ARTISAN LEADERSHIP: EXPLORING THE RELATIONSHIP BETWEEN AUTHENTIC LEADERSHIP AND JOB SATISFACTION OF VIRTUAL HEALTHCARE CONSULTANTS

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DISSERTATION

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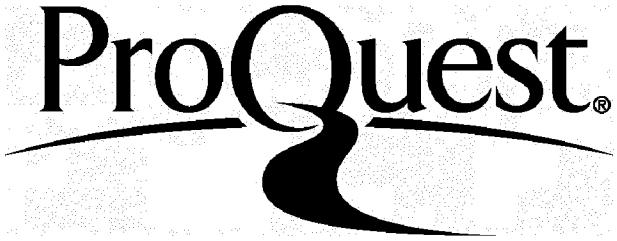

DEDICATION

This project is dedicated to God and all those who journeyed before me clearing my path so I could advance and aid those who venture after me; The selfless efforts of my predecessors have enriched my life by tapping into the tranquil wisdom of self-awareness, social-justice, and love that God has bestowed on all those willing to journey.

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I owe all gratitude to God, who has blessed me with an independent spirit of curiosity and an over abundant gift of persistence. I owe a deep debt of gratitude to my wife who has encouraged and inspired me from the first class and who continued to support me through 5 years of weekends not home working on school projects, research, and dissertation. I love you more than words can ever describe. Furthermore, I appreciate Dr. Jared Montoya, my chair, mentor, and friend for all his support and knowledge throughout my journey. Additionally, my fellow Cohort 22 peer's workers which are a group of life filled and pushy individuals. I deeply appreciated the faculty at Our Lady of the Lake University having made this process possible. I would also like to thank Texas Medical Foundation for allowing me to launch my data collection with my healthcare consulting peers. I will be eternally grateful for their contribution.

Today, I honor a promise made to my father, Armando M Gonzalez, MD, before his death. I made it Dad, I am Doctor. Thank you Dad for all your kind, gentle, and firm encouragement. Finally, to my children, Ezequiel, Zacarias, and Maria-Salome, trust in God in your personal journey. Put effort into your life long expeditions. Aspire to go up the next rise, sit and fill your heart with your triumph. Then find another adventure. The circle of success if filled with failure so be bold and steadfast in your resolve to accomplish your pursuits; respect all and demand respect from others, and love often. May God, bless you all on your journeys.

ABSTRACT

This research study examined the relationship between authentic leadership and job satisfaction of virtual healthcare consultants within several Quality Innovative Organizations subcontracted by the Center for Medicare Medicaid Services. A total of 190 participants throughout the United States participated in this study. One hundred nineteen subjects participated in a demographic questionnaire, *Authentic Leadership Questionnaire* (ALQ, Avolio, Gardner, & Walumbwa, 2007), and the *Brief Index Affective Job Satisfaction Survey* (BIAJS, Thompson & Phua, 2012). Statistical analysis was conducted using Pearson product-moment correlation coefficients, analysis of variance, and multiple regression analyses. The study results also indicate authentic leadership, specifically *total authentic leadership* has a statistically moderate positive relationship with *affective job satisfaction* ($\Delta R^2 = .137, \beta = .374, r_p = .387, p = .00$). Additionally, the results also indicate authentic leadership specifically *self-awareness* has a statistically moderate positive result with *affective job satisfaction* ($\Delta R^2 = .133, \beta = .369, r_p = .381, p = .00$). Finally, the results of this also found the control variable virtual consulting had a *significant* predictive relationship with affective job satisfaction. Discussion of implications, limitations and recommendations for future research is provided.

Keywords: Healthcare, Consultant, Virtual, Leadership, Authentic Leadership, Job Satisfaction, Self-awareness

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CHAPTER ONE

Introduction

For decades' medicine has been evolving in theory and practice through early diagnosis and treatment techniques extending and improving the quality of life for many patients. Arriving at improving quality of life is expensive and wasteful (Guerin, 2016). It is estimated that half of all medical expenditures are squandered because repeated procedures, the expenses associated with more traditional methods of sharing information, delays in care, errors in care or delivery (Guerin, 2016). For these and numerous more reasons healthcare is undergoing a dynamic renovation at multiple levels within the industry to create greater efficiency, improve coordination care, and create greater patient participation.

In the current healthcare system, pressure to cut costs and deliver care more efficiently and sustainable solutions driven by patient satisfaction will be more important than ever in 2016 and beyond (Schultz, 2015). The market-wide shift from fee-for-service payment model to value-based care will prove even more significant than Affordable Care Act on the U.S. healthcare industry with an expected global growth in healthcare consulting of 10% in 2016 (Shultz, 2015). Healthcare consultants assist physicians, medical staff, and healthcare organizations close the gap in knowledge while increasing internal healthcare organization coordination, and alignment to current and future healthcare renovation. Healthcare consultants bring extensive knowledge in health informatics, data analysis and strategies for improving outcomes for all stakeholders involved. Healthcare consultants contribute additional intangible skills to medical providers and organizations, promoting

hope, resiliency, and a balanced process for understanding and applying the healthcare changes more effectively.

Physicians and medical organizations feel constrained due to the ever changing complexity of the healthcare renovation. The confinement has created a lack of trust and tangible resentment voiced by medical professionals and organizations with so many dynamic changes in the healthcare industry mandated by the Centers for Medicare and Medicaid Services (CMS).

The downward spiral of hope and trust in today's leaders has created a current climate of ethical meltdowns, challenging economic times, and medical organization realignment and other seminal events similar to these have led to uncertainty and lack of trust. Violation of trust occur within relationships between, parent and child, husband and spouse, mentor and student, and medical providers and the CMS mandates. These relationships are important. However, our focus lies with the relationship between the leader and the follower. Another, example of a violation of trust occurs when the leader provides ambiguous information to the follower. Information disseminated by a leader should include a clear understanding of potential outcomes which will enable greater confidence and trust in the leader.

The leaders should always be prepared. The ability to collect data and be prepared adds value to the rank of a leader. Walumbwa, Avolio, Gardner, Wernsing, and Peterson (2008) defined a leader's preparation as a *balanced process*. This is one of the four components of authentic leadership, characterized by the leader seeking input from others before making critical decisions (Walumbwa, et al 2008). The character of an authentic

leader's ability to balance and process multiple streams of information builds trust and adds deeper value to the relationships leaders are forming with their followers.

Typically, healthcare consultants bring a full complement of knowledge to medical providers and medical organizations. The healthcare consultants experience can translate into developing viable options in aligning realistic goals for the organization, ensuring federal program compliance and improving the revenue cycle.

In the current healthcare industry, a vast number of changes are occurring every 18 months this is a rapid pace. One example is the Meaningful Use Electronic Healthcare Record (EHR) incentive program. This CMS federally mandated healthcare reform program pays incentive dollars for the use of certified EHR software programs (https://www.cms.gov/Regulations-and-Guidance/). The program also penalizes individual eligible medical providers by reducing their Physician Fee Schedule (PFS) by as much as 5% for failing pass the Meaningful Use EHR Incentive criteria (https://cms.gov). This program has evolved through the first two stages with progressively more difficult compliance. Stage three of the EHR Incentive program is slated to start in 2017 and is considered by many industry experts as the most challenging program to date. In 2017, the EHR program, Meaningful Use and PQRS, will fold into the newest federal healthcare program called Merit Based Incentive Payment System (MIPS) (https://www.quailitynet.org). MIPS is a federally mandated program healthcare organizations and medical providers must incorporate into their operational environment. A timeline of these events and penalties associated with the individual programs is illustrated in Table 1 from the America Academy of Dermatology (https://www.aad.org/practice-tools/macra-resource-center#MIPS). The MIPS program

will incorporate three CMS federal mandated program changes, Meaningful Use, Physician Quality Reporting System, and a new program Improvement Activities.

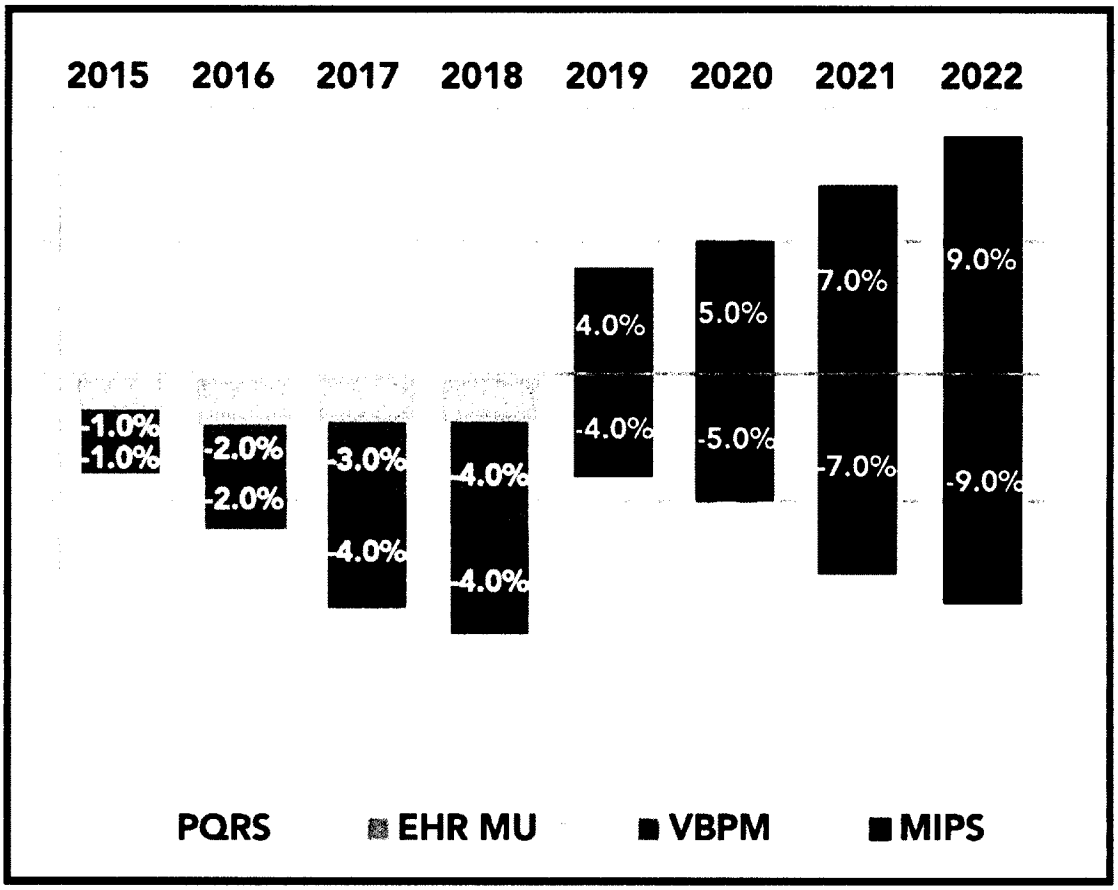


Table 1: Merit Based Incentive Payment Timeline.

