the tone for accepted assumptions and organizational behaviors (Hartmann & Linn, 2008). Mixed-up assumptions that are not clearly defined by managers can sometimes create blind spots leading to organizational errors (Canyon, 2014). Often times, organizations find that self-rationalization and assumption based reliance can lead to an organizational crisis. Thus, support from managers is entirely dependent upon its leaders' values and attitudes (Canyon et al., 2011a). Support for preparedness will not occur if incorrect assumptions

are made about organizational vulnerability. Lack of corporate responsibility and flexibility in beliefs are the two primary reasons for failure in organizational changes (Burnes, 2011). Managers and leaders attitudes thus have a large impact on the direction and attitude to employ. Major organizational change efforts fail at least 70% of the time due to the ability to take the holistic approach and move towards change (Burke, 2011). Nevertheless, by adapting the eight-step process defined by Kotter (2012), healthcare organizations are able to dodge disappointment and become capable of change. Improving the capability to change can surge the odds of achievement today and undoubtedly for forthcoming events. Healthcare organizations that do not have the ability to adapt continuously will fail (Bodenheimer & Grumbach, 2012). However, Kotter has proved that by adapting The Eight-Step Process for Leading Change will aid healthcare organizations to thrive in a tough changing world. Figure 1 lists are the steps healthcare organizations need to adapt for change leadership:

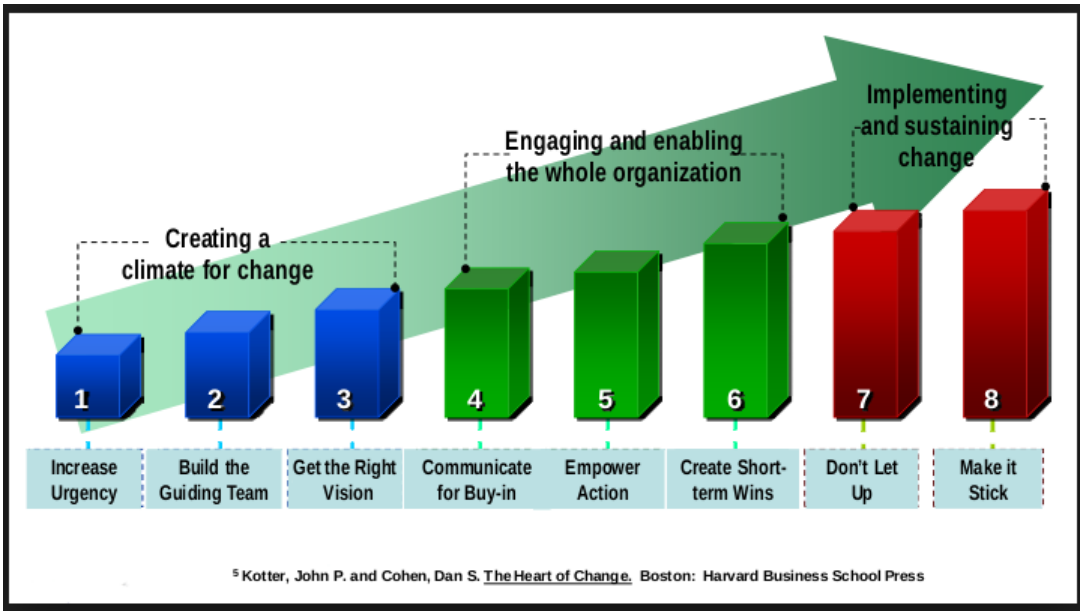

Figure 1. From "*The Heart of Change"* (p. 10), by J. P. Krotter and D. Cohen, 2013, Boston, Massachusetts: Harvard Business Press. Copyright 2005 by Deloitte Development LLC. Reprinted with permission.

The first step is to establish a sense of urgency. Organizations can fall into complacency thinking that everything is fine when there truly is a need to change. Unproductive results produce a false urgency leading to a burnout from a false work load. What really needs to be the focus of leaders and the people of the organization is true progress (Clawson, 2012). Individuals are then attentive to real progress every single day. This behavior creates a level of determination to move forward and contains great opportunities. A solid case for change that appears to the individual's head and not the heart provides a false sense of urgency as well (Burke, 2011). Great leaders who will connect with individuals at the deepest set of values tend to inspire towards greatness.

This allows the organization to make a plan and then react. Kotter (2008) stated that leaders who can understand the pulse of the organization can determine the state the organization is in.

The second step is creating a guiding coalition and placing individuals within a group to lead the change (Kotter, 2012). This is a crucial part of the organization's success because not one organization is built on one person. It takes a coalition with empathy, the right composition, and a major amount of trust to fulfill a shared objective (Hickman, 2010). In a fast-changing world, it is vital to the success of the organization that teams construct a certain amount of trust for one another. This is the process that makes the team thrive. In today's healthcare environment, swift team building is necessary. Typically, this happens in a facility that is usually off-site with facilitated activities that permits the team followers to create relations between both emotions and thoughts. Creating the precise team and then providing a level of belief with a mutual objective, in which the team believes, can produce a management team that has the capability to make change successful. The four talents of an effective team specifies that the team as a whole should reveal (a) position power: display enough players that are on board which prevents progress from not occurring, (b) expertise: all applicable thoughts should be articulated so that informed choices can be made, (c) credibility: the individuals should be valued by others in the organization so that their visions will be

taken seriously, and (d) leadership: the team must acquire a substantial amount of established leaders to strengthen the change process.

The third step is developing a change vision. In this phase it is vital to shed light on how the future will be unlike the past (Kotter, 2012). Presenting a clear vision serves three significant purposes. First, a vision can assist in simplifying the more detailed decisions. Secondly, it is a motivator to get individuals on the right path. Finally, it coordinates actions and simplifies more thorough decisions. Having a powerful vision that is clear goes much further than using a micromanagement approach (Clawson, 2012). Great leaders can make ambitious expectations look doable. In order for a vision to be creditable, it must exhibit guidance, be attentive, be flexible, and be simple to communicate (Hickman, 2010). A clear vision inspires others to act and is empowering. Lastly, it must be communicable and make intuitive sense; otherwise, it is useless (Kotter, 2012). Effective visions have six characteristics that are key:

- Imaginable: provides a clear picture of the future.
- Desirable: appealing to stakeholders.
- Feasible: has attainable realistic goals.
- Focused: provides guidance in decision making.
- Flexible: in changing environments, individuals are intuitive and respond to changing conditions.
- Communicable: can be easy to explain.

The forth step is to communicate the vision using simple terms and creating a metaphor. This is never an easy task, especially when new tasks need to be undertaken. A lack of communication causes inconsistencies and stalled transformations (Pieterse, Caniels, & Homan, 2012). To be effective and beat the under communication factor of 10, the vision must be translated in hour by hour activities such as e-mails, meetings, and presentations (Burke, 2011). Most importantly, a true leader sticks to what is said and leads by example. Nothing speaks more loudly than a leader who can back up words with behaviors. When an entire organization encompasses a change, this sends a powerful message increasing motivation and inspiring others (Bodenheimer & Grumbach, 2012).

The fifth step is to authorize action by removing barriers and allowing individuals to work and do their best. At times during change, there are internal structural barriers that are at odds with the change (Kotter, 2012). Being part of the company can make the change more difficult. Performance appraisal and realignment can have an intense effect on the capacity to accomplish the change. Another barrier is difficult supervisors. Often times these individuals have irritating habits that inhibit change (Burke, 2011). There are no real easy solutions to this issue, except honest dialogue.

Step 6 is to produce short-term wins that create visible success (Kotter, 2012). This is most crucial for changes that are going to need long-term efforts. Attaining these wins assures the overall change initiative's success. Organizations that complete short-term successes in 14 and 26 months after the change initiative begin are much more

likely to complete the transformation (Hickman, 2010). To assure accomplishment, short-term achievements must be noticeable, definite, and related to the change effort. These victories deliver confirmation that the sacrifices the individual makes are paying off. The wins also assist in fine-tuning the change effort. The guiding team obtains important information that allows individuals to maintain course when needed (Kotter, 2008). Although short-term successes scarcely occur, they are the product of careful development and effort. When done skillfully, short term wins create a sense of true urgency and cement the change initiative.

Next is Step 7 , which is to never let up. In this stage, resistance may get in the way. Even if the change is successful in the early stages, resistors are awaiting the opportunity to emerge and pounce when least expected (Kotter, 2012). Although this is considered a normal part of the change possess, more in-depth details are provided in the next paragraph. Whenever individuals give up before the task is completed, critical energy can vanish, and failure could quickly follow. New practices and behaviors are essential driving factors that are engraved in the culture to ensure long-term success. If successful change initiatives are completed in Step 7, an organization starts to see the following:

- Projects increase including the organizations productivity.
- Individuals are brought in to assist with the change process.
- Leadership provides clarity to an associated vision and respected purpose.

- Leadership empowers employees at all levels to lead projects.
- Interdependencies are reduced amongst areas.
- Urgency is kept at a constant high.
- Leaders and followers consistently demonstrate that the new way is functioning.

Leadership is important in accomplishing Step 7. Instead of announcing victories and moving on, transformational leaders will promote additional projects to compel the change more in the organization (Kotter, 2012). Transformational leaders will also confirm that the new platforms are strongly grounded in the organization's culture (Linn, 2008). It is up to leaders to direct the progression for the extended term. Deprived of sufficient and trustworthy leadership, the change will freeze, and succeeding in a swift changing healthcare environment becomes extremely problematic.

The concluding step is to establish new approaches and to make the change stick (Kotter, 2012). New concepts must produce profound backgrounds in order to continue being embedded in the culture. Culture is composed of norms and behaviors that are tuned to shared values (Van Dyne, L., Ang, S., & Livermore,2009). It is inevitable that each individual who connects with an organization is incorporated in the culture, often without even knowing it. Change in the organization's culture is difficult to ingrain, whether the change is consistent or inconsistent (Burke, 2011). It is because of the

difficulty of this action that cultural change is defined in Step 8, not Step 1. Some universal expectations about cultural change include the following:

- Change in culture must come last and not first.
- Proving that the new change is more superior to the old can be beneficial.
- Successes must be noticeable and communicated to participants.
- It is normal to lose individuals in the process with cultural change.
- Reinforcement of new customs and morals are reinforced with motivations and rewards to include promotion.
- The culture must be reinforced with all individuals, including those who are new.

Leaders can assist keeping change in position by creating an original, encouraging, and abundantly sturdy organizational culture. No team alone can create change regardless of the efforts. In order for long-term results to occur, the majority of the organization must embrace the new culture.

Resistance to Change

Oreg (2003) took change a step further, by looking at the individuals' tendency to resistance to change called the dispositional RTC. The development of the RTC took a series of seven studies that were based on a four factor structure: (a) routine seeking, which reflects the person's behaviors as being routine and not accepting unexpected events, (b) emotional reaction, indicating behavior as tension arising from an unexpected

change of plans, (c) short-term focus, which results in behaviors as change is a real hassle, and (d) cognitive rigidity, once the individual has reached a decision, changing of mind is not likely. Generally, RTC has been found to be associated with reactions to change in situations in employees' reactions to organizational change (Oreg, 2006) and followers' change attitudes (Oreg & Berson, 2011).