Since 2011 the launch of Meaningful Use, the program requirements have changed every 18 months and this pattern is expected to continue through 2021. It is likely that this program will continue in perpetuity based on heuristic experience. The full impact is not localized to individual eligible providers and medical organizations. The impact of the healthcare reform movement is far reaching affecting ancillary services. Impacted are the supporting industries for example pharmaceutical companies, software vendors, medical schools, and most importantly patients. The industry having the most opportunity for growth and change in the ancillary services to medical organizations are the software

industries and healthcare consulting. The emerging software purveyors to medical organizations have had to keep up with the CMS healthcare reform timelines in order to stay compliant. Software vendors produce new certified versions of their EHR software products ahead of the newest healthcare changes. Meeting the changing demands of the industry while keeping their current medical clientele compliant. The software vendors emerging as leaders in the turmoil of healthcare reform have found solace in collaborating with knowledge based leaders. This new emergence of knowledge based leaders since the release of the Health Information Technology Economic and Clinical Health Act of 2009 (www.hhs.gov) are needed in assisting individual medical providers and medical organizations navigate the complexity of medical reform act. Healthcare consultants have long assisted medical organizations, eligible providers, software vendors, and the Centers for Medicare and Medicaid Services to lead and educate many healthcare purveyors through the healthcare reform changes. Artisan healthcare consultants are using virtual technology products from Webex, Go-to-Meeting, and Skype to expand their ability to engage with more clients and reduce traditional consulting costs associated with face-to-face interactions. All the while building trust with medical providers and healthcare organizations through a virtual connection.

The rapid and dynamic changes require a new type of healthcare leader. This emerging Healthcare consultant leader is essential to the continued success of the healthcare industry. An essential element for the success of the healthcare consultant leader is for them to be trustworthy. These times of evolving change require leaders with a stable philosophy of the self, as well as of others in the organization and community (Harvey, Buckley, Brown & Evans, 2016). Indeed, authentic leaders are described as

leading by example as they demonstrating transparent decision making, confidence, optimism, hope and resilience, and consistency between their words and deeds (Avolio & Gardner, 2005). Authentic leaders have the ability to adapt and reengage in the personal journey of self-discovery, self-improvement, reflection, and renewal to enhance authentic leadership behaviors of empathy, respect, trust, connectedness, and balance (Shirey, 2009). The development of a leader's self-awareness and commitment to relationships is one key to renewing hope in a new healthcare future. As of October 2015, more than 479,000 healthcare providers received payment for participating in the Medicare and Medicaid EHR Incentive Program (https://www.cms.gov/Regulations-and-Guidance/). It is our premise a percentage of the 2015 success can be attributed to the supporting roles of healthcare consultant's leadership.

The purpose of this dissertation is to examine the relationships between authentic leadership style and job satisfaction among virtual healthcare consultants. The study will focus on the four components of authentic leadership by assessing the scores from the *Authentic Leadership Questionnaire* (ALQ) as it was developed by Avolio, Gardner, and Walumbwa (2007). The four components measured by the *Authentic Leadership Questionnaire* (ALQ) will be examined. The participants will complete the self-rater questionnaire version of the ALQ which will measure their authentic leadership; self-awareness, rational transparency, ethical/moral and balanced processing.

To measure affective job satisfaction among healthcare consultants the recently developed a 7-item instrument, the *Brief Index of Affective Job Satisfaction (BIAJS),* created by Thompson and Phua (2012) will be used. The *Brief Index of Affective Job Satisfaction (BIAJS),* takes into consideration seven facets in order to measure overall job

satisfaction. The seven facets are: 1) I find real enjoyment in my job, 2) My job is unusual*, 3) I like my job better than the average person, 4) My job needs me to be fit*, 5) Most days I am enthusiastic about my job, 6) My job is time-consuming*, and 7) I feel fairly well satisfied with my job. The three items with an asterisk (*) are distracters used to help attenuate method variance and may be removed from analyses (Thompson & Phua, 2012).

Background

Authenticity has been explored throughout history, from Greek philosophers to the work of Shakespeare ("To thy own self be true." –Polonius, Hamlet).

Authentic leadership involves being genuine and trustworthy but also requires the presence of important personal characteristics that include purpose, values, heart, relationship, and self-discipline (Shirey,2009). Bill George in his essay states: "We need leaders who lead with purpose, values, and integrity; leaders who build enduring organizations, motivate their employees to provide superior customer service, and create long-term value for shareholders" (George, 2003, p. 9). Authentic leaders are not interested in short term gains, either in profits or self-promoting relationships. Authentic leaders are motivated and characterized by the development of service that is firmly rooted in trust. The trust authentic leaders build in their relationships further strengthens the bonds with shareholders, employees, and customers. This slow development and modeling of behaviors combined with courageous actions of the authentic leader create a union between leader and follower that inspires revitalization of optimism for followers through difficult and challenging times.

Since 2011, healthcare reform and new healthcare regulations have changed the landscape of medicine forever. The need exists for highly knowledgeable quality oriented consultant leaders working cohesively within a medical organization. Healthcare consultants demonstrating authentic leadership could possibly influence the success in meeting the current climate of change. The authentic healthcare consultant may influence and revitalize optimism within the healthcare organizations. In the healthcare organizations working with a knowledgeable healthcare consultant may exist a more motivated culture to adopt federal mandates more fluidly which could lead to improved patient outcomes, greater organizational efficiency, and maximized incentive dollars.

Another unique aspect of the healthcare reform is the required adoption of electronic healthcare record systems in order to participate in the new healthcare programs. The adoption of a certified Electronic Healthcare Record (EHR) is defined as a certified software technology meeting the federal requirements for some or all of the hospital or eligible provider objectives of Meaningful Use (Charles, et al, 2013; Hsiao, Hing, Socey, & Cai, 2011). Additionally, Basic EHR adoption is defined as an EHR system that has a least a basic EHR function including clinician notes as a requirement (Blumenthal, DesRoches, Donelan, Ferris, Jha, Kaushal, 2006).

Adoption rates of EHR systems for hospitals with at least a basic EHR system has more than tripled since 2009, increasing from 12% to 44% according to Office of the National Coordinator and American Hospital Association (AHA) Annual Survey Information Technology Supplement (Charles et al, 2013). In 2012, state hospital adoption rates a basic EHR system ranged from 21% to 71%, with South Dakota (71%), Rhode Island (69%), and Colorado (68%) in the lead (Charles et al, 2013). The lowest

adoption rates were reported in New Hampshire (21%), New Mexico (26%), and Kansas (26%); and were found to be significantly lower than the national average (Charles et al 2013).

The adoption of EHR system by medical organizations and providers required the assistance of healthcare information technology consultant's familiar with multiple EHR's, clinic workflow design, and federal data reporting expertise. In order to build and sustain a relationship with their client, healthcare consultants require authentic self-aware behaviors to provide truthful assessment of software and the healthcare organizations limitations. The delivery of transparent actions and behaviors on behalf of the consultant creates a foundation built on trust providing the medical organization information to form a comprehensive strategy for successful compliance with medical reform programs.

Authentic Leadership

Authentic leadership is a nascent theory in leadership research. Contributing authors continue to explore the interactions of authentic leadership from different viewpoints. Authentic leadership can incorporate transformational, charismatic, servant, spiritual or other forms of positive leadership (Avolio & Gardner, 2005). Such leaders build enduring relationships, work hard, and lead with purpose, meaning and values, but are not necessarily described as charismatic by others, which has been defined as the core component of transformational leadership (Bass, 1985). Moreover, authentic leaders are anchored by their own deep sense of self; they know where they stand on important issues, values, and beliefs (Avolio & Gardner, 2005). Conveying to others, oftentimes through actions, not just words, what they represent in terms of principles, values, and ethics (Avolio & Gardner, 2005).

As a temporary leader in a medical organization, can healthcare consultants with an authentic leadership style build leader-follower trust within the organizations? Can the consultant have a significant influence on affective job satisfaction? Authentic leadership affects and changes the very nature of an organizations culture, behavior and interactive relationships between the leader and follower (Avolio, 2007). Authentic leadership has shown to create high levels of hope, positive emotions and enhanced trust, which in turn yields an increased commitment level, engagement and job satisfaction (Avolio et al., 2004).

Since 2010, there has been an unprecedented number of changes in the healthcare industry impacting individual physicians, hospitals, and medical organizations. The current climate requires this tremendous need for authentic leaders, which are people with the utmost integrity and are dedicated to building enduring organizations (George, 2003). Healthcare consultants are a requirement to medical organizations in these challenging times. The temporary authentic leadership of a seasoned navigator will yield hope and create a positive influence upon the healthcare organization as well as overall self-rated job satisfaction of the consultant.

To develop authenticity, each authentic leader must find their own leadership style that is consistent with their personality (George, 2004). Authentic leaders are driven by a greater need to empower people they serve guided by an internal quality centered in combined approach of passion and compassion for those they lead (George, 2004.) Bill George describes that authentic leaders demonstrate five qualities: practice solid values, lead with heart, establish connected relationships, and demonstrate self-discipline authenticity (George, 2004). Researchers have succinctly defined authentic leaders as:

"those individuals who know who they are, what they think, and behave and are perceived by others as being aware of their own and others' values/moral perspective, knowledge, and strengths; aware of the context in which they operate; and who are confident, hopeful, resilient, and high of moral character" (Avolio, Gardner, Walumbwa, Luthans,& May, 2004). Walumbwa, Gardner, Wernsing, and Peterson (2007) advanced the definition of authentic leadership through the characterization of a pattern of leader's behavior that draws upon and promotes both positive psychological capacities and positive ethical climate. These positive elements foster greater self-awareness, develop a deeper internalized moral perspective, provide balance processing of information, and lead to greater relational transparency on the part of leaders working with followers, fostering positive self-development.

Statement of the Problem

Leadership is more difficult in challenging times of constant evolution. The unique stressors facing medical organizations throughout the United States today require a call to renew the focus on what constitutes genuine leadership (Avolio & Gardner, 2005). Former head of Medtronic, Bill George (2003) states: "we need leaders who lead with purpose, values, and integrity; leaders who build enduring organizations, motivate their employees to provide superior customer service, and create long-term value for shareholders" (p. 9). Since the release of the HITECH law of 2009, grant professional services organizations like the Regional Extension Centers and Quality Innovative Organizations have moved from face-to-face consulting practices to high utilization virtual consulting business model eliminating the extra expenses of associated with face to face consulting. There is a need to investigate further the impact of virtual healthcare consulting in this rapidly evolving

healthcare era and if the relationship exists in the authentic leadership style and self-rated job satisfaction

The foundation of this research study was to identify weather or not authentic leadership style could have a relationship on the healthcare consultants job satisfaction in a virtual consulting setting. The literature reveals limited studies looking at the relationship of authentic leadership and job satisfaction in healthcare industry. Additionally, there is no noteworthy research pertaining to the healthcare consulting industry.

Purpose of the Study

The main purpose of the study is to identify the relationship between authentic leadership and job satisfaction among TMF-QIO employees. The study will focus on the four components of authentic leadership by assessing the scores from the *Authentic Leadership Questionnaire* (ALQ) as it was developed by Avolio, Gardner, and Walumbwa (2007). The four components of *Authentic Leadership Questionnaire* (ALQ) will be compared with the affective job satisfaction score of the *Brief Index of Affective Job Satisfaction (BIAJS)* created by Thompson and Phua (2012). The results of this research study may help virtual consulting organizations better understand the nature of authentic leadership. This study may also help leaders understand the nature of affective job satisfaction among virtual consulting organizations as well as other quality healthcare organizations.

Assumptions

The study was conducted with the following assumptions:

1. All of the respondents answered the *Authentic Leadership Questionnaire* (ALQ), the *Brief Index of Affective Job Satisfaction* (BIAJS), and the demographic survey to the best of their ability.
2. All of the respondents that participated in this study were employees from the TMF-QIO organization located in Austin, Texas with some participants working remotely from the main office of TMF-QIO.

Limitations

This study was conducted with the following limitations:

1. This research study examined several healthcare consultants in a variety of healthcare consulting organization located within the United States. The results from this study should not be generalized to all healthcare consulting organizations globally because there are various levels of consulting including face-to-face, virtual consulting, and automated Learning Action Network (prerecorded webinars).
2. The information obtained from all obtained from all of the respondents was limited to the *Authentic Leadership Questionnaire* (ALQ), the *Brief Index of Affective Job Satisfaction* (BIAJS), and the demographic survey.

Conceptual Definitions of Terms

The following conceptual terms are defined in order to gain a greater appreciation of the research:

Authentic Leadership

1. Self-Awareness describes a leader who is intimately aware of their strengths and weaknesses and refers to how others see the leader as well as how the leaders' impacts or influences others (Walumbwa et al., 2008).
2. Rational Transparency is another component of authentic leadership characterizing a leader's ability to reinforce a high-level of openness with their followers; allowing for communication to be forthcoming from the follower with opinions, ideas, and opposing viewpoints (Walumbwa et al., 2008).
3. Internalized Moral Perspective (Ethical/Moral) is an authentic leadership component describing the leaders who maintains an elevated standard of practicing moral and ethical conduct (Walumbwa et al., 2008).
4. Balanced Processing is the final aspect of authentic leadership describing leaders who seek the opinions and input of others, prior to making critical decisions (Walumbwa et al., 2008).

Affective Job Satisfaction

1. Affective job satisfaction is usually theorized as a "unitary concept" (Kalleberg, 1997, p.126) embodying an "overall positive emotional" (Moorman, 1993, p. 761 response to a job as a whole or in general.
2. Job satisfaction can be considered as a global feeling about [a] job (Spector, 1997, p. 2).

3. Affective job satisfaction is synonymous with what researchers sometimes term general, overall, or global job satisfaction, and is appropriately measured with items tapping how much people subjectively and emotively like their job as a whole (Thompson & Phua. 2012).

Gender

1. Characterized as Female or Male.

Age

1. Characterized as an individual's numerical age as of last birthday.

Tenure

1. Characterized as an individual's amount of time in years working as a consultant.

Leadership Role

1. Characterized as, "a consequence of their status—power of the position they occupy" (Bass, 1990, p.19), an individual's management position of others within the organization and categorized as a consultant, team lead, project manager/manager, director or other.

Education

1. Characterized as an individual's highest degree earned and listed as Associates, Bachelors, Masters, doctorate of any degree plus certification.
2. *Any degree plus certification* is characterizes healthcare professionals in one year or less completing an advanced study program and receiving a certification by passing a competency exam (https://www.healthit.gov).

Consultant

1. Consultant is characterized as an individual or firm who provides professional advice or services for a fee, not normally not as an employee of the engaging party (https://grants.nih.gov and Johnson, 2016).

Healthcare Consultant

1. Healthcare consultant is characterized as a consultant who provides professional advice or services for a fee in the healthcare industry (https://grants.nih.gov and Johnson, 2016).

Virtual Consulting

1. Characterized as the action of giving professional advice or performing a service for a fee using technology, excluding face-to-face contact with the engaging party or client.

Workload

1. Characterized as the number of client's consultants actively works with as part of their role within the organization.

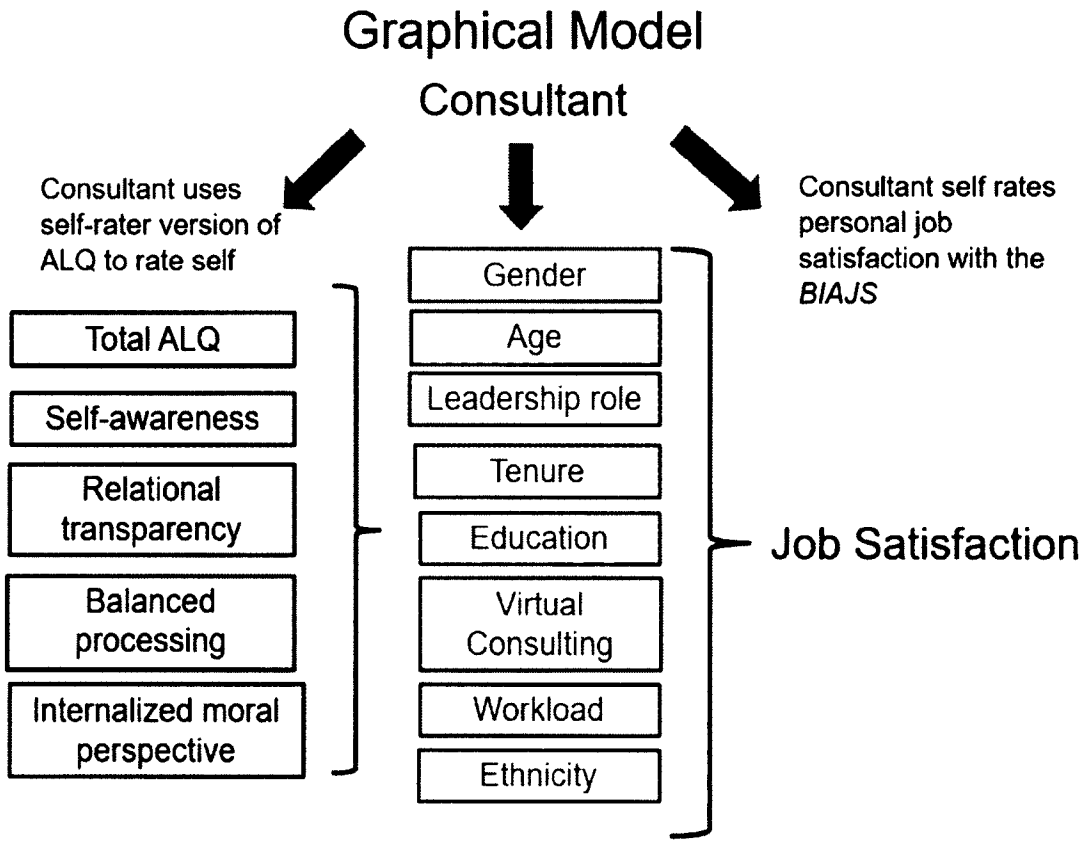
Ethnicity

1. Hispanic or Latino is characterized as a person of Cuban, Mexican, Puerto Rican, south or Central American, or other Spanish culture or origin, regardless of race (http://www.arlstatistics.org).

Research Questions

1. Is there a relationship between total authentic leadership of the virtual healthcare consultant and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity?
2. Is there a relationship between the self-perceived authentic leadership score (self-awareness, rationalized transparency, balanced processing, and internalized moral perspective) of healthcare consultant and affective job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity?

Graphical Model



Note: A consultants used self-rater survey's.

CHAPTER TWO

Review of the Literature

Introduction

The purpose of this chapter was to examine and synthesize previous research for authentic leadership and job satisfaction as it relates to the relationships of healthcare consultants self-rating their authentic leadership and their job satisfaction in virtual consulting. Walumbwa et al. (2011) recommended that future researchers extend generalizations from their study to different kinds of organizations such as virtual consulting/e-consulting firms.

This chapter provides a brief history of the emergence of authentic leadership and an overview of the authentic leadership theory. Authentic leadership is a recent phenomenon in leadership application (Luthans and Avolio, 2003). There will also include a section on the *Brief Index Affective Job Satisfaction Survey (BIAJS)* and how it has been applied to previous studies. The *BIAJS* is a relatively new job satisfaction survey developed by Thompson and Phua (2012) in order to access specially and discretely job satisfaction demonstrating content validity, internal consistency reliability, temporal stability, convergent and criterion-related validity, plus cross-population equivalence by nationality, job level, and job organization type.

The constructs of authentic leadership and job satisfaction were comprehensively examined to include definitions. The authentic leadership characteristics self-awareness, relational transparency, internalized moral perspective, and balanced processing were defined to provide a foundation for this research. Previous research on authentic leadership to include benefits within the scope of job satisfaction and virtual consulting in

the work environment is discussed. Surveys, methodology and samples from previous research are reviewed and a justification for measurement instruments and sample selection is provided. The literature review will conclude with discussion on consistent themes and assumptions for this research.

Authentic Leadership

Ng and Feldman (2014) conducted a meta-analysis that analyzed worker perceptions of their leaders' ethicality and the workers' job performance. This work relates closely to authentic leadership domain of ethical/moral behaviors of a leader. The analysis analyzed worker task performance two ways. The first was positively related to workers' self-ratings of task performance ($k = 5$, $N = 1389$, $r_c = .30$). In the second analysis, ethical leadership was also positively related to supervisors'' ratings of workers' = task performance ($k = 12$, $N = 2879$, $r_c = .21$).

Leadership and Job Satisfaction

Jackson, Meyer, and Wang (2013) conducted a meta-analysis between the relationship of Transformational/Charismatic leadership and commitment. The authors found a moderate positive relationship between Transformational/Charismatic leadership and affective commitment: $k = 116$, $N = 39{,}211$, $r_c = .45$. A weak positive relationship between Transformational/Charismatic leadership and normative commitment: $k = 30$, $N = 9{,}944$, $r_c = .337$. A moderate positive relationship between Idealized Influence (behavior) and affective commitment: $k = 17$, $N = 5{,}110$, $r_c = .421$.

Peus, Wesche, Streicher, Braun, and Frey, (2012) analyzed authentic leadership examining the antecedents and individuals and group level outcomes in business with 306 participants in Study One. Additionally, in Study Two, data was collected from 105

participants from varying organizations. In the first study the participants were recruited online and supplemented with direct recruiting practices utilizing the Authentic Leadership Questionnaire (Walumbwa et al. 2008). The individuals were from abroad range of industries. Satisfaction with supervisor was measured using the Multifactor Leadership Factor (MLQ 5x-short; Bass and Avolio, 1995). Self-knowledge significantly predicted authentic leadership ($\beta = 0.52, p < 0.001$) and self-consistency was also a significant predictor of authentic leadership ($\beta = 0.38, p < 0.001$). Furthermore, authentic leadership positively impacted followers' satisfaction with the supervisor ($\beta = 0.69$, $p < 0.001$) as well as the follower's organizational commitment ($\beta = 0.52, p < 0.001$). In study one, authentic leadership positively impacted followers' extra effort ($\beta = 0.51$, $p < 0.001$). Thus, predicting direct effects of authentic leadership on followers' job related attitudes received empirical support (Peus et al., 2012).