Based on the above, two questions are posed: With the individual's change attitudes, could the focus be an individual's RTC influences another's reactions? More specifically to this research, does leaders' RTC influence followers' reactions to change in healthcare for nonpatient care departments? (Oreg & Berson, 2011). In a given environment, individuals often react differently to change. Some accept it and others do not. This assumption can then be questioned: Is there a relationship between resistance to change and the influence of leadership for the individuals who fall under not-for-profit Catholic healthcare institutions? Making changes in a healthcare organization is a process complicated by resistance. Leaders' characteristics influence followers' reactions through leaders' choices and what they choose to emphasize (Berson, Oreg, & Dvir, 2008). Thus, leadership, with regards to transformational leadership, has a key role in times of change (Boal & Hooijberg, 2000). Transformational leaders reshape followers' views of change and assist in converting negative aspects of change to opportunities (Bass, 1985). This task is accomplished by offering a vision that is compelling to followers and providing a better future to the organization (Bass, 1985). The transformational leader uses

intellectual stimulation that poses acceptance of innovative solutions challenging the status quo (Bass, 1985; Berson & Avolio, 2004).

There has been limited research linking leader behavior with employee reactions to change (Bommer et al., 2005; Herold et al., 2007). Oreg (2003) took the concept further and indicated that transformational leadership also lessens the relationship between the followers' disposition and the resistance to change. Al-Swidiet et al. (2012) further illustrated that transformational leadership does have an optimistic influence on the behaviors of the organizations employees. The leader's role is to create an environment that provides best practices allowing individuals to adapt to change that is the most meaningful. Leadership inspired by Bass's transformational theory allows the healthcare system to rapidly accept changes (Canyon, 2013).

Summary

Transformational leadership has been recognized as being related to followers' change commitment when the change suggests substantial personal gain or bearing (Herold et al., 2008). Transformational leaders restructure followers' views of change and assist in the replacing negative pieces of change to eventful opportunities (Bass, 1985). Healthcare certainly is an area in which change can be unhurried despite the known response to find a quick answer. Enlightening and leading those to have the ability to influence change can expedite the change management processes today. Handling and launching change through effective leadership inspires positive behaviors and strengthens

the organization’s expectations (Bryson, 2011). To achieve change success, The Eight-Step Process for Leading Change by Kotter is essential in Healthcare organizations. Finally, with resistance to change, Al-Swidiet et al. (2012) proved that transformational leadership does have a hopeful influence on the behaviors of the organizations employees. The leader's role is to create an environment that provides best practices allowing individuals to adapt to change is the most significant.

Chapter 3: Research Method

Introduction

The purpose of this study determined (a) whether transformational leadership is associated positively with change in a not-for-profit Catholic organization, and (b) whether leadership has an influence on employees' behaviors and motivation to change. This chapter describes the research methods that were used in the study to acquire a foundation for understanding the relationship between leadership styles for a not-for-profit Catholic organization and RTC. Further exploring the link between how leadership influences the employees' behaviors and motivation to change in a not-for-profit Catholic organization. Chapter 3 is comprised of eight sections: The Research Design and Approach (includes Data Collection Design and Justification for Selection of Transformational Leadership), Population and Sample Size, Description of Study Variables (includes how variables are measured and operationalized), Instrumentation, followed by Data Analyses. The chapter also includes how confidentiality was handled.

Research Design and Approach

This study used quantitative statistics, including simple descriptive analyses of frequencies, means, and standard deviations. I can then make comparisons between leadership characteristics in a not-for-profit Catholic organization at a departmental level and the resistance to change among the employees in each of the three departments.

Based on answers to the custom MLQ 360 online questionnaire (a quantitative questionnaire that was conducted), I did seek to clearly answer the following questions:

- How does leadership dictate changes that are orchestrated today in healthcare?
- What factors provided relevance in understanding change?
- What leadership style influences change in a healthcare organization?

The primary independent variable in this study was leadership style and the dependent variable was resistance to change. To examine the relationship between the primary independent variable and the dependent variable, the scores of individual chi square tests, *t* tests, binomial, and multiple regression analysis were used. ANOVA will then be used to determine whether the differences in the samples average scores are large enough to conclude that the groups' average scores are unequal.

Data Collection

The method for gathering the quantitative data was a customized MLQ 360 online survey (CF-448A [Leader] & CF-448B [Rater]), questionnaire sent via e-mail using Transform by Mind Garden. The questionnaire contained a series of multiple- choice questions. The leader had three sections in the survey to answer. The first section asks about demographics including age, gender, region, and race. The questionnaire consists of 37 questions in two sections. The first section of the questionnaire has 20 questions correlated to the leader and the raters their describing leadership style and focusing on transformational leadership style. The leaders must start with the first question and judge

how frequently each statement fits themselves using the rating scale from "Unsure" to "Frequently, if not always." If an item is irrelevant or if the leader and rater are unsure of the answer, there is an "Unsure" marking available. The second section contains 17 statements concerning a participant's overall beliefs and attitudes about change. The leader and rater must specify the degree to which they agree or disagree with each statement by selecting the suitable response from "Strongly agree" to "Strongly disagree." The leader and rater must describe themselves as what they are generally now and not as what they wish to be in the future. The rater questionnaire includes four sections, including the 37 questions used with the leader. In Section 3 for the rater, respondents answered seven questions pertaining to his or her leader and the contributing variables that are crucial to consider during change.

The questionnaire was web-based, and respondents were able to retrieve the survey through Mind Garden Transform. With a confidence level of 95% and a sample size of 500, the percentage is 50%, leaving the confidence interval at 4.38. Five hundred random associates (raters) and 85 random leaders have been identified through human resources as current employees based on payroll status. Human resources will provide Mind Garden the e-mail address of each participant. This way, the researcher is unable to identify individual participants since the names are not tied to the e-mail addresses. The survey will remain confidential and not indicate any form of identity. The benefit of the web-based questionnaire is having participants' answers automatically kept in

Transform's database and readily converted into data in SPSS. Prior to the questionnaire, an informed consent form was sent via email to each participant. Participants taking the questionnaire will automatically be considered as having given consent to participate as indicated in the consent form. Participants will receive a notification a week prior to the survey being sent from Talent Management about the significance of their contribution to the study. This effort is intended to lower the possibility of a low response rate. A three-phase follow-up e-mail sequence will also be employed to assist in the reduction of the response rate to the questionnaire (Dillman, 2007). The individuals' who have not responded by the set date received an e-mail reminder five days after distributing the questionnaire. After ten days, another e-mail notification was sent to individuals who have still not responded. After 15 days, a third e-mail notification was distributed to the participants, reminding the individuals of the significance of their input.

The following describes the data collection design and the processes used in selecting the measures. The questionnaire includes three identified tools for measurement. The first includes the Multifactor Leadership Questionnaire (MLQ). Developed by Bass and Avolio (2004), the MLQ is an instrument for measuring the leadership behaviors of the Full Range Leadership Model. This study, however, focused only on the transformational leadership style. The customized MLQ 360 Rater/Leader Form was used in this study. The Rater/Leader Form is composed of 20 questions that were valued on a 6-point scale. The scale ranged from Unsure to Frequently, if not

always. These 20 questions are what encompass transformational leadership and the identified sources are as follows: Idealized Influence (Attributed), Idealized Influence (Behavior), Inspirational Motivation, Intellectual Stimulations, and Individual Consideration.

The next measure is the Leader–Member Exchange (LMX) Measurement. The LMX theory differs from other theories of leadership such as trait leadership theories and contingency theories. The main focus of LMX is the unique relationship leaders cultivate with their followers (Schyns & Day, 2010). Consequently, the distinctive relationship between a leader and follower is the principal focus of concern. The LMX theory suggests that high-quality social interactions exchanged between leaders and subordinates bring a greater number of rewards compared to low-quality relationships (Schyns & Day, 2010). The rewards include better communication, emotional support, and higher roles. The LMX measurement has been a successful measurement tool among organizational change researchers because its contributing variables are crucial to consider during change. The associates (raters) will answer seven questions on a scale from Rarely to Very often. The LMX-7 scale will determine the raters' relationships with their leaders.

Finally, most healthcare organizations are able to initiate change; however, it's the followers' resistance that remains the challenge. The 17-item scale, Dispositional Resistance to Change (RTC), introduced by Oreg (2003) was used to measure resistance to change. The scale identifies four factors: (a) routine seeking, (b) emotional reaction,

(c) short-term focus, and (d) cognitive rigidity. The respondents' will answer on a 5-point scale from Strongly Disagree to Strongly Agree. More recent studies by Oreg and colleagues have shown that dispositional RTC affects occupational interests and choices (Oreg et al., 2009). Additionally, Oreg and Sverdlik (2011) demonstrated that the feelings toward the change agent correlated with the relationship between dispositional RTC and resistance towards change, meaning that change was only positive amongst employees who were positively oriented toward the change agent. Therefore, RTC is a valid resource for a resistance of change measurement.

Justification for selection of transformational leadership style. Bernard Bass's (1997) research interests were based on the context in which a leader influences followers. Most of the time, followers identify with a leader due to trust, honesty, and loyalty. Bass, however, believed the leader transformed the followers while keeping transactional leadership style motives in mind, like goals and procedures (Bass, 1997). Bass (1995) identified four aspects of the transformational leadership style: (a) individual consideration, (b) intellectual stimulation, (c) inspiration, and (d) idealized influence. The categories identified by Bass can be considered as the functional attributes of transformational leaders. These functional attributes correspond to accompanying attributes, identified in Figure 2.

Functional Attributes	Accompanying Attributes
Idealized influence / charisma	Vision
	Trust
	Respect
	Risk sharing
	Integrity
	Modeling
Inspirational motivation	Commitment to goals
	Communication
	Enthusiasm
Intellectual stimulation	Rationality
	Problem solving
Individualized consideration	Personal attention
	Mentoring
	Listening
	Empowering

Figure 2. Attributes of transformational leaders. From "Transformational Versus Servant Leadership: A Difference in Leader Focus," by A. G. Stone, R. F. Russell, and K. Patterson, 2004, *Leadership & Organizational Development Journal, 25*, p. 349. Copyright Emerald Group Publishing. Adapted with permission of the author.

Bass and Steidlmeier (1999), suggests that transactional leadership involves contingent reinforcement. Here, the followers are motivated with praise, promise, and rewards. According to Bass and Avolio (2003), transformational leadership is the best style for managing an organization through change. The main focus in the research conducted by Herold et al. (2008), is having the ability to personally connect with followers while providing motivation to change. Additionally, transformational leadership has been linked to followers' change commitment when the change proposes substantial personal bearing (Herold et al., 2008). According to Fernandez (2007), general perspective of a leader is to not only understand one's self but to seek the needs of followers. This, in turn, assists in defining the culture and then can help meet the overall vision of the organization (Fernandez, 2007). Transformational leaders like to work amongst followers and provide an environment that is encouraging to workers (Hayati, Charkhabi, & Naami, 2014). This occurrence is known as leading along the side instead of leading from within (Hayati, Charkhabi, & Naami, 2014). In order for change to occur, leaders must gain the trust of followers and utilize transformational leadership qualities while also taking into consideration a holistic and ethical approach by acting on the perceptions of others. Below are characteristics that define transformational leadership:

- Establishes a "vision" for the future
- Has the ability to set long-term goals/results

- Encourages inquisitiveness in followers
- Encourages follower performance beyond expectations
- Unselfish
- Motivates and inspires followers
- Emphasizes social exchange between leaders and followers
- Wants to satisfy the desires of followers (Boerner, Eisenbeiss, & Griesser, 2007, p. 15)

Population and sample size. The population size consists of a random-sized group from three departments containing 500 associates and 85 leaders. Population ecology and contingency theory have some similarities, since the theory assumes only the best performing leaders survive (Donaldson, 2001). Therefore, "Fit" is considered a natural selection process (Gerdin & Greve, 2004). This assumption can be questioned as indicated by Gerdin and Greve (2004) who argued that, in short-term, there may be misfit (fit) between contingency and structural variables resulting in lower (higher) performance. This finding, indicates that utilizing a random sample (RS) as a population group may be resourceful. Random sampling is the purest form of probability sampling (Creswell, 2009). Because of its purity, each individual has a chance of being selected which, in turn, eliminates biases. This particular study will look at three comparably-sized departments in the selected healthcare organization.

- Objective: Take a sample from the population, measure some characteristic on each of the sampled units, and use this information to estimate the characteristic in the entire population.
- Simple random sampling is the most basic sampling procedure for drawing the sample.
- Simple random sampling forms the basis for many of the more complicated sampling procedures.
- Simple random sampling is easy to describe but is often very difficult to carry out in the field where there is not a complete list of all the members of the population. For this study, the population will consist of three departments that are comparable in size.
- According to Frankfort-Nachmias and Nachmias (2009), a simple random sample is a sample of size *n* drawn from a population of size *N* in such a way that every possible sample of size *n* has the same chance of being selected. Note that this definition requires that the researchers know the population size N.

Gays's (1996) formula was used to select the sample size. Gays's (1996) guidelines are as follows:

- For small populations (N < 100), there is little point in sampling. Survey the entire population.

- If the population size is around 500, 50% of the population should be sampled.

Study Variables: Operationalization, Descriptions, and Measurements

Operational Definitions for Dependent Variable

Resistance to Change was operationally defined as the mean score of the 17 questions from the Dispositional Resistance to Change (RTC) introduced by Oreg (2003).

Operational Definitions for Independent and Control Variables

- Transformational leadership was defined as the mean score of the 20 questions rated by respondents on the customized MLQ 360 online survey (CF-448A (Leader) & CF-448B (Rater)) questionnaire.
- Age was defined as each respondent's age in years as indicated in the online survey.
- Gender was defined as male or female as indicated in the online survey.
- Ethnicity was defined as each respondent's ethnic group as indicated in the online survey. Ethic groups will include Hispanic, White, Black/African American, Asian, and Other.
- Location was defined as the state that each respondent's facility was geographically located in as reported by the human resources information system. States will include Louisiana, Texas, and New Mexico.

- Department type were defined as the department category in which each respondents was working as self-reported on the demographic survey. Department type categories will include Information Management (including Health Informatics), Human Resources, and Patient Financial Services.

Instrumentation

There are three instruments that were utilized to explore the hypotheses of the study. Quantitative data from the questionnaire was analyzed using simple descriptive statistics (frequencies, means, and standard deviations). This will enable the researcher to make comparisons between leadership characteristics in a not-for-profit Catholic organization at a departmental level and the resistance to change among the employees in each of the three departments. Additionally, with limited studies that focus on the context of employees reactions to change and leadership styles in a not-for-profit Catholic organization.

Three primary research areas were explored. The first research area was a factor analysis comparing the factor structures of the Dispositional Resistance to Change (RTC) and the Multifactor Leadership Questionnaire. The second area was at the department level. This research area will include the departments in which respondents work, and the departments were classified as Information Management (including Health Informatics), Human Resources, and Patient Financial Services. The third research area was at the

individual respondent level and will examine Leader–Member Exchange (LMX), focusing on relationships leaders develop with their followers.

Research Area One-Instrument Analysis

How do leaders dictate changes in a healthcare setting using transformational leadership when faced with resistance to change? To analyze the correlations among the variables, ANOVA and multivariate regression was conducted in research area one. General differences was evaluated using separate *t*-tests, a Pearson correlation, and the R2 statistic.

$H_0$1 (null hypothesis): There is no difference in the factor structures of the Dispositional Resistance to Change (RTC) questionnaire and the Multifactor Leadership Questionnaire.

Research Area Two-Department Level

Do the relationships leaders have with subordinates influence change in a healthcare organization? An analysis was performed in research area two at the individual respondent level, focusing on relationships leaders develop with their subordinates as the criterion variable.

$H_0$2 (null hypothesis): There is no relationship between leader-follower relationships and leaders' transformational leadership scores when controlling for age, gender, ethnicity, and location.

ANOVA will then be utilized to decide whether the variances in the samples average scores are large enough to conclude that the groups' average scores are unequal.

Reliability and Validity

The study will look at quantitative measures via electronic questionnaire. In quantitative research, avoiding measurement issues in the research reliability and validity of the instrument are imperative for diminishing errors. Reliability is defined as the accuracy of a measurement procedure (Golafshani, 2003). The stability of the survey instruments has been identified as reliable. The Multifactor Leadership Questionnaire (MLQ) measures a wide range of leadership styles. In the review of the literature, MLQ was found to be of a highly reliable scale. The reliably of the transformational scale was (0.98) recently applied to a sample of 102 employees in a Mexican public hospital.

Next, the Leader–Member Exchange (LMX) Measurement has been a successful measurement tool amongst researchers. LMX has an important association of such variables as increased satisfaction (e.g., Graen & Uhl-Bien 2008), increased performance (e.g., Dansereau et al., 1995b), enhanced career outcomes (e.g., Wakabayashi, Graen & Uhl-Bien, 1990), and a decreased tendency to leave to job (e.g., Vecchio, 1993), all of which are contributing variables that are crucial to consider during change. Although Graen and Uhl-Bien (1995) acknowledged the limitations of the LMX–7, they also supported the use of the measure because it had been utilized in studies the past 25 years. Additionally, the LMX average reliability is $\alpha = .89$ (Wu et al., 2010). LMX

differentiation is defined as “a process by which a leader, through engaging in differing types of exchange patterns with subordinates, forms different quality exchange relationships (ranging from low to high) with them” (Henderson, Liden, Gilbkowski, & Chaudhry, 2009, p. 519). It has been operationalized as the standard deviation (Nishii & Mayer, 2009; Stewart & Johnson, 2009) or variance (Erdogan & Bauer, 2010; Liden, Erdogan, Wayne, & Sparrowe, 2006) of LMX ratings with a group.

Finally, there is the resistance to change measure. Most healthcare organizations are able to initiate change; however, it's the resistance to change and overcoming the individuals that resist change that is the challenge. What are their personalities? The 17-item scale, Dispositional Resistance to Change (RTC), introduced by Oreg (2003) was used to measure resistance to change. The scale identifies four factors: a) Routine Seeking, b) Emotional Reaction, c) Short Term Focus, and d) Cognitive Rigidity. Respectively, these factors can be viewed as dispositions reflecting behavioral, affective, and cognitive aspects of resistance to change (Oreg, 2003). The reliability of Dispositional Resistance to Change (RTC) has been validated in more than 25 samples from 19 countries (Oreg et al., 2008; Stewart, May, McCarthy, & Puffer, 2009) and has consistently demonstrated reliability.

The validity of leadership studies conducted in the 70s and 80s consisted of individual characteristics of leaders focusing on the effectiveness of success in the organization (Donaldson, 2007). Simple descriptive quantitative data was utilized in a

questionnaire format looking at the means, standard deviations, and frequencies using an updated measurement. Using this type of information will allow the researcher to make comparisons. The validity of the framework was determined by discussing criteria for quantitative research designs. It is difficult for researchers to come up with a perfect design to test hypotheses, and, at times, questions are not easily defined. Therefore, it is imperative to measure leadership style with a questionnaire whose validity has been proved.

Validity refers to accurately reflecting the specific perception that the researcher is trying to measure (Golafshani, 2003). This study will analyze the content and construct validity of the questionnaire. Content validity will demonstrate the degree to which the questionnaire items and the scores from these questions are illustrative of all the probable questions about leaders' influence on resistance to change. The customized survey was developed using three reliable tools which are relevant to the subject it aims to measure.

Construct validity looks for the correspondence between a theoretical concept and a particular quantifying mechanism or process (Golafshani, 2003). To reach construct validity, factor analysis of the customized questionnaire items are completed. Factor loadings from the questionnaire items will display a correspondence between the questionnaire and the overall factor (Tabachnick & Fidell, 2000). Preferably, the analysis will produce a simple structure which is characterized by the following: a) the factors should contain several variables and strong loading, b) individual variables should have a

strong loading for only one factor, and c) each variable should have a large degree of shared variance (Kim & Mueller, 1978).

Quasi-experimental designs are used when researchers cannot control the assignment of participants to conditions or cannot manipulate the independent variable (Creswell, 2009). Comparisons are conducted between individuals in a certain group and one or more existing participants. The quality of a quasi-experimental design depends on its ability to minimize threats to internal validity (Frankfort-Nachmias & Nachmias, 2008). Quasi-experimental designs are not generally considered able to define cause and effect relationships. However, a well-built quasi-experiment can give incidental evidence of the effect of one variable on another (Creswell, 2009). The independent variable in this study is resistance to change and dependent variable is leadership style. Creswell states that validity in quantitative research includes variables that are described, related, categorized into group for comparison, and the independent and dependent variables are measured separately (Creswell, 2009).

Data Handling

A formal consent form describing the research study was attached to the questionnaire explaining why this research is being conducted. The consent form will provide contact information for the Committee Chair, organizational IRB, and researcher. The consent form meets the requirements under Federal Policy for the Protection of Human Subjects. Thus, providing complete disclosure of the study, purpose of the study,

description of Mind Garden and the procedures that was used, expected length of the research, explanation of any anticipated risks, a statement that there is no costs to the participant or financial benefit to the researcher was acquired, assurance of confidentiality, and an explanation that the study is strictly voluntary.

Data Transfer

After receiving approval from the Walden University IRB, all data was collected by Mind Garden via e-mail link to their platform called Transform. For security purposes, when a user accesses the platform, the end-users are on secure servers using industry-standard SSL Secure Sockets Layer encryption. SSL is a procedure established by Netscape for transmitting private documents through the Internet.

Data Translation

All raw scores were captured by Mind Garden through Transform. The data will then be disseminated and provided to the researcher. A Microsoft Excel spreadsheet was created for copying the data provided by Mind Garden and pasting it into the Excel spreadsheet. Once the data is cleaned, complete, and organized, the data was transferred to SPSS statistical software version 22.0 (SPSS INC., 2014) for statistical analysis.

Data Cleaning and Organizing

All information was scrubbed for all personal identifiers. The only personal information identifiers are age, gender, and race. No names or personal e-mail addresses was included. Before the statistical analysis of the quantitative questionnaire results, the

cleaning of the data will occur on the univariate and multivariate levels (Kline, 1998; Tabachnick & Fidell, 2000). To assist in identifying potential multicollinearity, data cleaning is necessary. Due to poor model fit, any outliner was excluded from the analyses (Gerdin & Greve, 2004). The descriptive statistics for all the variables is included in the data screening. Descriptive statistics for the questionnaire items are summarized in the text and reported. In addition, a frequency analysis was conducted. The frequency analysis will assist to identify a valid percent for answers to all the questions in the questionnaire.

Data Analysis

This study will utilize three tools that were customized into one questionnaire but were first separately analyzed and then analyzed together. The first section of the questionnaire is the MLQ, focusing only on transformational leadership, which was redesigned (Bass & Avolio, 2003). The integrated data gathered from the 20 questions focusing on transformational leadership were analyzed using the Statistical Package for the Social Sciences (SPSS) version 22.0. To evaluate the correlations and relationships among the variables, ANOVA and Multivariate regression analysis was used. The comparisons of means are included but limited to a significance test of the variables (t-test); a Pearson correlation; the R2 statistic, indicating how the independent variables are explained; the adjusted R2, indicating the percent in error; a substantial F change to prove if there is a correlation among the variables; and the f statistic, demonstrated by ANOVA

set at a .05 confidence level, to see if there is a variable relationship. In order to determine the frequency of the dependent variable and the standardized residuals, a histogram was used.

A series of regression tests are needed to test the null hypotheses and their relation to transformational leadership style. There are 20 questions from the MLQ section that make up the total independent variables of transformational leadership. The series of regressions are as follows: Y = constant + x1 + x2 + x3…+error. Y is the dependent variable, Dispositional Resistance to Change (RTC). The constant was calculated; the Xs are the independent variables for transformational leadership, and the error is the unexplained error of the model.