Study Two expanded the investigation of authentic leadership to the group level. Peus et al (2012) measured authentic leadership using the Mindgarden, Inc, Walumbwa et al (2008) questionnaire. Satisfaction with supervisor was measured by one item from a validated job satisfaction scale (Neuberger and Allerbec, 1978). Perceived team effectiveness was assessed by a teamwork assessment questionnaire developed by Borrill and West (2000). Authentic leadership perceived predictability yielded a positive correlation ($\beta = 0.80, p < 0.001$). Finally, authentic leadership and perceived team effectiveness was found to have positive relationship ($\beta = 0.71, p < 0.001$). Study two provided additional support with a significant positive relationship between authentic leadership and satisfaction with the supervisor as well as leader predictability as mediator of this relation thus confirming results of study one (Peus et al. 2012).

Giallonardo, Wong, and Iwasiw (2010) examined the relationship between new graduate nurses' perceptions of the preceptor's authentic leadership, work engagement, and job satisfaction. Authentic Leadership Questionnaire (Avolio et al., 2007), Utrecht Work Engagement Scale (Schaufeli and Bakker, 2003), and the Index of Work Satisfaction, Part B scale (Stamps, 1997) all self-assessment questionnaires were administered and collected from 107 nurses with less than or equal to 3 years' experience. Correlation between authentic leadership and work engagement found positive relationship ($r = 0.21, p < 0.01$). Giallonardo, Wong, and Iwasiw (2010) found positive correlation between work engagement and authentic leadership variable of relational transparency, balance processing, self-awareness, and internalized moral perspective ($r = 0.19, p < 0.01$; $r = 0.18, p < 0.01$; $r = 0.14, p < 0.01$; $r = 0.24, p < 0.01$). Moreover, correlation between authentic leadership of nurse preceptors was positively related to work engagement ($\beta = 0.21, p < 0.01$) and authentic leadership was positively related to job satisfaction ($\beta = 0.34, p < 0.01$).

Podsakoff, Bommer, Podsakoff and MacKenize (2006) conducted a meta-analytic review incorporating all the published data on the relationships between leader reward and punishment behavior and a wide variety of employee attitudes, perceptions, and behaviors, plus the previously unpublished data in one of the studies reviewed. The authors postulate a leader contingent reward and punishment behavior influences employee criterion variables is that it clarifies which behaviors the leader desires the employee to exhibit. This is important because reducing role ambiguity has been shown to increase job satisfaction (Podsakoff et al, 2006). In the study the Podsakoff et al.

(2006) identified a moderate positive relationship between contingent reward and job satisfaction ($k = 43$, $N = 11{,}461$, $rho = .52$).

Dirks and Ferrin (2002) identified in their meta-analysis trust in leadership appears to have had a significant relationship with each of the work behaviors and outcomes, trust had a relationship with each of the types of organizational citizenship behaviors: altruism, civic virtue, conscientiousness, courtesy, and sportsmanship. Dirks and Ferrin (2002) identified a strong positive relationship between trust (relational transparency) and job satisfaction ($k = 34$, $N = 10{,}631$, $r_c = .65$).

Kim, Liden, Kim, and Lee (2014) Researchers used multiple regression analysis surveying 546 matched supervisor-subordinate dyads of South Korean organizations found a moderate positive relationship between transformational leadership and job satisfaction.

Gender and Authentic Leadership

Wang, Sui, Luthans, Wang, and Wu (2014) administered the ALQ, *Leadership Member Exchange* (LMX) and *Psychological Capital* (PsyCap) to 801 respondents in a Chinese logistics firm located in the capital city of Beijing. The company has been established for 18 years in the business of collection and delivery of parcels for customers. Wang et al. (2014) utilized regression analysis in their research and identified gender differences. The authors identified females were more likely to exhibit self-leadership characteristics than men.

Walumbwa et al. (2010) conducted a study to examine individual differences in authentic leadership scores. Three-hundred and eighty-seven employees and supervisors took the *Authentic Leadership Questionnaire* (ALQ) and a demographic survey. A

correlation analysis was employed to examine the individual differences among participants. Results revealed that gender does not significantly predict ALQ scores.

Tate (2009) conducted a study to investigate individual differences in Authentic Leadership. One-hundred and fifteen undergraduate students completed a survey based upon George's (2003) five dimensions of authentic leadership (no instrument was available at the time of Tate's study). Eighteen items were generated for measuring individual levels of authentic leadership. A *t*-test was employed to determine if any gender differences in authentic leadership. Results did not reached significance, suggesting there was no difference in authentic leadership based on gender.

Norris (2008) conducted a study to examine individual differences in self-leadership: leaders who are more likely to engage in and exhibit higher levels of self-direction and self-motivation. Self-leaders practice more positive self-talk, self-goal setting, and self-reward practices. Further, self-leadership is thought to correlate with general self-efficacy, which is considered a determinate of authentic leadership development. One hundred and twenty-four graduate students completed the *Revised Self-Leadership Questionnaire* (RSLQ; Houghton & Neck, 2002) to measure levels of self-leadership strategies. A correlation analysis was performed for examining the relationship among predictor and criterion variables in the study. Results showed gender ($M = 1.41$, $SD = .49$) played a significant role in self-leadership strategies ($r = -.44$, $p < .01$). Females were more likely than males to exhibit self-leadership characteristics. Results can be explained by the practices consistent with self-leadership such as self-talk practices which have not consistency shown to correlate with authentic leadership.

Arguably, authentic transformational leadership shares some similar characteristics of authentic leadership. Therefore, research pertaining to individual differences in transformational leadership scores can be viewed as relevant to the present research. Turner et al. (2002) conducted a study to examine the differences in transformational scores. Four hundred and seven participants took the *Multifactor Leadership Questionnaire* (MLQ) to examine the individual differences in MLQ scores. Participants were randomly assigned to three samples. Sample One included 51% female participants, 27% in Sample 2, and 95% in Sample 3 (0 = female, 1 = male). A correlation was conducted on each of the variables in the study. Collective MLQ scores revealed that transformational leadership was significantly related to leader's gender ($r = -.19, p < .05$).

Age and Authentic Leadership

Leroy, Palanski and Simons (2012) administered the ALQ to 225 participants in 25 different Belgium organizations. A significant positive correlation was found between the age of the participant and score on the authentic leadership scale ($r = 0.74, p < 0.001$).

Ng and Feldman (2013) meta-analyzed 36 studies exploring the relationship between age and innovation related behaviors. The authors found participants in the < 30 years of age category had a significant weak negative relationship between age and self-reported innovative related behavior ($k = 3, N = 1{,}051, r_c = 0.01$). Additionally, Ng and Feldman (2013) found similar significant weak relationships in age category of 36-39 years of age ($k = 7, N = 1884, r_c = 0.02$) and in age category of 40 or more years of age ($k = 9, N = 1{,}392, r_c = 0.01$).

Walumbwa, Wang, Wang, Schaubroeck, Avolio (2010) conducted a study to examine individual differences in authentic leadership scores. Three-hundred and eighty-seven employees and supervisors took the *Authentic Leadership Questionnaire* (ALQ) and a demographic survey. A correlation analysis was employed to examine the individual differences among participants. Results of this research did not yield significant results pertaining to age and ALQ scores.

Impett, Sorsoli, Schooler, Henson, and Tolman (2008) conducted a study to examine authentic relationship among adolescent girls. One-hundred and eighty-three adolescent girls in the longitudinal study, revealed that both relationship authenticity and self-esteem increased steadily in a linear fashion from 8th grade to the 12th grade. Girls that scored higher on the measure of authentic in 8th grade had greater increases in self-esteem over the course of adolescence.

(Tolman & Porche, 2006) to measure levels of self-perceived authenticity in relationships. Items were reverse codes and showed that authenticity increased with grade level of participants. The means, standard deviations, ranges, and alphas were computed and yielded the following results: Eighth-grade authenticity (M = 3.97, SD = .74, *Range* = 1.9 – 5.4, α = .71), 10th grade (M = 4.15, SD = .76, *Range* = 2.3 – 6.0, α = .76) and 12th grade (M = 4.26, SD = .73, *Range* = 2.2 – 6.0, α = .77). Results suggest that authenticity in relationships increases with age and grade level. The researchers note that increases in authenticity could be explained by increases in self-esteem as well.

Leadership Role and Leadership

Wang, Waldman, and Zhang (2014) meta-analytically cumulated 42 independent samples of shared leadership and examined its relationship to team effectiveness. The

authors findings revealed overall positive relationship between shared leadership and team effectiveness. Wang et al. (2014) reported both the sample-size weighted, mean observed correlations and the correlations that have been corrected for measurement errors. The meta-analysis identified a weak positive relationship between shared traditional leadership and team-effectiveness ($k = 11, N = 684, r_c = .18$). Additionally, the authors acknowledge a moderate positive relationship between shared new-genre leadership and team-effectiveness ($k = 25, N = 2{,}162, r_c = .34$). Finally, Wang et al (2014) found a moderate positive relationship between overall shared leadership and team-effectiveness ($k = 14, N = 1{,}170, r_c = .35$).

Dirks and Ferrin (2012) performed overall meta-analysis and subsequent analyses on published and unpublished articles using Johnsons (1993) DSTAT computer program which applies the Hedges and Olkin (1985) approach. Dirks and Ferrin (2012) computed the sample-size weighted mean for each set of correlations and the corresponding confidence intervals. The authors identified a strong positive relationship between Trust (relational transparency) and management of others ($k = 13, N = 3{,}302, r_c = .85$) (Dirks & Ferrin, 2012).

Tenure and Authentic Leadership

A total of 794 followers and their immediate leaders from a Chinese logistics firm located in the capital city Beijing were invited to participate. The authors using a multiple regression summarized the results of regression analysis for testing Authentic Leadership as negatively related to tenure ($r = -.10, p < .001$) and positively related follower performance ($r = .10, p < .001$) (Wang, Sui, Luthans Wang & Wu, 2014).

Wang and Hsien (2013) A study collected data from 368 Taiwanese employees and found a moderate positive relationship between marital status, position level, job type, and job tenure had a statistically significant influence on employee trust.

Ng and Feldman (2013) meta-analyzed 36 studies that included relationship of age and tenure with innovation related behaviors. The authors found in their study employee self-reported behavior, 5-10 years with an organization, a significant weak positive relationship existed between tenure and innovated behavior ($k = 6$, $N = 2891$, $r_c = 0.23$). Additionally, employees with more than 10 years of tenure also displayed a significant weak positive relationship between tenure and innovative behavior ($k = 6$, $N = 2891$, $r_c = .01$).

Education and Authentic Leadership

Wang et al (2014) Researchers of the previous study of Beijing logistics employees found a weak negative relationship between authentic leadership and education.

According to Avolio and Gardner (2005) authentic leaders possess high moral reasoning capabilities, are able to initiate self-regulation and are highly self-aware. Studies pertaining to these variables generally suggest one's ability self-regulate, act ethically, and are aware of their own strengths and weaknesses correlate with education level (Impett, et al. 2008; Rest, 2000; Turner, 2002). Therefore, it can be inferred that a predictable relationship may exist between participant's level of attained education and manifested authentic leadership behaviors. Participants in the present study will have attained a high level of education, ranging from first year Masters students to final year

PhD students, therefore education level will be controlled when measuring authentic leadership.

Cooper et al. (2005) suggest that authentic leadership can be developed and incorporated in a leadership development program and argue that ethical training should be an important part of the authentic leadership development process. Brown and Trevino (2006) suggest that social learning increases one's ability to become an ethical leadership (they also argue that ethical leadership and authentic leadership overlap), citing Kohlberg's (1969) argument that morality increases as cognitive capabilities increase. Since age and cognitive abilities naturally increase as education level increases, the present author will argue that education may play a role in authentic leadership behaviors. These articles, while not empirical, suggests that authentic leadership increases with deliberate educational practices concerning authentic leadership, which would be consistent with teaching practices within a university level leadership program.

Virtual Consulting and Leadership

Lin, Standing, and Liu (2008) meta-analyzed 50 studies that included relationship building, cohesion, coordination, performance, satisfaction, and communication. Perceived relationship building was positively related to virtual team performance (k =11, N = 2867, r_c = 0.21). Perceived communication was positively related to virtual team performance (k =10, N = 3342, r_c = 0.32). Researchers further analyzed a positive relationship building and virtual team satisfaction (k =4, N= 513, r_c = 0.39). Also cohesion was positively related to virtual team satisfaction (k =6, N = 1298, r_c = 0.57).

Richter and Schmidt, (2006) analyzed the type of education and experience of consultants as they affect the performance of professionals in modern knowledge-

intensive service industry of management consulting. The authors identified 50 consultants working on 100 projects from a Switzerland company that matches consultant with clients. The age varied from 22 to 68 with the average age of the consultants being 42. The authors investigations showed a weak but positive correlation between education level and performance ($r = 0.22, p < 0.05$) and a significantly stronger correlation between total work experience and consulting experience ($r = 0.40, p < 0.001$), and non-consulting experience ($r = 0.79, p < 0.001$). Additionally, there was evidence that consultants with a lower education level (one Master's degree only) has a negative and highly significant effect on performance ($r = -0.45, p < 0.001$). Gender is positive and highly significant, suggesting that female consultants received better performance rating than male counterparts ($r = 0.052, p < 0.001$). Type of education among consultants played a role in perceived performance ratings. Engineering degreed consultants were found to be significantly lower performance levels ($r = 0.54, p < 0.001$). Overall these results suggest that not only the level of education, but level but the type of education the consultants have matters for their performance.

Workload and Leadership

Luchman and Gonzalez-Morales (2013) performed meta-analytic review using a final set of 106 studies of relevant articles included in their present study. Luchman and Gonzalez-Morales (2013) reviewed five measure types (i.e. time pressure, workload, other task-related demand, control or type of support) sample size, and effect size were recorded for each study. The authors meta-analysis identified a weak positive relationship between co-worker support (relational transparency) and workload ($k = 30, N = 110, 734,$

$r_c = 0.23$). Additionally, A weak positive relationship between supervisor support (relational transparency) and workload ($k = 28$, $N = 111, 409$, $r_c = 0.30$).

Ethnicity and Leadership

After extensive review of the existing literature, no noteworthy research was found examining the relationship between authentic leadership and ethnicity. However, it should be noted that extensive research does exist pertaining to differences in cultural influences on leadership behavior (House et al., 2004; Chokar et al., 2012). However, no studies were discovered pertaining to ethnicity and leadership.

Summary of Leadership Literature

Positive results were found between leadership and the control variables of job satisfaction, gender, age, and education. No studies were found pertaining to ethnicity and leadership.

Job Satisfaction

Podsakoff et al. (2005) studied leaders using reward was positively related to general job satisfaction (k = 43, N = 11461, rho = .52). Leader use of contingent reward was also positively related satisfaction with work (k = 23, N = 6510, rho = .38). Additionally, a positive relationship was also found for satisfaction with supervisor (k = 52, N = 19380, rho = .55) and satisfaction with coworkers (k = 26, N = 7019, rho = .34). Positive satisfaction was also found for satisfaction with pay (k = 24, N = 5985, rho = .25) and job satisfaction with opportunities for promotion (k = 14, N = 4320, rho = .44).

Dirks and Ferrin (2002) examined the findings and implication of the research on trust in leadership through the performance of a meta-analysis of 106 studies over 4 decades. The authors used Johnson's (1993) DSTAT computer program which applies

the Hedges and Olkin (1995) approach. Trust in leadership had a significant relationship with each of the outcomes. Work behaviors and outcomes in an organizations leaders trust had a relationship with altruism ($r=.19$, $p<.05$), civic virtue ($r=.11$, $p<.05$), conscientiousness ($r=.22$, $p<.05$), courtesy ($r=.22$, $p<.05$), and sportsmanship ($r=.20$, $p<.05$), and job performance ($r=.16$, $p<.05$). Trust in organization leader had the strongest relationship with job satisfaction ($r=.51$, $p<.05$) and organizational commitment ($r=.49$, $p<.05$). Additionally, trust in leader showed relationships with turnover intentions ($r=-.40$, $p<.05$), belief in information ($r=.35$, $p<.05$), and commitment to decisions ($r=.24$, $p<.05$). Last, trust in leader was highly related to satisfaction to the leader ($r=.73$, $p<.05$) and Leader Member Exchange Theory ($r=.69$, $p<.05$). Moreover, trust in the direct supervisor and job satisfaction was significantly related ($r=.55$, $p<.05$), organizational commitment ($r=.44$, $p<.05$), and was related to job performance ($r=.17$, $p<.05$). However, trust in the direct leader showed a negative relationship to the intent to quit ($r=-.38$, $p<.05$). Trust in leadership is significantly related to attitudinal, behavioral, and performance outcomes (Dirks and Ferrin, 2002).

Judge and Bono (2001) presented meta-analytic results of the relationship of 4 traits—self-esteem, generalized self-efficacy, locus of control, and emotional stability (low neuroticism) with job satisfaction. With respect to job satisfaction, the estimated true score correlations were for self-esteem ($k = 56$, $N = 20,819$, $r_c = .26$), for generalized self-efficacy ($k = 12$, $N = 12,903$, $r_c = .45$), for internal locus of control ($k = 80$, $N = 18,491$, $r_c = .32$), and for emotional stability ($k = 21$, $N = 7,658$, $r_c = .24$)

(Judge & Bono 2001). The results based on 274 correlations suggest that these traits are among the best dispositional predictors of job satisfaction.

Gender and Job Satisfaction

Shirom, Gilboa, Fried, and Cooper, (2008) found a significant joint (interactive) effect only for regression of the meta-correlations of role ambiguity and general performance with the interactive term of age X percent-males was found to be significant ($k = 30$, $N = 7700$, $r_c = -.44$). In female dominated workplaces, represented by low percent of males, as [female] age increases, there is a steep decline in the negative correlations between role ambiguity and general performance (Shirom, Gilboa, Fried, & Cooper, 2008). This finding supports the rationale that as age increases people tend to obtain higher coping resources benefiting them in performing stressful work demands (Shirom, Gilboa, Fried, & Cooper, 2008).

Hersch and Xiao (2015), performed Bonferroni comparison test between female and male within race or ethnicity. The collected data from the 2010 National Survey of College Graduates. The authors found significant results with Hispanic/Latino female graduates with overall job satisfaction ($R = 47.16$, $N = 6{,}217$, $p < 0.01$) and Asian male ($R = 36.17$, $N = 10{,}119$, $p < 0.01$) and Black male ($R = 37.17$, $N = 5{,}629$, $p < 0.01$) results were also significant.

Wood, Veldhoven, Croon, and De Menezes (2012) explored the relationship between organizational performance and enriched job design and high involvement management. The authors utilized the United Kingdoms' Workplace Employment Relations Survey 2004 (UK's-WERS2004) and the management survey. Management survey interviews were face-to-face with senior persons at the workplace Interviews were

conducted with managers in 2295 workplaces from an in-scope sample from 3587 addresses. The UK's-WERS2004 self-questionnaire produced a sample of 22,451 employees. The authors utilized a Pearson correlation coefficient between the measures of job satisfaction and anxiety comfort at the individual employee level. Additionally, Wood et al (2012) used a multivalve model to confirm the intra-class correlations which measured the well-being of the individuals. Wood et al (2012) identified at the employee level, being a woman (r = -0.25), age (r = 0.12), tenure (r = -0.24), and being a manager (r = 0.13) are all positively associated with job satisfaction at the 1 percent level, while hours/week (r = -0.15) is negatively associated with it. Being a woman (r = 0.28), age (r = 0.18), and being a manager (r = 0.11) are positively associated with anxiety–comfort.

Age and Job Satisfaction

Johnson (2016) using a multiple regression analysis of 65 telecommuters demonstrated that age emerged as significantly positive correlation to job satisfaction (r = .247, $p < 0.05$).

Wood, Veldhoven, Croon, and Menezes (2012), in their study continue to expand the meaning of job satisfaction to be associated with increased autonomy, meaningfulness of work, skill utilization, flexibility and increased social contacts within the work network. The authors identified at the employee level (N = 14,127) a weak positive relationship between job satisfaction and age (r = 0.12, $p< 0.01$) (Wood, Veldhoven, Croon, and Menezes, 2012).

Wang and Hsien (2013) collected data from 386 participants in the top 1000 manufacturing companies and top 500 service companies in Taiwan. The authors

preformed an analysis of data using a multiple regression analysis showed that age (r = .22, $p < 0.05$); marital status (r = .14 $p < 0.05$); and position level, (r = .24, $p < 0.001$) significantly influence employee engagement. Wang and Hsien (2013) The results also showed that age (r = .19, $p < 0.01$), marital status (r = .144, $p < 0.05$); and position level (r = .24, $p < 0.001$) had a significant effect on employee engagement.

Shirom et al. (2008) using a regression analysis (k = 30, N = 7700, r_c = .47). found age had a significant moderating effect on the relationship between role ambiguity and general performance; as age increases, the negative relationship between role ambiguity and general performance decreased Supporting the theoretical rational that as age increases people tend to obtain higher coping resources benefiting them in performing stressful work demands (Shirom et al., 2008).

Leadership Role and Job Satisfaction

High involvement management is about organizational involvement, which entails workers participating in decision making beyond the narrow confines of the job (Wood, Veldhoven, Croon & Menezes, 2012). The authors further state under high involvement management workers are involved in work organization decisions and other immediate aspects of other environment, as well as in the 'business whole' (Benson and Lawler, 2003:156). Wood, Veldhoven, Croon, and Menezes (2012) identified in workplace (N = 1177) at the employee level (N= 14,127), high involvement management is directly and positively related to job satisfaction (r = .036, $p < .001$), labor productivity (r = .035, $p < .001$), financial performance (r = .034, $p < .001$) and quality (r = .034, $p < .001$).