Correlations between instruments are measured using the Pearson correlation. The variables correlated were those tested using the MLQ section and RTC section. A relationship or lack of relationship between the variables were determined by correlating these variables. The second set of questions indicate the Dispositional Resistance to Change (RTC). There are 17 question developed by Oreg (2003). The results were compared using a comparison of the means. The findings are presented in a table format, providing an explanation of the results. The final data analysis will determine the relationships between transformational leadership and the leaders' relationships with the followers. The data analysis of this segment will parallel the tests used for the MLQ and LMX. The data is presented in tables and graphs and include an explanation of their

significance. Correlations of MLQ and LMX were used to analyze the null hypothesis that there is no difference in the transformational leader and relationship with the follower.

Potential Limitations

The following are potential limitations to the study:

- Leadership and management have a nature to change. Concepts and ideas are not static with the growth of principles and science. Traditional leadership and management styles are being eliminated due to innovation. Therefore, establishing concepts that are familiar in leadership is essential to the data being reviewed in the survey.
- The independent and dependent variables are measured as the associates' and leaders' perceptions and not their actual behaviors. The study will not look at actual participation in change management nor will it address actual aspects that make up a person’s leadership style. Rather, it translates the values that the individuals ascribe to the areas.
- Leadership and management are culturally-bounded. Social customs, culture, politics, religion, and environment influence leadership and management. Every human is a product of the rapidly changing environment; therefore, leaders have to make decisions while keeping in mind the cultural

environment. This factor may then become a bias. A randomized sample was used to establish some variance in the answers provided.

- The effects of external factors can influence leadership. Leadership and management have to operate in economic fluctuations, specific policies, climate conditions, and interventional relations. People can be effective in certain situations. Therefore, changing the situation or perhaps placing the right individual in a given situation can raise the leader's efficiency.
- Anytime an instrument is being utilized, the results are subject to the known reliability and validity of the instrument. Although some information about the instruments in regard to reliability and validity is known, the instruments may have limitations in measuring what they purport to measure (Creswell, 2009). Only further research with other individuals and with different instruments will assist in further understanding.

Role of the Student Researcher

The researcher will administer the questionnaire and gather the data using standardized procedures. In this PhD dissertation project, it is the sole responsibility of the students to write the theoretical foundations, conduct an extensive search of literature to support the project, and conduct the full analysis and reporting of findings. The standard procedures include proper sampling, naturally-existing groups, and validity and reliability instrument checks. The data analysis was accomplished using rigorous

statistical analysis techniques. The results are based on the established values provided via the statistical significance of the functions.

Protection of Human Subjects

Participants for the study were recruited from a Catholic healthcare system. The consent form was the first page seen prior to taking the survey. A statement was attached to the survey stating that taking the survey indicates consent to participate in the research. Permission from the organization's Institutional Review Board Committee, Legal and Governance, and Human Resources have been obtained prior to the research being conducted. Furthermore, a signed letter of approval from Talent Management from the organization was acquired to indicate that this research is beneficial to the organization. Permission from Dr. Shaul Oreg, Mindgarden, Inc., and the International Leadership Association has been granted for use of Dispositional Resistance to Change (RTC), Multifactor Leadership Questionnaire, and the Leader–Member Exchange (LMX) Measurement. The study and research instruments are approved by Walden University Institutional Review Board.

An informed consent form has been developed with contents addressing the following: a) purpose of the study, b) description of procedures to be used, c), expected length of the study, d) any probable risks, e) a statement that no costs to the participant or financial benefit to the researcher is sustained, f) participants' voluntary agreement to be involved in the study, g) participants' acknowledgement that their rights are protected,

and h) a statement that participation reflects compliance. The anonymity of participants is protected by non-association of email correspondence and generically labeling of respondents as “Leader” or “Rater.” Contact information for the researcher and the Committee Chair is provided on the consent form. The consent form meets the requirements of the Federal Policy for the Protection of Human Subjects. Prior to survey being sent out to the respondents’ for data collection, both organizational IRB and Walden University IRB approval 07-29-15-0176163 were obtained.

Dissemination of Findings

All study data, including the survey electronic files, is kept in locked metal file cabinets and destroyed after a reasonable period of time. Mind Garden has stated that the researcher can request destruction of data at any point. Participants were notified in the consent that the data summary is published anonymously.

Summary

This chapter presented the research methods for analyzing the possible relationship between transformational leadership and resistance to change in a not-for-profit Catholic Healthcare organization. A randomized sample was utilized from three comparably-sized departments using 500 associate and 85 leaders. The purpose of the data analysis is to determine if there is a distinctive relationship between transformational leadership and the resistance to change. Additionally, the researchers want to determine if transformational leadership has a direct relationship with followers in a healthcare

organization. After organizational and Walden IRB approval, data were collected. It was analyzed in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this chapter was to examine the results of integrated data gathered from the 20 questions on transformational leadership based on the results of the Multifactor Leadership Questionnaire (MLQ) (Bass & Avolio, 2003). Next, is to determine if there is an association between the variables by correlating the results of MLQ and the Dispositional Resistance to Change (RTC), which refers to the 17 questions developed by Oreg (2003). $H_0$1 (null hypothesis): There is no difference in the factor structures of the RTC and the MLQ focusing on transformational leadership. This answered the question, whether transformational leadership is associated positively with change in a not-for-profit Catholic organization.

Finally, this research examined the relationship leaders cultivated with followers using the Leader–Member Exchange (LMX); it examined whether it has a significant influence on change. According to *H*02 (null hypothesis), the relationship leaders have with subordinates does not influence change in a healthcare organization. This answered the second research 2 question, whether leadership has an influence on employees' behaviors and motivation to change. After examining the results of these study areas, the data determined if leadership can facilitate change, which, today, is orchestrated using transformational leadership against resistance to change in healthcare.

According to the results, transformational leadership has a strong correlation with each other and the relationship that leaders have with their employees is significant. However, when comparing MLQ and RTC, only a few of the items in MLQ are correlated with the items in RTC. As for the direct relationship leaders have with followers, there were no significant outcomes, according to LMX7, that demonstrate that relationship influences change. While the validity of MLQ (Bass & Avolio, 2004) and RTC (Oreg, 2003) have both been documented, the nature of this study—a not-for-profit healthcare organization—suggests that the study should be repeated in other healthcare settings. Repeating the study would also help to ensure validity.

Data Collection

The data in this study were collected from a survey sent out via e-mail to 500 raters who were randomly selected from information management (including the health informatics department), human resources, and patient financial services. The survey also included 85 leaders randomly selected from the same department areas. To make sure the randomly selected individuals were currently employed, the Human Resource Director used the organizations current pay period cycle. A response rate of 50% or higher—a good return rate—was sought (Gays, 1996). The data collection period resulted in a month timeframe with reminders sent out on a weekly bases. At the end of the data collection period, 158 respondents had submitted data, 30 leaders and 133 raters. Of the leaders, the data from five leaders were excluded from analysis because their raters did

not respond. Tables 2–6 include demographic information about the 153 respondents whose data were used in final analyses. Below are the results of the demographics collected from each respondent.

Table 1

Age of Respondents

Age	Frequency	Percent	Cumulative Percent
18 - 25	7	4.6	4.6
26 - 35	18	11.8	16.3
36 - 45	47	30.7	47.1
46 - 55	54	35.3	82.4
56 - 75	27	17.6	100.0
Total	153	100.0	

Table 2

Gender of Respondents

Gender	Frequency	Percent	Cumulative Percent
Female	100	65.4	65.4
Male	53	34.6	100.0
Total	153	100.0	

Table 3

Region of Respondents

Region	Frequency	Percent	Cumulative Percent
Texas	143	93.5	93.5

Louisiana	10	6.5	100.0
Total	153	100.0	

Table 4

Race of Respondents

Race	Frequency	Percent	Cumulative Percent
Caucasian	65	42.5	42.5
Africa American	50	32.7	75.2
Hispanic	26	17.0	92.2
Asian	7	4.6	96.7
Two or more races	2	1.3	98.0
Others	3	2.0	100.0
Total	153	100.0	

Table 5

Department of Respondents

Department	Frequency	Percent	Cumulative Percent
Information Management	89	58.2	58.2
Human Resources	26	17.0	75.2
Patient Financial Service	38	24.8	100.0
Total	153	100.0	

Study Results

Various statistical tests were conducted in the study to test the hypotheses. Coefficients were standardized using regressions analysis, so the variances of the dependent and independent variable were equal to 1 (Creswell, 2009). Standardization of the coefficient is normally conducted when independent variables have a greater effect on the dependent variable in a multiple regression analysis. While statistically controlling the other independent variables, standardization determines the average change in the dependent variable associated with one-unit change in the independent variable (Kline, 2002).

The simple *t*-test compares the definite change between two means in relation to the variation in the data. It is expressed as the standard deviation of the difference between the means. The *t*-test also assumes that the hypothesized value of an individual coefficient is zero rather than the estimated regression value. The *t* test indicates that, at a particular confidence level (95%), the hypothesized value is an acceptable approximation of the true value.

Analysis Procedure

The research questions were investigated using regression analysis, which delivered descriptive statistics, the analysis of variance (ANOVA), the *F* test, *t* stat or the statistical significance of the variable, the P (two-tail) test and the *R*-squared statistic. The data to analyze the research questions and hypothesis are signified by using the Statistical

Package for the Social Sciences, version 21 (SPSS). All survey instruments, the MLQ, the RTC, and the LMX7, provided the data to analyze the research questions and the hypotheses.

Hypotheses Tests

A variety of different approaches were used to test the hypotheses. For instance, ANOVA uses the *F*-test which examines the hypothesis utilizing the entire coefficient estimate. Each *F*-statistic is a ratio of mean squares. The numerator is the mean square for the term. The denominator is chosen such that the expected value of the numerator differs from the expected value of the denominator only by the effect of interest. The effect for a random term is represented by the variance component of the term. Therefore, a high *F*-statistic indicates a significant effect. The *F*-test evaluates the hypothesis that all of the coefficients are zero. If the *F* statistic is greater in absolute value than the critical *F*, the null hypothesis is rejected.

In regression, the total sum of squares helps express the total variation of the Ys. The regression sum of squares is the variation attributed to the relationship between the Xs and Ys. The sum of squares of the residual error is the variation attributed to the error. By comparing the regression sum of squares to the total sum of squares, one can determine the proportion of the total variation that is explained by the regression model (R^2, the coefficient of determination). The larger the R^2, the better the relationship. The

R-squared statistic yields a percentage that represents the amount of the dependent variable that is explained by the independent variables chosen (Gujarati, 2003).

The *p*-test (two-tailed), or significance test, determines the probability of rejecting a true hypothesis. At the 95% confidence level, the null hypothesis is rejected at a *p*-value less than .05.

Backward elimination involves starting with all candidate variables and testing the deletion of each variable using a chosen model comparison criterion. The variable whose deletion improves the model the most (if any) is deleted and this process is repeated until no further improvement is possible.

Looking at the results from the analysis, it is observed that almost in all the cells have values that represents correlation between variables considered. For the importance of this study, each correlation coefficient was further subjected to significant test in other to identify only the significant correlation coefficients and to avoid misinterpretation of the whole data. Pearson correlation, which can range in size from -1.00 to +1.00. The power of the association of the variables is determined by this test (Gujarati, 2003). A correlation of 0 indicates no relationship, while 1.0 indicates a perfect positive correlation and -1.0 indicates a perfect negative correlation. Table 6 implies that the correlation is significant at $\alpha = 0.05$ for MLQ @ Question 8, “I spend time teaching and coaching resulted higher correlation with RTC questions. MLQ question 4, “Whenever my life forms a stable routine, I look for ways to change it”, is -.175. MLQ question 12, “When

someone pressures me to change something, I tend to resist it even if I think the change may ultimately benefit me", resulted in -.161. MLQ question 16, "Once I've come to a conclusion, I'm not likely to change my mind," resulted -.190. Also MLQ 8 implies that the correlation is significant at $\alpha = 0.01$. and showed higher correlation with RTC 11, "Often, I feel a bit uncomfortable even about changes that may potentially improve my life", resulted at -.227. In addition to MLQ question 8, a higher correlation resulted at $\alpha = 0.01$ was recognized with MLQ question 11, "I act in ways that build others' respect for me", and RTC question, "Often, I feel a bit uncomfortable even about changes that may potentially improve my life. See Table 6 for full results.

Table 6

Correlations between MLQ and RTC Items

Item	RTC1	RTC2	RTC3	RTC4	RTC5	RTC6	RTC7	RTC8	RTC9	RTC10	RTC11	RTC12	RTC13	RTC14	RTC15	RTC16	RTC17
MLQ1	-.139	-.074	.022	-.120	-.098	.051	.045	.004	-.082	-.115	-.094	-.160	-.082	.068	-.062	-.127	.009
MLQ2	-.045	-.078	.052	-.114	-.032	.156	.086	-.014	-.032	-.110	-.085	-.029	-.061	.050	-.084	-.172*	-.083
MLQ3	-.114	-.031	-.022	-.114	-.091	.064	-.005	-.034	-.092	-.113	-.153	-.163*	-.153	.037	-.129	-.143	.011
MLQ4	-.038	-.114	-.044	-.151	-.101	.014	.012	.004	-.010	-.085	-.109	-.108	-.122	-.053	-.165*	-.105	-.073
MLQ5	-.063	-.045	-.002	-.120	-.091	.086	.024	-.031	-.031	-.086	-.093	-.124	-.087	-.020	-.079	-.061	-.010
MLQ6	-.035	-.043	.021	-.096	-.049	.047	-.014	-.050	.006	-.085	-.096	-.087	-.063	.035	-.103	-.164*	-.088
MLQ7	-.080	.005	.042	-.122	-.004	.139	.057	-.019	.016	-.043	-.136	-.075	-.076	.029	-.129	-.162*	-.064
MLQ8	-.128	-.107	-.047	-.175*	-.050	.052	-.014	-.124	-.043	-.122	-.227**	-.161*	-.156	.073	-.122	-.190*	-.086
MLQ9	-.062	.025	-.031	-.155	-.068	.069	.039	-.040	-.059	-.086	-.133	-.119	-.101	.059	-.093	-.087	-.056
MLQ10	-.086	-.021	-.036	-.140	-.116	.070	.004	-.060	-.070	-.147	-.161	-.138	-.112	.069	-.139	-.077	-.079
MLQ11	-.139	-.063	-.083	-.119	-.167*	.027	-.028	-.149	-.124	-.143	-.212**	-.148	-.142	.049	-.137	-.101	-.053
MLQ12	-.125	-.050	.033	-.002	-.063	.109	-.017	-.070	-.110	-.088	-.125	-.082	-.127	.061	-.082	-.064	-.018
MLQ13	-.083	.018	.045	.003	-.077	.022	-.008	-.070	-.061	-.107	-.076	-.046	-.052	.181*	-.008	-.148	.044
MLQ14	-.100	-.013	-.036	-.063	-.100	-.020	-.062	-.159	-.084	-.156	-.195*	-.158	-.197*	.144	-.073	-.114	-.016
MLQ15	-.099	-.077	-.042	-.088	-.124	.005	-.027	-.081	-.097	-.123	-.146	-.150	-.142	-.062	-.181*	-.129	-.072
MLQ16	-.139	-.016	-.041	-.121	-.083	.014	-.055	-.114	-.108	-.135	-.159	-.184*	-.111	.059	-.165*	-.111	-.084
MLQ17	-.157	-.020	-.001	-.109	-.084	-.018	-.050	-.146	-.094	-.136	-.174*	-.167*	-.139	.038	-.173*	-.114	-.038
MLQ18	-.074	-.014	-.041	-.122	-.109	.086	.012	-.066	-.064	-.123	-.168*	-.135	-.096	.018	-.136	-.059	-.034
MLQ19	-.085	-.032	-.019	-.070	-.057	.057	-.008	-.042	-.048	-.106	-.142	-.062	-.101	.023	-.082	-.100	-.040

MLQ20	-.122	-.057	-.030	-.079	-.126	.061	-.022	-.084	-.080	-.137	-.115	-.127	-.113	.008	-.094	-.134	-.004

* α = 0.05. ** α = 0.01.

Comparison of the Means

An analysis of the overall Resistance to Change was performed by comparing the means of Leaders and Raters. The 17 questions from RTC were rated on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). The mean scores of RTC Items Grouped by Leaders and Raters demonstrated a general overall steadiness with no mean averages over 3.84 for the leaders and 4.35 for the raters. The overall mean average for the leaders resulted at 2.54 and the overall mean average for raters resulted at 2.78, thus demonstrating that resistance to change is higher for raters. The mean average for the questions relating to Subscale scores of RTC: Routine seeking: Items 1-5 showed an average of 2.43. Emotional reaction: Items 6-9 provided an average of 2.72. Short-term focus: Items 10-13 gave an average of 2.22. Finally, Cognitive rigidity: Items 14-17 resulted in 3.70. Oreg's (2003) Resistance to Change states the cognitive component of resistance to change, results in "frequency and ease with which people change their minds". With an average mean result of 3.70 between both leaders and raters, individuals in a not-for-profit Catholic healthcare setting, appear to not struggle much with resistance to change. An analysis of overall resistance to change was performed by comparing the mean RTC scores of leaders and raters. Tables 8 and 9 contain detailed results of the mean analysis.

Table 7

Mean Comparison of RTC Item Scores Grouped by Leaders and Raters

	Leaders					Raters					
RTC Item	Min	Max	Mean	Std. D.	Variance	Min	Max	Mean	Std. D.	Variance	Mean Diff.
1	1	3	1.88	.666	.443	1	6	1.98	1.200	1.440	-0.1
2	1	4	2.64	.907	.823	1	6	3.05	1.348	1.816	-0.41
3	1	4	2.04	.935	.873	1	6	2.11	1.124	1.264	-0.07
4	1	5	2.56	.961	.923	1	6	3.23	1.264	1.598	-0.67
5	1	4	1.96	.889	.790	1	6	1.97	1.034	1.070	-0.01
6	1	6	2.96	1.274	1.623	1	6	2.66	1.307	1.708	0.3
7	1	4	2.64	.907	.823	1	6	2.74	1.275	1.626	-0.1
8	1	6	3.08	1.152	1.327	1	6	3.03	1.334	1.779	0.05
9	1	4	2.36	1.075	1.157	1	6	2.41	1.153	1.330	-0.05
10	1	4	2.36	.860	.740	1	5	2.43	.994	.987	-0.07
11	1	4	2.16	.850	.723	1	6	2.25	.988	.976	-0.09
12	1	4	2.28	.792	.627	1	5	2.17	.973	.947	0.11
13	1	4	1.96	.841	.707	1	5	2.05	.955	.911	-0.09
14	2	6	3.52	1.159	1.343	1	6	4.18	1.251	1.566	-0.66
15	1	5	2.76	1.012	1.023	1	6	3.48	1.334	1.779	-0.72
16	1	5	2.76	.970	.940	1	6	3.16	1.226	1.503	-0.4
17	1	5	3.84	.898	.807	1	6	4.35	1.127	1.269	-0.51

Table 8

Mean of RTC Items

RTC Item	*N*	Mean	Std. D.
1	153	1.96	1.129
2	153	2.99	1.293
3	153	2.10	1.093
4	153	3.12	1.242
5	153	1.97	1.009
6	153	2.71	1.302
7	153	2.73	1.221
8	153	3.04	1.302
9	153	2.40	1.138
10	153	2.42	.971
11	153	2.24	.965
12	153	2.19	.944
13	153	2.03	.935
14	153	4.07	1.257
15	153	3.36	1.311
16	153	3.09	1.194
17	153	4.27	1.106

ANOVA Test Results

Resistance to Change

A one-way between ANOVA was conducted to compare the resistance to change amongst those in a health care setting. Testing the studies hypotheses employed a variety of approaches. For instance, ANOVA exhibits the F- test which exams the hypothesis utilizing the entire coefficient estimates. Each F-statistic is a ratio of mean squares. The numerator is the mean square for the term. The denominator is chosen such that the

expected value of the numerator mean square differs from the expected value of the denominator mean square only by the effect of interest (Gujarati, 2003). The effect for a random term is represented by the variance component of the term. Therefore, a high F-statistic indicates a significant effect. All p values were greater than .05, except there was a significant finding with only one dependent variable with resistance to change. The dependent variable: If I were to be informed that there's going to be a significant change regarding the way things are done at work, I would probably feel stressed. The model is significant with P-value $0.039 < \alpha = 0.05$.

In regression, the total sum of squares helps express the total variation of the y's. The regression sum of squares is the variation attributed to the relationship between the x's and y's. The sum of squares of the residual error is the variation attributed to the error. By comparing the regression sum of squares to the total sum of squares, you determine the proportion of the total variation that is explained by the regression model (R2, the coefficient of determination). The larger this value is, the better the relationship. The F test tests the hypothesis that all of the coefficients are jointly zero. If the F stat is greater in absolute value than the critical F, then the null hypothesis is rejected in that all of the coefficient estimates are zero. The P (two-tail) test, or significance test, tests for the probability of rejecting a true hypothesis. At the 95% confidence level, if the P value is less than a .05 significance level, the null hypothesis is rejected. The R-squared statistic yields a percentage that represents the amount of the dependent variable that is explained

by the independent variables chosen (Gujarati, 2003). Backward elimination, which involves starting with all candidate variables, testing the deletion of each variable using a chosen model comparison criterion, deleting the variable (if any) that improves the model the most by being deleted, and repeating this process until no further improvement is possible. Table 9 showed the model is significant with p-value $0.039 < \alpha = 0.05$ because all p-values were greater than .05, this test shows that this data provide substantial evidence that individuals are not resistance to change unless change occurred significantly at work.

Table 9

Resistance to Change and Regression Outputs RTC

RTC Item	*SS*	*df*	*MS*	*F*	*p*
1	166.992	128	1.333/1.300	1.024	0.441
2	220.920	128	1.767/1.718	1.028	0.437
3	165.488	128	1.902/1.180	1.612	0.062
4	195.504	128	.719/1.677	0.429	0.984
5	128.806	128	1.174/.975	1.204	0.265
6	222.806	128	2.702/1.566	2.702	0.039*
7	196.062	128	1.346/1.566	0.860	0.637
8	208.930	128	1.696/1.621	1.046	0.416
9	174.388	128	1.593/1.320	1.207	0.263
10	131.225	128	1.333/.968	1.376	0.150
11	112.899	128	1.229/.818	1.503	0.095
12	111.581	128	1.039/.841	1.235	0.240
13	109.969	128	1.251/.787	1.591	0.068
14	206.806	128	1.873/1.568	1.195	0.273
15	222.667	128	1.759/1.736	1.013	0.454
16	182.930	128	1.243/1.464	0.849	0.649

17	173.023	128	.881/1.439	0.612	0.896

** $p < 0.05$

Model Development

RTC 6 was used to determine the final model. The final model was RTC 6 = 1.983 + 0.715(MLQ 12) – 0.610 (MLQ 14). Detailed results can be found in Table 10.