Dirks and Ferrin (2002) examined the findings and implication of the research on trust in leadership through the performance of a meta-analysis of 106 studies over 4 decades. The authors used Johnson's (1993) DSTAT computer program which applies the Hedges and Olkin (1995) approach. Trust in leadership had a significant relationship with each of the outcomes. Work behaviors and outcomes in an organizations leaders trust had a relationship with altruism (r=.19, p<.05), civic virtue (r =.11, p<.05), conscientiousness (r =.22, p<.05), courtesy (r =.22, p<.05), and sportsmanship (r =.20, p<.05), and job performance (r =.16, p<.05). Trust in organization leader had the strongest relationship with job satisfaction (r=.51, p<.05) and organizational commitment (r =.49, p<.05). Additionally, trust in leader showed relationships with turnover intentions (r =-.40, p<.05), belief in information (r =.35, p<.05), and commitment to decisions (r =.24, p<.05). Last, trust in leader was highly related to satisfaction to the leader (r =.73, p<.05) and Leader Member Exchange Theory (r =.69, p<.05). Moreover, trust in the direct supervisor and job satisfaction was significantly related (r =.55, p<.05), organizational commitment (r =.44, p<.05), and was related to job performance (r =.17, p<.05). However, trust in the direct leader showed a negative relationship to the intent to quit (r = -.38, p<.05). Trust in leadership is significantly related to attitudinal, behavioral, and performance outcomes (Dirks and Ferrin, 2002).

Tenure and Job Satisfaction

Wang and Hsien (2013) using a multiple regression analysis demonstrated that position level of manager (r = .128, $p< 0.05$), job type of administrator (r = .19, $p<$

0.01), and job tenure more than 20 years (r=.021 $p < 0.05$) had a statistically significant influence on employee trust.

Natarajan and Nagar (2011) conducted a study exploring the impact of service tenure and occupational category on organizational commitment and job satisfaction. 220 managers in Indian organizations from three tenure categories and three occupational categories were asked to take the Meyer and Allen commitment scales and a self-developed job satisfaction scale. Using analysis of variance, the researchers found longer tenure exhibited higher affective and normative commitment and intrinsic job satisfaction (Natarajan & Nagar,2011).

Shirom et al. (2008) conducted a meta-analysis using a regression analysis demonstrating the relationship of the interactive term of *age X tenure.* Shirom et al. (2008) found tenure was significant when years of tenure were high in turn corresponding to a moderate positive relationship between tenure and role ambiguity (enhanced role clarity) and general performance ($k = 30$, $N = 7700$, $r_c = .48$).

Education Level and Job Satisfaction

Hersch and Xiao (2015) performed a multiple regression using data collected from the 61,870 participants from 2010 National Survey of College Graduates examining the impact of educational levels on overall job satisfaction. A significant, positive correlation was found between degrees of Juris Doctorate (r =0.068, $p < 0.05$), Medical Doctor (r =0.215, $p < 0.01$), Masters of Arts not in business (r =0.081, $p < 0.01$), and Philosophy Doctorate (r =0.101, $p < 0.01$).

Trommelen (2013) investigated the relationship between globalization and job satisfaction in the European Union with the main conclusion of the research there is

correlation in globalization and job satisfaction. The author found a positive relation between globalization and job satisfaction is significantly stronger for high educated workers than for low educated workers (N =4889, Pseudo $R^2 = 0.03$, $p > .05$).

Richter and Schmidt (2006) analyzed the importance of both the level and the type of two critical dimensions of human capital for the performance of management consultants, namely education and experience. Researchers used both qualitative and quantitative data on client rating for the performance of 50 senior consultants on 100 projects using a multiple regression analysis, demonstrated a weak positive relationship between job performance and education level ($r = 0.22$, $p < 0.05$).

Virtual Consulting and Job Satisfaction

Johnson, (2016) using multiple linear regression analysis of 65 telecommuter survey respondents, the results ($F(3,61) = 2.4$, $p > .05$) indicated that no statistical significant relationships were found between job satisfaction and the predictor variables, however, the results indicated that job satisfaction among telecommuters was high, regardless of demographic variables.

Hersch and Xiao (2015) performed a multiple regression using data collected from 61,870 participants from the 2010 National Survey of College Graduates examining the impact of educational levels on providing consultation and advice to other and overall job satisfaction. No relationship was found between the consultation and job satisfaction score ($p > 0.05$).

Lin, Standing, and Lui (2008) mentioned earlier in this work further analyzed coordination, cohesion, relationship building and virtual team satisfaction. Coordination was positively related to virtual team satisfaction ($k = 11$, $N = 2808$, $r_c = 0.39$). Also

cohesion was positively related to virtual team satisfaction (k =6, N = 1298, r_c = 0.57). The last variable, relationship building was positively related to virtual team satisfaction (k =4, N = 513, r_c = 0.39).

Workload and Job Satisfaction

Luchman and Gonzalez-Morales (2013) performed a meta-analysis review of 106 studies using the jobs demands-control-support model (DCS) to understand how work characteristics relate to employee well-being, health and performance. Luchman and Gonzalez-Morales (2013) used the random effects Hedges and Olkin (1985) to estimate population-level effect sizes with composite correlations computed using Spearman-Brown formula to obtain a single effect size estimate. In their investigation, the authors identified a weak positive relationship between workload and overall job satisfaction (k = 58, N = 222,143, r_c = 0.20 (Luchman & Gonzalez-Morales, 2013).

Ethnicity and Job Satisfaction

No noteworthy research was found examining the relationship between ethnicity and job satisfaction.

Koh, Shen, and Lee (2016) found that, on average, White workers were slightly more satisfied with their jobs than Black workers (k = 63, N= 753,791, r_c = 0.09) and the effect was lager in more nationally representative samples (k = 63, N= 753,791, r_c = 0.24). However, job complexity and sample demographic composition did significantly moderate this relationship. Our results show that the magnitude and direction of Black–White mean differences in job satisfaction are influenced by the context (Koh, Shen, & Lee, 2016).

Madera, Dawson, Neal (2013) surveyed 180 hospitality managers throughout the Texas. A multiple regression analysis was conducted for predictor variables of diversity of client, role ambiguity, role conflict, and job satisfaction. Diversity of climate was a significant predictor on job satisfaction ($R^2 = .15$, $B = .30$, $p < .01$).

Summary of Job Satisfaction Literature

Mixed results were found between job satisfaction and the control variables of gender, age, leadership role, education, and virtual consulting. Mean difference between black and white ethnic groups identified in a meta-analysis performed by Koh, et al., (2016). However, no noteworthy studies were found on job satisfaction and ethnicity as identified within the healthcare industries definition of either Hispanic or Latino or not Hispanic or Latino.

CHAPTER THREE

Overview

The purpose of this study was to examine the relationship between authentic leadership and the affective job satisfaction of healthcare consultants when controlling for the effects of gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity.

Methodology

In the previous chapters, an introduction to the proposed areas of research was presented. This included a description of the research problem and conceptualized several key terms important to the present topic. In addition, an appraisal of the relevant research related to the variables of authentic leadership and job satisfaction will be presented. The present research topic is an effort to determine if job satisfaction will predict authentic leadership.

The purpose of this chapter is to describe the research methodology of this study by (1) providing a sampling plan, (2) describing the instruments being used in the study, (3) providing operational definitions for the independent variables and the dependent variable, (4) describing the overall research design and procedure of the study (5) and accounting for any ethical concerns pertaining to the research proposed.

Sampling Plan

Sources of participants: Working adult consulting leaders from Texas Medical Foundation Quality Innovative Organization (TMF-QIO), a very large organization centralized in Austin, Texas with branch offices in Missouri, Oklahoma, Puerto Rico, and Arkansas provided the initial convenience sample for the study. Consultants work in

specific task areas providing advice to clients in several federally mandated programs such as Meaningful Use, Behavioral Health, Immunization, Value Based Payments, and Cardiac Health. Consultant leaders provide advice and education services to medical organizations with one medical provider within the organization to as many as 1300 medical providers within medical organizations. These services are offered at no cost through a grant from the Centers of Medicare Medicaid Services.

Recruitment of participants: Participants were initially recruited by attaining permission from the consulting firm TMF-QIO where the principle investigator was employed. The initial email was sent to 89 TMF-QIO consultant leaders by the program director of TMF using email solicitation which included an online survey link. Additionally, the program director from TMF-QIO forwarded the online survey link to seven other Quality Innovative Organizations (QIO's) throughout the United States asking their program directors to forward the link to their consulting leaders. The email went out to 123 possible participants with instructions for participants to forward the online survey link to fellow peer consultant leaders creating a snowball sample from the original convenience sample. Online survey is hosted by Survey Monkey®. The survey was sent out three times by the program director of TMF-QIO also notifying the principle investigator. However, response rate was 70 completed surveys' out of the possible 212 initially sent out, yielding a 58.3% response rate. Since our target goal was 200 completed surveys it was decided to petition the Our Lady of the Lake Institutional Review Board to expand the participant search by utilizing social media venues to solicit more response. Utilizing professional consulting social media sites including LinkenIn® and healthcare consulting blog's, expanded the survey using social media venues which

added 120 attempted surveys bringing the total to 190 attempted survey. It was difficult to estimate the accurate response rate using social media as a venue to collect data because of the snowball effect. The response rate using social media was estimated at 63.15% with a completion rate of 36.84% when using 190 attempted surveys as a baseline. These numbers were an estimation of the differences between the two IRB approved methods for data collection.

The survey yielded 190 attempted surveys with 119 of those surveys being completed by the participants representing an overall completion rate of 62.63%. Further break down of the collection of data identified the demographic survey data; 147 participants completed to the demographic survey with 43 participants skipping the submission of responses. The completion rate for the demographic survey was 77.36% and skipped submission was 22.63%. The Authentic Leadership Questionnaire Survey was completed by 138 of the participants, representing 72.63% of the sample, with 27.36% of the participants skipping this instrument. Similar response rates were noted for the Brief Index of Affective Job Satisfaction with 136 participants completing the survey representing 71.57% of the sample and 28.42% of the participants skipping this instrument.

Instrumentation

Demographic Survey

After the informed consent form was administered, participants completed a brief demographic survey. Participants were asked to answer the following questions:

What is your gender?

What is your age as of last birthday?

Describe your management position of others?

How many years have you worked as a consultant?

Identify the highest level of education you have obtained?

Indicate your ethnicity.

At the company or organization level, enter the number of clients you currently work with as a consultant?

To the best of your ability describe the percentage of time spent consulting clients in each category, using the scale below?

Consultants included in the study were Associates, Bachelor, Master, and PhD consultants working for the organization in several federally mandated task areas and throughout several states. Ethnic categories were chosen based upon those included in the United States Census and Our Lady of the Lake's official Institutional Review Board (IRB) form. Education level was based upon the samples of adult consultant populations.

Authentic Leadership Questionnaire

The *Authentic Leadership Questionnaire* (ALQ) was developed by Avolio, Gardner, and Walumbwa (2006) to measure the dimensions of authentic leadership conceptualized in the literature. These dimensions include: Transparency, Ethical/Moral Conduct, Balanced Processing, and Self-Awareness. The ALQ has been tested in the literature as both a reliable and valid measure of Authentic Leadership. However, more testing needs to be done because of research readily available is limited.