Table 10

Coefficient Standardization Using RTC 6 as the Dependent Variable

	Nonstd. Coeff.		Std. Coeff.			95% CI Interval for B	
Model	B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
(Constant)	1.983	0.385		5.145	0	1.219	2.747
MLQ 1	0.021	0.157	0.019	0.132	0.895	-0.29	0.331
MLQ 2	0.234	0.176	0.226	1.325	0.188	-0.116	0.583
MLQ 3	-0.068	0.209	-0.064	-0.324	0.746	-0.481	0.346
MLQ 4	-0.058	0.181	-0.051	-0.32	0.75	-0.417	0.301
MLQ 5	0.167	0.232	0.168	0.723	0.471	-0.292	0.626
MLQ 6	-0.011	0.264	-0.01	-0.04	0.968	-0.533	0.512
MLQ 7	0.406	0.220	0.405	1.846	0.068	-0.03	0.842
MLQ 8	-0.16	0.173	-0.174	-0.922	0.359	-0.503	0.184
MLQ 9	0.318	0.232	0.314	1.372	0.173	-0.142	0.777
MLQ 10	-0.01	0.201	-0.01	-0.051	0.959	-0.408	0.387
MLQ 11	-0.46	0.239	-0.466	-1.924	0.057	-0.933	0.014
MLQ 12	0.715	0.245	0.655	2.918	0.004	0.229	1.2
MLQ 13	0.017	0.155	0.016	0.112	0.911	-0.29	0.324
MLQ 14	-0.61	0.220	-0.605	-2.775	0.007	-1.046	-0.174
MLQ 15	-0.327	0.206	-0.324	-1.583	0.116	-0.736	0.082
MLQ 16	0.034	0.245	0.034	0.138	0.891	-0.452	0.519

MLQ 17	-0.033	0.223	-0.036	-0.148	0.883	-0.475	0.409
MLQ 18	0.069	0.209	0.07	0.331	0.741	-0.345	0.483
MLQ 19	-0.32	0.260	-0.319	-1.233	0.22	-0.836	0.195
MLQ 20	0.251	0.217	0.234	1.156	0.25	-0.179	0.682

Table 11 is a table of mean for responses under each subscale (Routine seeking (inclination to adopt routines), Emotional reaction (the amount of stress and uneasiness induced by change), Short-term focus (the extent to which individuals are distracted by the short-term inconveniences associated with change), and Cognitive rigidity (frequency and ease with which people change their minds). It measures alongside the respective standard error. Analysis of variance has been performed on the dataset, and the significant parameters were subjected to post hoc test DMRT (Duncan Multiple Range Test) which brought about the alphabets that has as a superscript on every standard error. The figures at the left are the mean while those at the front are the corresponding standard error. Looking at the superscript on the standard error for each subscale, one can observe that they are different. This show that the responses for these scales differ significantly from each other. ANOVA test in Table 12 indicated that the responses on the subscales differs from each other, in other to known which one differs from the other additional test was conducted (post hoc test) making use of Duncan Multiple Range Test which brought about the superscript alphabet on each standard error in Table 13. Cognitive rigidity has the highest mean and its' mean significantly differs from that of other subscales. Emotional reaction also has a mean next to Cognitive rigidity, nevertheless, it differs

from cognitive rigidity as well from other subscales. Routine seeking has a mean 3rd in ranking when compared in descending order. Its mean is different from the mean observed for other subscales. And finally, Short-term focus has the lowest mean value. In conclusion, from the result of the analysis, there is a significant difference between the observed means for the subscales.

Table 11

Mean Comparison for Significant Difference between RTC Subscale Responses

RTC Subscale	Mean ± Std. Err.
Routine seeking	2.43 ± 0.046
Emotional reaction	2.72 ± 0.051
Short - term focus	2.22 ± 0.039
Cognitive rigidity	3.70 ± 0.053

Table 12

ANOVA of Mean Comparison for Significant Difference between RTC Subscale Responses

Comparison	Sum of Sq.	*df*	Mean Sq.	*F*	Sig.
Between Groups	802.453	3	267.484	182.465	.000
Within Groups	3807.057	2597	1.466		
Total	4609.509	2600			

Table 13

Duncan Multiple Range Test Output

		Subset for alpha = 0.05			
Subscale	N	1	2	3	4
Short - term focus	612	2.22			
Routine seeking	765		2.43		
Emotional reaction	612			2.72	
Cognitive rigidity	612				3.7
Sig.		1.000	1.000	1.000	1.000

Note. Means for groups in homogeneous subsets are displayed. Since group sizes are unequal, the harmonic mean of the group sizes was used. Type 1 error levels are not guaranteed.

The regression equation is simpler if variables are standardized so that their means are equal to 0 and standard deviations are equal to 1, for then b = r and A = 0. Detailed regression results can be seen in Table 14. From the model summary table, the criteria to be considered is Adjusted R2, as it adjusted for any variable added or removed from the model. A total of 20 models were reviewed at the end of the analysis using backward elimination method. Model 15 has the highest Adjusted R2, even though the value is 0.069, therefore we are going to consider it as the best model. Table 15 includes

detailed information about this model. The Dependent Variable: I generally consider changes to be a negative thing was analyzed against constant MLQ Predictors: I talk optimistically about the future, I spend time teaching and coaching, I specify the importance of having a strong sense of purpose, I consider each individual as having different needs abilities and aspiration from others, I go beyond self-interest for the good of the group, and I act in ways that build others respect for me. Table 16 includes detailed results. The results of the regression equation is RTC1 = 2.094 + 0.289 (MLQ4) – 0.298 (MLQ11). We can therefore conclude that MLQ4 , I consider each individual as having different needs abilities and aspiration from others and MLQ11, I act in ways that build others respect for me does have positive results and could assist in to RTC question, I generally consider changes to be a negative thing, to become a positive influential factor.

Table 14

Regression Analysis Output Using Backward Elimination Method

Model	R	R^2	Adjusted R^2	Std. Err.
1	.399[a]	0.159	0.004	1.140
2	.399[b]	0.159	0.013	1.135
3	.399[c]	0.159	0.022	1.130
4	.399[d]	0.159	0.031	1.125
5	.399[e]	0.159	0.039	1.120
6	.397[f]	0.158	0.046	1.115
7	.395[g]	0.156	0.052	1.112
8	.392[h]	0.153	0.058	1.109
9	.387[i]	0.150	0.062	1.106
10	.382[j]	0.146	0.066	1.104

11	.370[k]	0.137	0.064	1.105
12	.358[l]	0.128	0.062	1.106
13	.350[m]	0.122	0.064	1.105
14	.341[n]	0.116	0.065	1.104
15	.336[o]	0.113	0.069	1.102
16	.322[p]	0.104	0.067	1.103
17	.310[q]	0.096	0.067	1.103
18	.291[r]	0.085	0.063	1.106
19	.266[s]	0.071	0.056	1.110
20	.395t	0.156	0.052	1.112

Table 15

Model 15 ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Regression	18.854	6	3.142	2.588	.021[p]
Residual	148.138	122	1.214		
Total	166.992	128			

Note. Dependent variable was RTC 1. Predictors were MLQ 4 and MLQ 11.

Table 16

Coefficient Standardization

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
Model	B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound
	2.094	0.291		7.191	0	1.517	2.67
MLQ4	0.289	0.134	0.292	2.148	0.034	0.023	0.555
MLQ8	0.206	0.15	0.237	1.371	0.173	-0.091	0.502
MLQ7	-0.23	0.13	-0.289	-1.774	0.078	-0.487	0.027
MLQ15	0.207	0.186	0.237	1.117	0.266	-0.16	0.575
MLQ9	-0.252	0.175	-0.295	-1.444	0.151	-0.598	0.094
MLQ11	-0.298	0.148	-0.342	-2.014	0.046	-0.592	-0.005

LMX 7 Data Analysis

To find the answer to H02, There is no relationship between relationships leaders develop with their subordinates and leader transformational scores, the following analyses were conducted. Using the LMX 7 questionnaire, the total score was calculated for each respondent. Additionally, the MLQ questionnaire consisted of using the five leadership style scale in consideration were: Individual Consideration, Intellectual Stimulation, Idealized Influence (Behavior), Inspirational Motivation, and Idealized Influence (Attributes). Each of these have been related to transformational leadership style. The average was then calculated for each of the five scales. This process was done to come up with a concise and valid analysis. Having made these modifications, the variables in question became quantitative and could easily be analyzed using Pearson's correlation coefficient to test for the presence of association among the variables. Below is a list of finding that was gathered using the LMX 7 questionnaire:

1. There is an association between relationships leaders develop with their subordinates and individual consideration with a correlation value of 0.902, $p<.000$. Meaning that the higher the relationship leaders develop with their subordinates, the higher individual consideration.

2. There is an association between relationships leaders develop with their subordinates and Intellectual Stimulation with a correlation value of 0.869, $p < .000$.

Which implies the higher the relationship leaders develop with their subordinates, the higher Intellectual Stimulation becomes.

3. Also, there is an association between relationships leaders develop with their subordinates and Idealized Influence (Behavior) with a correlation value of 0.860, $p<.000$. To be interpreted as the higher the relationship leaders develop with their subordinates, the higher Idealized Influence (Behavior).

4. There is an association between relationships leaders develop with their subordinates and Inspirational Motivation with a correlation value of 0.841, $p<.000$. Meaning that the higher the relationship leaders develop with their subordinates, the higher inspirational Motivation.

5. There is relationship between relationships leaders develop with their subordinates and Idealized Influence (Attribute) with a correlation value of 0.883, $p<.000$. Which implies the higher the relationship leaders develop with their subordinates, the higher Idealized Influence (Attributes) becomes.

Since the hypothesis states that “there is no correlation between relationships leaders develop with their subordinates and leader transformational scores” one can only reject this if there is a significant relation between the variables “relationships leaders develop with their subordinates and leader transformational scores”. From the above table, there is a correlation coefficient between LMX 7 total scores and the Five Leadership style scales in consideration. It is observed that all LMX 7 total scores

correlate significantly with all the Five Leadership style scales, we therefor can reject the null hypothesis “there is no relationship between relationships leaders develop with their subordinates and leader transformational scores” and conclude that there is relationship between relationships leaders develop with their subordinates and leader transformational scores. The data can be found in Table 18.

Table 17

Pearson’s Correlation between LMX 7 and MLQ Leadership Style Subscales

	N	*r*
Individual Consideration	126	.902**
Intellectual Stimulation	127	.869**
Idealized Influence (Behavior)	128	.860**
Inspirational Motivation	128	.841**
Idealized Influence (Attributes)	128	.883**

** $p < .001$.

Summary

The purpose of this study was to determine if (a) transformational leadership is positively correlated with change in a not-for-profit Catholic organization and (b)

leadership has an influence on employees' behaviors and motivation to change. The data indicated that transformational leadership style is positively correlated with change and has some significant influence on change in a healthcare setting. In the following chapter, a discussion of the results, conclusion, and recommendations is provided explaining why healthcare organizations should consider transformational leadership style when change is needed.

Chapter 5: Discussion, Conclusions, and Recommendations

This research was intended to study the use of transformational leadership within a healthcare organization to address resistance to change. Using transformational leadership to overcome the barriers of change can result in a more productive healthcare work environment. This chapter highlights the importance of transformational leadership and explores the relationship between leadership style and followers' resistance to change. The purpose of this study was to demonstrate that transformational style leadership was associated positively with change in a not-for-profit Catholic organization and determine if leadership influenced employees' behaviors and motivation to change. The results indicate that transformational leadership style and resistance to change are significantly correlated but do not necessarily influence each other. Additionally, this section includes recommendations, research limitations, social change significance, and a conclusion statement.

Summary

The purpose of this study was to see whether transformational style leadership is associated positively with change in a not-for-profit Catholic organization, and whether leadership influences on employees' behaviors and motivation to change. The study was done to encourage improvement in a healthcare setting to promote transformational leadership in an organization and understand resistance to change. These outcomes could

result in a more productive healthcare work environment while using transformational leadership style to overcome the barriers of change.

The study was conducted using an electronic survey format by Mind Garden. A total of 500 surveys were sent out to a randomly selected group of individuals for three departmental areas compatible in size: Information Management (including Clinical Informatics), Human Resources, and Patient Financial Services. The response rate was 31.6% for a total response of 158 surveys. The next paragraphs provide the findings that can improve a healthcare setting while at the same time looking at resistance to change in a healthcare setting and the transformational leadership style.

Interpretation of Findings

The outcomes of this study are intended to help healthcare organizations reach a better understanding of the transformational leadership style and resistance to change answering the following five questions. How does leadership dictate changes that are orchestrated today using transformational leadership in healthcare with resistance to change? This study demonstrated that there is a strong correlation between transformation leadership and resistance to change. However, after further analysis was conducted using ANOVA and multivariate regression, the adjusted R2 remained low, which demonstrated that the best Model 15 Dependent Variable was “I generally consider changes to be a negative thing” with a result of (0.096). Tabachnik and Fidell (2007, p. 123) recommend that,” a regression model with m predictors require a sample size

greater than 50 + 8 * m for tests of the overall model and a sample size greater than 104 + m for evaluating whether a specific predictor has an influence." The overall sample size was 153. However, when considering the predictor, transformational leadership style, only 25 leaders were evaluated. A low R2 value doesn't necessarily mean a negative thing, according to statistician Jim Frost (2013). Frost (2013) indicated that in some selected fields, it is entirely expected that the R-squared values are low. For example, Field stated, "any field that attempts to predict human perceptions/behaviors, such as psychology, typically has R-squared values lower than 50%. Humans are simply harder to predict than, say, physical processes". Since this study predicted human perceptions, the low R2 scores can be considered relevant. The results of the regression equation is RTC1 = 2.094 + 0.289 (MLQ4) – 0.298 (MLQ11). We can therefore conclude that MLQ 4 , I consider each individual as having different needs abilities and aspiration from others and MLQ 11, I act in ways that build others respect for me does have positive results and could assist in to RTC question, I generally consider changes to be a negative thing, to become a positive influential factor. Therefore it can be assumed that the H01 (null hypothesis): There is no difference in the factor structures of the Dispositional Resistance to Change (RTC) and the Multifactor Leadership Questionnaire focusing on transformational leadership can be true.

Research Area 2, the relationship leaders have with subordinates does not influence change in a healthcare organization, provided additional answers to the second

hypotheses, *H*02 (2): There is no relationship between relationships leaders develop with their subordinates and leader transformational scores. This study clearly indicated that there is relationship between relationships leaders develop with their subordinates and leader transformational scores. Utilizing the LMX 7 questionnaire, the total score was calculated for each respondent. Additionally, the MLQ questionnaire consisted of utilizing, the 5 Leadership style scale in consideration were: Individual Consideration, Intellectual Stimulation, Idealized Influence (Behavior), Inspirational Motivation, and Idealized Influence (Attributes) for each of these have been related to transformational leadership style as indicated by Bass et al. (2003) and are the best attributes to evaluate transformational leadership style. Each of the variables indicated a high Pearson's correlation coefficient. Demonstrating that there is a significant relation between the variables relationships leaders develop with their subordinates and leader transformational scores. Therefore, the hypothesis there is no relationship between relationships leaders develop with their subordinates and leader transformational score can be rejected.

Until the mid 1980s, transactional leadership was considered the primary leadership style utilized in business organizations. Today, many theories and models have influenced current leadership styles that can be applied to the healthcare setting. When considering leadership of healthcare professionals, most theories were not developed in a healthcare setting but were developed for the business setting and then later applied to

healthcare (Al-Sawai, 2013). Change in healthcare needs guidance from effective leadership. Each leader when considering change should focus on the dynamic relationships between the values, culture, capabilities and the organizational context (Al-Sawai, 2013). Additionally, the leader's growing journey must function with the high level of understanding one's self, creating a positive working environment, and applying organizational awareness. These characteristics are transformational in style and leadership development has undoubtedly reached a serious crossroad in the healthcare setting due to the ever-changing healthcare environment. Findings in the study have been contextual to the theoretical and conceptual framework as appropriately indicated by Bass and his theory of transformational leadership style. Thus, it is the researches hopes that additional studies provide further research that transformational leadership style is beneficial in a healthcare setting when overcoming resistance to change.

Limitations

A strong correlation exists between transformational leadership and resistance to change. However, after additional analysis utilizing ANOVA and multivariate regression, the adjusted R^2 remained low. A low R^2 value is not necessarily negative. Frost (2013) stated that "Any field that attempts to predict human perceptions/behaviors, such as psychology, typically has R-squared values lower than 50%. Humans are simply harder to predict than, say, physical processes" (para.8). Since this study is predicting human perceptions, the low R^2 scores may still be considered relevant.

Tabachnik and Fidell (2007) recommend that “a regression model with m predictors requires a sample size greater than 50 + 8 * m for tests of the overall model and a sample size greater than 104 + m for evaluating whether a specific predictor has an influence” (p. 123). The overall sample size was 153; however, only 25 leaders were evaluated regarding transformational leadership style.

Additionally, the independent and dependent variables in this study were associates' and leaders' opinions rather than their actual behaviors. The study did not verify participation in change management nor did it address actual aspects that frame a person’s leadership style. Ultimately, the study measured the values that the individuals ascribed to the respective research areas.

Leadership and management are both culturally-constrained. Religion, social customs, politics, values, and the environment can influence leadership and management. The product of working in a healthcare setting is a rapidly changing environment. Thus, the culture of a specific setting may also change. An organization may establish its cultural norms and values, but that does not mean each individual participates. This factor may lead to a bias since culture is sometimes misunderstood in a healthcare setting. To offset this, a randomized sample of 500 was utilized to establish some variance with the answers provided. In contrast, the results might not apply to all healthcare settings because of cultural differences.

External factors can also influence leaders and management styles. Economic restraints, specified policies, interventional relations, and climate conditions are just a few of the operational circumstances in which leaders have to operate. Each individual can thrive and function effectively in certain situations. These factors were not evaluated in this research. Therefore, in order to raise the leader's efficiency, changing the situation or perhaps placing the right individual in a given situation can change and predict the needed outcome or result.

Finally, the validity of MLQ (Bass & Avolio, 2004) and RTC (Oreg, 2003) have both been documented. However, this study, focused on a Not-for-profit healthcare organization. To ensure validity, the study should be repeated in other healthcare settings.

Recommendations

The evidence produced in this study indicates that transformational leadership style can influence resistance to change in a healthcare setting. Furthermore, the quality of relationships leaders create with their subordinates is positively correlated with transformational leadership. Utilizing transformational leadership style as training mechanism could improve the implementation of changes and help leaders function well in a rapidly changing healthcare setting.

The discoveries in this research will contribute to social change in a few ways. First, leadership styles tied to employees' behaviors may expand collaboration among healthcare organizations implementing change. For most, organizational change can be is

considered a threat. For instance, whether the threat is real or not, most can perceive the change as a threat to job security or disruption to normal routines. Transformational leadership style can assist in in transitioning those fears. There has been research conducted in organizations with resistance to change; however, very limited research studies have been done on the effects of transformational leadership behaviors in a not-for-profit Catholic healthcare organization. Research has proven that change can make an organization successful, but change can be costly if not enforced in a positive manner (Canyon, 2013).

Many healthcare organizations are starting to feel the heavy impact of the direction healthcare is going. The once well-known "keeping heads in beds" healthcare system is no more. Today, government policies like Affordable Care Act (ACA) have swung the pendulum in a different direction, and the focus is now on keeping the overall population healthy in order to get reimbursed. According to ObamaCareFacts (2015), The ACA provides affordable quality healthcare for all Americans and reduces the growth in healthcare spending. The expansion of public health insurance to 138% of the federal poverty definition means tens of millions more Americans get access to care (ObamaCare Facts, 2015). This also guarantees less unpaid emergency care brought on by lack of coverage.

Obamacare Facts (2015) stated that the costs of healthcare to the taxpayer are more than any other provision in the ACA. The ACA both increases annual taxpayer

costs and decreases emergency healthcare spending. ObamaCare Facts (2015) stated that hospitals' uncompensated care costs are estimated to be $7.4 billion, 21% lower in 2015 than they would have been in the absence of coverage expansions. Since 75% of healthcare spending goes toward treatment of chronic diseases, developing a healthier society would prevent many costs (Obamacare Facts, 2015). Since the ACA was introduced, there has been rapid changes healthcare. Therefore, it is important for leaders to understand change management and the resources it can provide to the healthcare settings.

In order for healthcare organizations to survive, it is essential that they grasp this rapid change and possess leaders who are ready to handle the changes. Change is here now, and it has a great impact on our current healthcare systems. The results of this study may be used to help leaders understand the benefits of transformational leadership. Transformational leaders can positively motivate change in a healthcare organization to meet new demands and profit from making any necessary adjustments to their current healthcare settings and leadership styles.

Finally, the relationship between leadership style, employees' behaviors, and motivation to change is also not well-known. This study will contribute to the expanding knowledge base regarding different leadership styles and change management in a specific healthcare organization. This research needs to be replicated in different regions

of the country and in different healthcare organizations and settings in order to further expand the researched knowledge base.

Implications

Healthcare settings in the United States face change management challenges and resistance to change often. Leaders who practice transformational leadership can assist subordinates to be more responsive to change and efficient in support. Thus the end result, would be to move towards the expected outcomes and change. Tseng (2011) observed that training strategies that included empowerment and commitment by the leaders could also influence subordinates in a positive manner. Healthcare organizations and talent management should consider training leaders in leadership techniques that reflect a transformational leadership style. This would help leaders adapt and respond to the rapidly changing healthcare system.

Transformational leadership is about executing new concepts, maintaining importance, being adaptable and flexible, and constantly striving to improve relationships with anyone around. Bass (1985) suggested that transformational leaders build relationships by engaging in the factors associated with transformational leadership:

- Charisma
- Inspirational motivation
- Intellectual stimulation
- Individual consideration

Charisma is a leadership talent that is hard to define. Just like beauty, charism is recognizable when seen or heard. Charisma tends to be based on the individual's own inherent values. Transformational leaders' charisma is characterized by having high moral and ethical standards which builds trust. During change, inspirational motivation can definitely come into play. This characteristic includes the illumination of the big picture for the future. Creating a goal with which people can identify makes change easier to consider and implement. In addition to identification and commitment, inspirational motivation provides a common goal that allows individuals to accept a buy-in. Transformational leaders use intellectual stimulation to look at existing problems and challenging the issues without boundaries. Taking a risk is often necessary when implanting change. Lastly, but probably most importantly, transformational leaders utilize individual consideration. The meaning of individual consideration is in the phrase itself. A leader must treat everyone as individuals but, at the same time, provide mentoring and coaching. This allows each individual to develop and seek growth opportunities. The transformational leadership style not only teaches the next generation of leaders but also satisfies the person's need for self-worth. By being transformational, leaders seize the opportunity to show others that their vision and direction can achieved. Transformational leadership is necessary for commitment to any organizational change.

Conclusion

Leadership and healthcare change management have faced many obstacles and change throughout the years. The tools needed to implement change in a healthcare setting have been researched, but finding a solid solution remains a challenge. This study addressed the ways a leader can mark the course using transformational leadership. Change is inevitable in a healthcare setting and great leaders identify environmental shifts that aid the business to answer those changes (Al-Sawai, 2013). According to Depre (1990), this in turn empowers leaders to help guide individuals to a new vision (). Depre defined this concept as organizational learning: "understanding the changes occurring in the external environment and then adapting beliefs and behavior to be compatible with those changes" (p. 16).