Walumbwa et al. (2008) performed a confirmatory factor analysis (CFA) using two independent samples from the United States and the People's Republic of China; results yielded a CFA value of .95. The estimated internal consistency, Cronbach's alpha,

for each measure reached acceptable levels for each of the subscales within the ALQ: Self-awareness, $\alpha = .92$; Relational transparency, $\alpha = .87$; Internalized moral perspectives, $\alpha = .76$ and Balanced processing, $\alpha = 91$.

Valsania, León, Alonso, & Cantisano (2012) conducted a Cronbach's alpha on each of the subscales of the ALQ. Results showed satisfactory reliability on each of the subscales (Self-awareness: $\alpha = .85$; Balanced processing: $\alpha = .78$; Moral perspective: $\alpha = .81$; Relational transparency; $\alpha = .83$).

Williams, Pillai, Deptula, and Lowe (2011) conducted a study to determine perceptions of authentic leadership pertaining to McCain and Obama in the 2008 presidential election. The coefficient alpha of reliability for the authentic leadership scale in the study was .92 and .94, respectively.

Riggio, Zhu, Reina, and Maroosis (2010) administer the ALQ and the *Leadership Values Questionnaire* to 172 managers to determine level of ethical leadership. The ALQ was tested against the subscales of justice, fortitude, prudence, and temperance. A correlation analysis revealed that scores on the ALQ correlated with each of the subscales of ethical leadership: Results were as follows: (justice: $r = .86$, fortitude: $r = .79$, prudence: $r = .86$, temperance: $r = .82$, $p < .001$). Results strengthen the criterion validity of the ALQ. A Cronbach's alpha was run to test reliability of the ALQ. Results yielded an acceptable reliability score of $\alpha = .97$.

The Brief Index of Affective Job Satisfaction Survey.

The *Brief Index of Affective Job Satisfaction Questionnaire* was developed by Thompson and Phua (2012) to access specially and discretely job satisfaction demonstrating content validity, internal consistency reliability, temporal stability,

convergent and criterion-related validity, plus cross-population equivalence by nationality, job level, and job organization type.

The 7-item Brief Index of Affective Job Satisfaction (BIAJS) includes four items measuring subjective satisfaction with current job plus three distractor items on a 5-point Likert-type response, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) (Sekol & Kim, 2014; Thompson, et al., 2012). After excluding the distractor items, the mean score ranges from 1 to 5, with the higher score indicating higher job satisfaction. The internal consistency reliability was reported with Cronbach's alphas ranging from 0.81 to 0.83 (Sekol & Kim, 2014; Thompson, et al., 2012).

Sekol and Kim (2014) administered the BIAJS to a convenience sample of registered nurses working in four different units (N = 240). Nurses in the hematology/oncology unit reported the lowest level of burnout and highest levels of job satisfaction and compassion satisfaction (Sekol & Kim, 2014). The mean job satisfaction and compassion satisfaction scores were lowest for the surgical unit (3.29 and 39.0, respectively) and highest for the hematology/oncology unit (4.26 and 43.0, respectively) (Sekol & Kim, 2014). The mean score differences across the four units were statistically significant for job satisfaction (F 3, 234 = 15.561; $p < .001$) (Sekol & Kim, 2014). The internal consistency reliabilities, as measured by Cronbach's alpha, was 0.80 for Job Satisfaction (Sekol & Kim, 2014).

Snyman and Loh (2015) administered the BIAJS to 146 participants in a study in order to measure optimism and found optimism to be a significant predictor of job satisfaction b = .284, t (144) = 3.374, p < .01. In addition, the BAIJS demonstrated

convergent validity of 0.75 with similar job satisfaction questionnaires (Thompson & Phua, 2012). The Cronbach alpha in this study was .89 (Snyman & Loh, 2015).

Research Variables

Independent variables. The independent variables in this research were the four authentic leadership subcomponent scores (self-awareness, transparency, ethical/moral, and balanced processing) of the healthcare consultant leader as rated by the healthcare consultant.

Dependent variables. The dependent variable in this research is the self-rated affective job satisfaction score of the healthcare consultant as measured by the *Brief Index Affective Job Satisfaction Survey* (Thompson & Phua, 2012).

Demographic variables. The demographic variables in this research included the gender of the healthcare consultant as reported by the healthcare consultant, age as reported by healthcare consultant, last birthday, leadership role as identified by healthcare consultants job title (consultant, team lead, manager/project manager, director), tenure identified by healthcare consultants years of employment as a healthcare consultant, education (Associates, Bachelors, Masters, Doctorate, any degree plus certifications), ethnicity (Hispanic or Latino or Not Hispanic or Latino), workload identified as the healthcare consultants number of clients they manage, and virtual consulting as identified by the type of consulting (face-to-face, combination, virtual consulting) and the percentage spent at each type of consulting level.

Research Design

The statistical analysis of the collected data included multiple regression, which was run using the statistical software, SPSS. This study accepted a level of significance

as $p \leq 0.05$. The research area is to determine if job satisfaction can predict authentic leadership behaviors. In addition to measuring job satisfaction, composite and individual authentic leadership behaviors were measured. To test authentic leadership behaviors, participants will take the self-rated *Authentic Leadership Questionnaire*, which identified authentic leadership behaviors based upon four subscales: Self-awareness, Transparency, Ethics/Morals, and Balanced processing. Only the combined authentic leadership scores are to be considered in this study. A regression analysis will be employed to determine if job satisfaction reasonably predicts authentic leadership behavior when controlling for gender, age, leadership role, tenure, education level, virtual consulting, and ethnicity.

Null Hypotheses

The null hypothesis' included in this study are:

1. There is no relationship between total authentic leadership and job satisfaction controlling for gender, age, leadership role, tenure, education level, virtual consulting, workload, and ethnicity.
2. There is no relationship between authentic leadership subcomponents (self-awareness, transparency, ethical/moral, and balanced processing) and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity.

Procedure

Participants were recruited in person and via electronic media administration, i.e. email, professional social media sites, and professional blogs. Prior to administering the instruments participants were briefed on the purposes of the study. All surveys were administered and collected via online survey company, Survey Monkey®. First,

participants were presented with an informed consent form explaining the intention of the study, assuring confidentiality, and assurance their participation is voluntary. Once all informed consent forms were completed participants took a brief demographic survey which included gender, age, leadership role, tenure, education level, virtual consulting, workload, and ethnicity. Next, the *Authentic Leadership Questionnaire (ALQ Version 1 self) was* administered followed by the *Brief Affective Job Satisfaction Questionnaire*.

Participants took the online version; a link was provided via email. The web-link was emailed to the appropriate individuals by the program director of the consulting department. Participants were presented with a briefing on the intention of the study. Informed consent was presented and participants had the opportunity to electronically agree or disagree to participation of the study. If participants agreed to the informed consent electronically, then they were directed to the demographic survey, which required participants to take a brief demographic survey including questions on gender, age, leadership role, tenure, education level, virtual consulting, and ethnicity. Next, the *Authentic Leadership Questionnaire (ALQ Version 1 Self)* was administered followed by the *Brief Affective Job Satisfaction Questionnaire*. Participants who disagreed to participation were exited from survey. There was mandatory completion of any part of the survey questions.

Surveys were accepted based on agreement of informed consent, age of participant (18 to 64 years of age), and completion of surveys presented. Surveys that lack one of the three criteria were omitted from the study.

Hypotheses Testing

Descriptive statistics, reliability estimates, and Pearson correlations were computed for all study variables using Statistical Program for Social Sciences (SPSS) Version 21.0 for Widows (IBM 2010). To test the first hypothesis, a regression analysis was employed to determine if a predictable relationship exists between job satisfaction and total authentic leadership when controlling for participants' gender, age, leadership role, tenure, education level, virtual consulting, and ethnicity. To test the second hypothesis, a regression analysis was employed to determine if a predictable relationship exists between job satisfaction and the subcomponents of authentic leadership when controlling for participants' gender, age, leadership role, tenure, education level, virtual consulting, and ethnicity. If the regression analysis found significance an analysis of variance was run to find differences in means followed by the Fishers Least Squared Differences was run as the post hoc analysis.

Ethical Considerations

Ethical considerations were few concerning this study. This study was approved by Our Lady of the Lake's Institutional Review Board. Informed consent was administered to each participant prior to full participation in the study. Participants were informed their participation was not mandatory and they were able to stop their participation at any time. Identity of each participant remained anonymous. The survey was completely anonymous and no identifying information was attached to the survey results.

CHAPTER FOUR

Results

The purpose of this study was to evaluate the relationships between total composite and the individual four subcomponents of authentic leadership and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity.

Multiple regression analysis was conducted using a statistical software package SPSS® Version 21, to test the null hypothesis of the research. Multiple regression allows the researcher to identify the independent variables which are predictors of the dependent variable.

Data Collection

Data for the research was collected using a convenience sample sampling method by requesting permission from Texas Medical Foundation Quality Innovative Organization by sending an introductory email to from the program director to the healthcare consultants. The email included an invitation to complete the survey and to forward the survey invitation to other peer consultants in the healthcare industry. A total of 190 responses were recorded by Survey Monkey® (https://www.surveymonkey.com/r/ArtisanLeadership) with 119 responses meeting the completion criteria for use.

Descriptive Statistics

Descriptive analyses were conducted for all the categorical, continuous control, independent, and dependent variables. Some of the demographic responses were omitted by the respondents and therefor the *N* for those variables varies from 113 to 119.

Demographic variables

Demographic data collected included consultant leaders defined by gender as a dichotomous variable, age as of their last birthday, leadership role (consultant, team leader, manager/project manager, director, and other), tenure (years as a healthcare consultant), education the received degree (Associates, Bachelors, Masters, PhD, Any degree plus certification), virtual consulting (any technology other than face to face), workload defined as the number of clients, and ethnicity (Hispanic or Latino or Not Hispanic or Latino).

Gender

The 117 usable responses included 79 females and 38 males, as illustrated in Figure 1. The gender distribution is approximately 68% females and 32% males.

Figure 1. Frequency graph for Gender

Age

The respondents to the survey reported ages in years which ranged from 22 to 64. The mean age of the participants was 47.00 ($N = 118$) and the median age was 38. The age distribution evident in the graph has a negative skew. This distribution has one mode of 38 years of age.