Leaders are constantly striving for methods to identify the correct course of action when change is necessary. However, just recognizing a need for change is not enough. According to Hiatt (2008), change management helps individuals to support the change and work toward the goals of the change. However, as humans, it is natural to have resistance to change (Oreg, 2003). This study provided evidence that transformational leadership is essential when conquering resistance to change. Transformational leadership has characteristics that encompass change. In general, influencing individuals' attitudes, events, behaviors, and choices comes easily to transformational leaders. These leaders are good at switching perspectives. For example, subordinates that value constancy and

steadiness may perceive organizational change as a danger and therefore resist it. Whereas individuals that desire stimulation and rejuvenation may interpret it as an opportunity and will more than likely welcome it. Therefore, leaders' values inspire the goals they assign and the outcomes that they will reward (Oreg & Berson, 2009). For instance, leaders that are risk takers and value openness are more than likely to reward followers that exhibit new ideas that are unconventional. Along these same lines, leaders' values form organizational procedures and customs. Sequentially, these procedures and customs then influence employees' attitudes (Oreg & Berson, 2009). In other words, by setting the expectation that relate to their value systems, transformational leaders shape employees' attitudes and beliefs. This study showed that a leader's relationship with subordinates does have a cause and effect when influencing change. With the information obtained in this study, it is essential for healthcare organizations to encourage transformational leadership when facing the everyday challenges of healthcare.

With the rapidly changing healthcare environment placing more demands on leaders to increase productivity while cutting costs, it is important to know if leaders are maximizing their effectiveness. Many challenges remain ahead for healthcare leaders. This research demonstrated that transformational leadership is significantly correlation with lower resistance to change in a not-for-profit Catholic healthcare setting. If this research can be reproduced in other healthcare settings, then transformational leadership should be implemented across the United States to assist with rapid changes.

Transformational leadership has been established as the leadership style that facilitates change (Herold, Fedor, Caldwell, & Liu, 2008). It would be beneficial for healthcare organizations to enforce it.

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Appendix A: Introduction Letter

Dear Associate:

By way of introduction, my name is Tanisha Garcia. I'm currently a Doctoral Candidate at Walden University and work in the Information Management department.

I am seeking your assistance in completing my doctoral dissertation. My research study will investigate possible correlation between leadership style and employee resistance to change. This is a formal invitation to invite you to participate in this study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please feel free to reach out to me at the number provided on this form or via e-mail.

All that is needed from you is completion of a survey of questionnaires which will take approximately 20 minutes. The questionnaire is scale based and will be provided to you via e-mail by Mind Garden. Mind Garden is a research organization that is providing the custom for the tools utilized in gathering the research.

There are no known risks to you as a participant of this research study. You are not expected to gain any benefit from this study. However, this study will add valuable information to the existing literature on resistance to change and leadership. My research study will also provide your organization with information that can be used in Management Talent. There is no cost to you to be in this research study.

The information collected in this study will be kept strictly confidential. The data will be collected for analysis and no one specific individual's score will be revealed in any way. To assure complete anonymity and protection, your name will not appear on any of the survey instruments, analysis, or final research documentation.

Your participation in this research is completely voluntary. If at any time you feel uncomfortable participating in the study and do not wish to proceed, please feel free to discontinue your participation. The results are needed to assist in understanding resistance to change and leadership.

If you have any questions or concerns during or after this research study, you may contact:

Researcher: Tanisha Garcia
E-mail: Tanisha.garcia@waldenu.edu
Phone: 469-282-0121

Faculty Chair: Dr. Patrick Tschida
E-mail: patrick.tschida@waldenu.edu

If you have any questions regarding your rights as a participant, you can contact the Institutional Review Board (IRB) at 469-282-2686.

Appendix B: Questionnaire

Section 1 Demographics

AGE:

18-25

26-35

36-45

46-55

56-75

76-95

GENDER:

F

M

REGION:

Texas

Louisiana

New Mexico

DEPARMENT:

Informational Management (including

Health Informatics)

Patient Financial Services

Human Resources

Section 2 MLQ Rater/Leader

Using the rating scale from Unsure -Not at all - Once in a while - Sometimes - Fairly often - Frequently, if not always. If an item is irrelevant or if the leader and rater are unsure of the answer, there is an "Unsure" marking available.

RQ 1:

Re-examines critical assumptions to question whether they are appropriate.

RQ 2:

Talks about his/her most important values and beliefs.

RQ 3:

Seeks differing perspectives when solving problems

RQ 4:

Talks optimistically about the future.

RQ 5:

Instills pride in others for being associated with him/her.

RQ 6:

Talks enthusiastically about what needs to be accomplished.

RQ 7:

Specifies the importance of having a strong sense of purpose.

RQ 8:

Spends time teaching and coaching.

RQ 9:

Goes beyond self-interest for the good of the group.

RQ 10:

Treats others as individuals rather than just as members of the group.

RQ 11:

Acts in ways that build my respect.

RQ 12:

Considers the moral and ethical consequences of decisions.

RQ 13:

Displays a sense of power and confidence.

RQ 14:

Articulates a compelling vision of the future.

RQ 15:

Considers that I have different needs, abilities, and aspirations from others.

RQ 16:

Gets me to look at problems from many different angles.

RQ 17:

Helps me to develop my strengths.

RQ 18:

Suggests new ways of looking at how to complete assignments.

RQ 19:

Emphasizes the importance of having a collective sense of mission.

RQ 20:

Expresses confidence that goals will be achieved.

Section 3 Leader–Member Exchange (LMX) Rater

RQ 1: Do you know where you stand with your leader and do you usually know how satisfied your leader is with what you do?

Drop down select one. Rarely- Occasionally –Sometimes- Fairy often -Very often

RQ 2: How well does your leader understand your job problems and needs?

Drop down select one. No a bit - A little - A fair amount - Quite a bit - A great deal

RQ 3: How well does your leader recognize your potential?

Drop down select one. Not at all-A little-Moderately-Mostly-Fully

RQ 4: Regardless of how much formal authority your leader has built into his or her position, what are the chances that your leader would use his or her power to help you solve problems in your work?

Drop down select one. None-Small-Moderate-High-Very high

RQ 5: Again regardless of the amount of formal authority your leader has, what are the chances that he or she would “bail you out” at his or her expense?

Drop down select one. None-Small-Moderate-High-Very high

RQ 6: I have enough confidence in my leader that I would defend and justify his or her decision if he or she were not present to do so.

Drop down select one. Strongly agree-Disagree-Neutral-Agree-Strongly agree

RQ 7: How would you characterize your working relationship with your leader?

Drop down select one. Extremely ineffective-Worse than average-Average-Better than average-Extremely ineffective

Section 4 The 17item scale, Dispositional Resistance to Change (RTC).

Answered by Rater/Leader

The leader and rater must indicate the degree to which they agree or disagree with each statement by selecting the appropriate response from "Strongly agree" to "Strongly disagree." The leader and rater must describe themselves as what they are generally now and not as what they wish to be in the future.

RQ 1: I generally consider changes to be a negative thing.

RQ 2: I'll take a routine day over a day full of unexpected events any time.

RQ 3: I like to do the same old things rather than try new and different ones.

RQ 4: Whenever my life forms a stable routine, I look for ways to change it.

RQ 5: I'd rather be bored than surprised.

RQ 6: If I were to be informed that there's going to be a significant change regarding the way things are done at work, I would probably feel stressed.

RQ 7: When I am informed of a change of plans, I tense up a bit.

RQ 8: When things don't go according to plans, it stresses me out.

RQ 9: If my boss changed the performance evaluation criteria, it would probably make me feel uncomfortable even if I thought I'd do just as well without having to do extra work.

RQ 10: Changing plans seems like a real hassle to me.

RQ 11: Often, I feel a bit uncomfortable even about changes that may potentially improve my life.

RQ 12: When someone pressures me to change something, I tend to resist it even if I think the change may ultimately benefit me.

RQ 13: I sometimes find myself avoiding changes that I know will be good for me.

RQ 14: I often change my mind.

RQ 15: I don’t change my mind easily.

RQ 16: Once I’ve come to a conclusion, I’m not likely to change my mind.

RQ 17: My views are very consistent over time.

Curriculum Vitae

Tanisha Garcia Ph.D.

Email: garcia.tanisha@yahoo.com

Teaching Experience

Southwest Regional Allied Health Director

[Years 2007 — 2012]

Instruction including on-line teaching utilizing WebCT, Blackboard and ECollege. Taught various courses in-class and on-line including Pharmacology, Career Management, Strategies for Success, Leading the Organization, and Information Management.

Education

Ph.D. Health Services (Healthcare Administration)

[2016]

Walden University, Minneapolis, Minnesota

Dissertation Topic: Associations Between Leadership Style and Employee Resistance to Change in a Healthcare Setting

Masters of Management in Healthcare Administration

[2008]

National American University, Rapid City, South Dakota

B.S. University Studies Health Sciences

[2007]

University of New Mexico, Albuquerque, New Mexico

Recent Coursework

• Building a Multidisciplinary Approach to Health
• Research, Theory, Design, and Methods
• Quantitative Reasoning and Analysis
• Advanced Quantitative Reasoning and Analysis
• Qualitative Reasoning and Analysis
• Contemporary Topics in US Healthcare
• Principles of Population Health in Healthcare Administration
• Law, Ethics, and Policy in Healthcare Administration
• Healthcare Financial Management and Economics
• Human Resources Management and Organizational Development and Leadership for Healthcare Administrators
• Public Health Administration and Leadership
• Public Health Leadership and Systems Thinking
• Strategic Planning: Collaboration, Cooperation, and Coordination
• Governance and Public Policy
• Organizational Development
• Health Economics
• Healthcare Financial Management
• Preparing for Dissertation
• Dissertation

Awards

Who's Who Among Students in American Universities and Colleges

Organizational Leadership and Development

Related Experiences

Clinical Implementation Application Analyst (CHRISTUS Health Irving, Texas)

[2012 — Present]

• Works with the Division Clinical Specialist Team and facility core team members to deliver hands-on training as needed, and to implement division standardization, utilization, integration and optimization plans for major clinical applications.

• Responsible for Change Management and best practices of organizational change focusing in Information Management.

• Responsible for implementations of new clinical /financial systems as required for full integration of services utilizing hospital EMR. Many applications included laboratory, pharmacy, radiology and full implementation of standalone facilities

SW Regional Director of Allied Health/Campus Director (National American University, Albuquerque NM/Lewisville TX)

[2007 — 2012]

• Overall operations of the campus. Including supervising/leadership multiple individuals.

• Fiscally responsibility for developing and monitoring program budget.

• Network and Coordinate program agreements with outside entities.

• Recommend methods for measuring student attainment of program competencies and outcomes to system assessment director.

• Ensured the organization maintained complete and accurate records along with the supporting documents.

Registered Medical Assistant for OB/GYN, PEDs, Gen Surg
[1994 — 2007]
(Presbyterian Hospital/SW Medical Associates, Albuquerque, NM)
• Assisted with Quality Control and improvement of clinical setting.
• Administrative duties include scheduling appointments, maintaining medical records, billing, and coding for insurance purposes.
• Clinical duties include taking and recording vital signs and medical histories, preparing patients for examination, drawing blood, and administering medications as directed by physician. Adhere to HIPPA.

Information Management Specialist (United States Air Force, San Antonio, TX)
[1990 — 1993]
Honorable discharge. Served in the intelligence security squadron during Desert Storm.