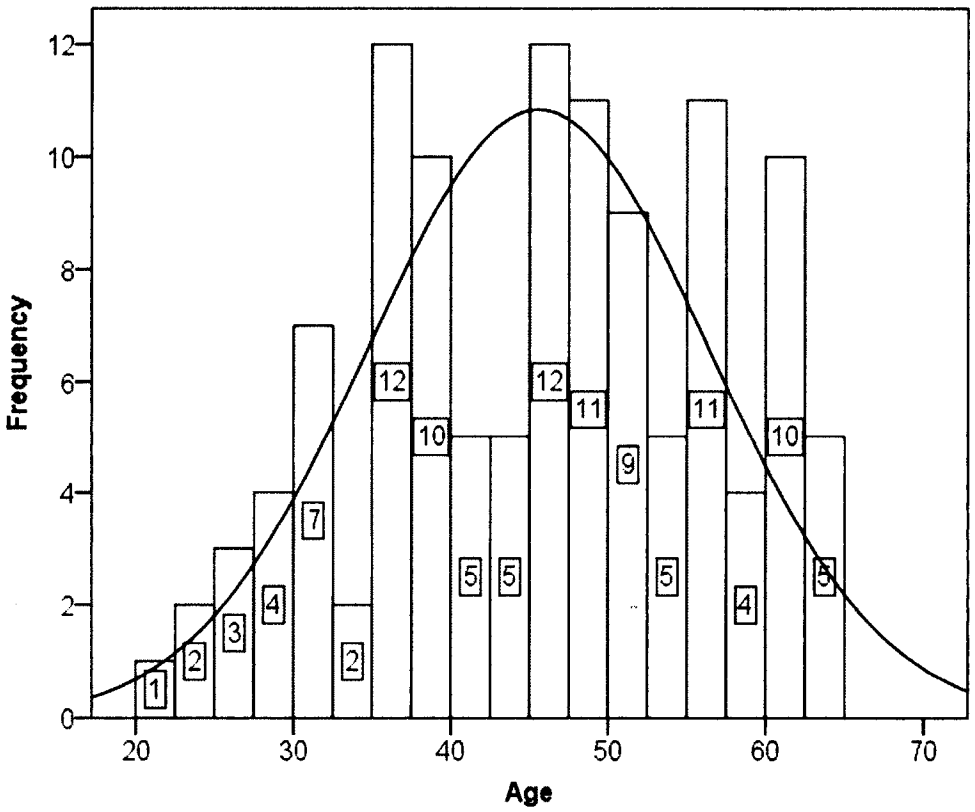


Figure 2. Frequency graph for age in years

Leadership Role

Leadership role was measured by respondents selecting a predetermined description within the survey. The 117 usable responses included 59 consultants, 14 team leads, 22 manager/project managers and 22 director positions were selected as illustrated

in Figure 3. The consultant job title in their leadership role distributed approximately 50% consultants, 12% team leads, 19% manager project managers, and 19% directors.

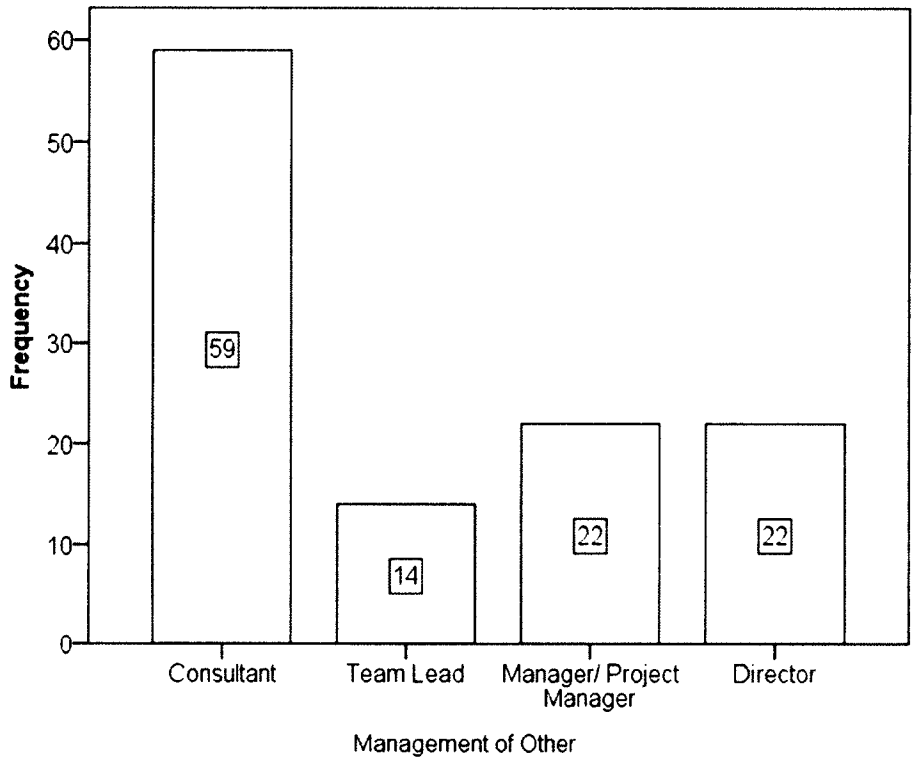


Figure 3. Frequency graph for leadership role

Tenure

Tenure was measured in one way. This was achieved by asking the respondents the number of years they have worked as a healthcare consultant. The mean was 8.06 years ($N = 118$) with a range from zero (less than one year) to 35 years and a mode of 0 year with 33 respondents in this category. The median value was 5.5 years. This distribution is depicted in Figure 4 and is positively skewed (1.29) with a floor effect representing the mode is the lowest response of zero to one year.

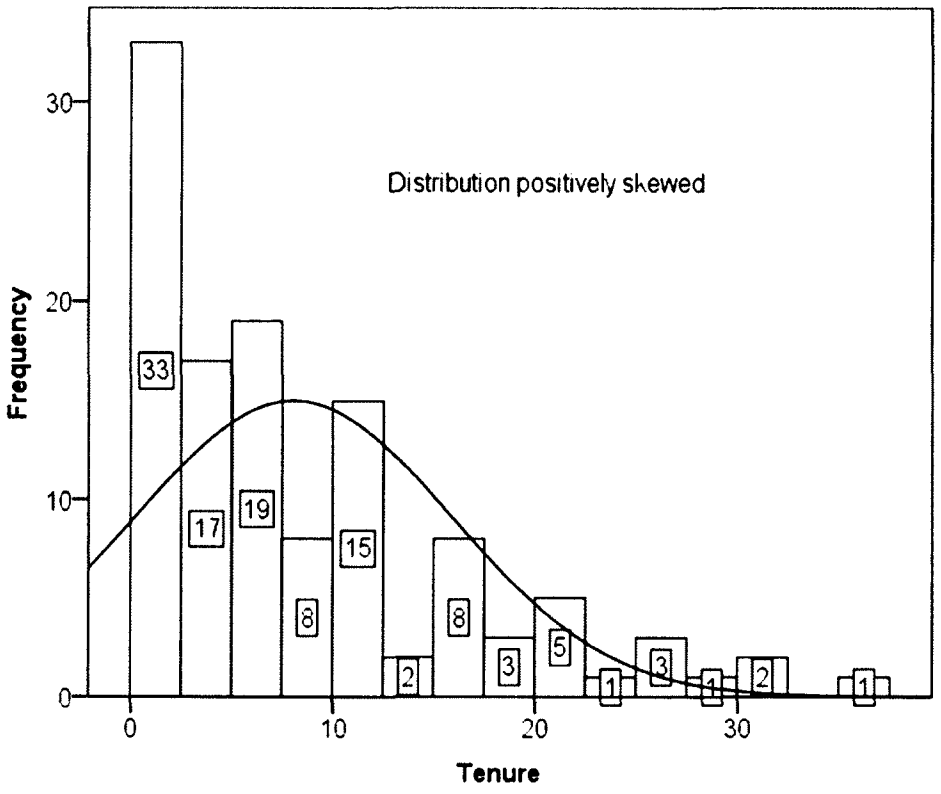


Figure 4. Frequency graph for years as a consultant

Education

Education was measured through the respondents' selection of completed education level from associates degree to doctorate. We also elected to add the education category of any degree plus certification. We created this category due to current observable trends in the healthcare industry asking for additional certifications, i.e. certified medical assistant. Six different education variables were measured using 117 responses including 13 Associates degrees, 32 Bachelors, 46 Masters, 14 Doctorate, and 11 any degree plus certifications were selected as illustrated in Figure 5. The respondents' education distribution is approximately 11% associates, 27.4% bachelors, 39% masters, and 12.5% doctorate, and 9% any degree plus certification.

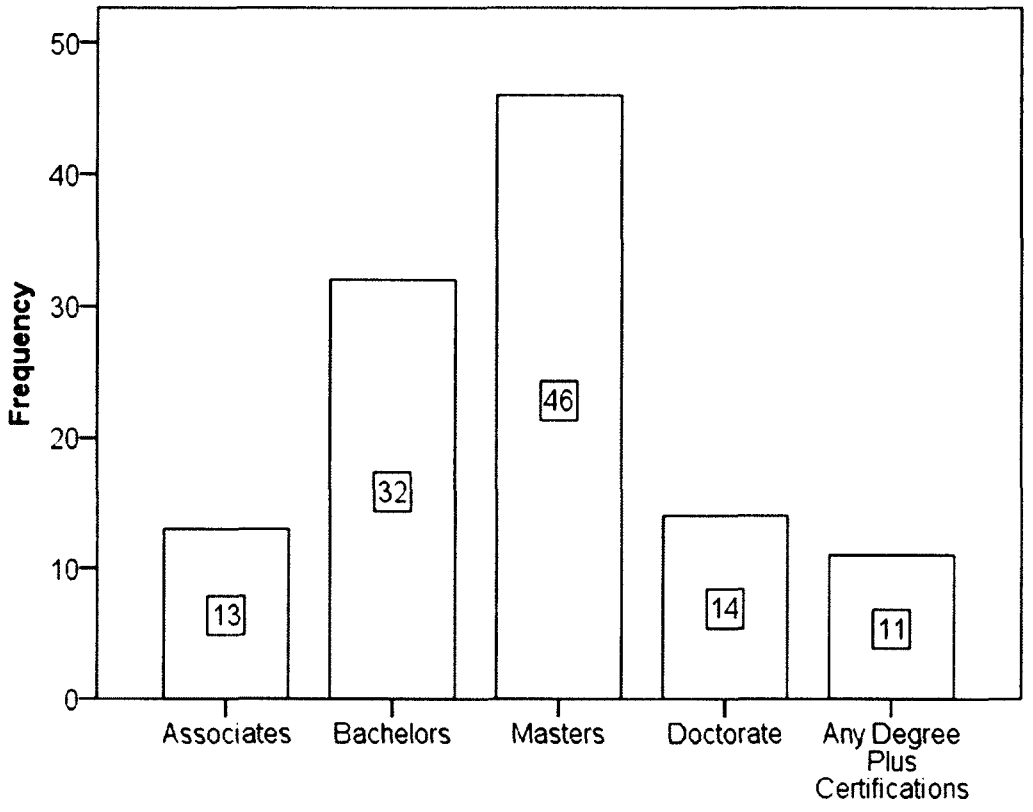


Figure 5. Frequency graph for education

Virtual Consulting

Virtual consulting style was measured through the respondents' selection of frequency of time spent performing consulting tasks with clients. Five different frequency variables were measured. The 110 usable responses included the respondents' frequency spent virtually consulting. Frequency was categorized as follows; approximately 39 consultants in the 0% to 20%, 14 consultants in the 21% to 40% category, 10 consultants in the 41% to 60% category, 18 consultants in the 61% to 80% category, and 29 consultants in the 81% to 100% category of the time virtually consulting as illustrated in Figure 6.

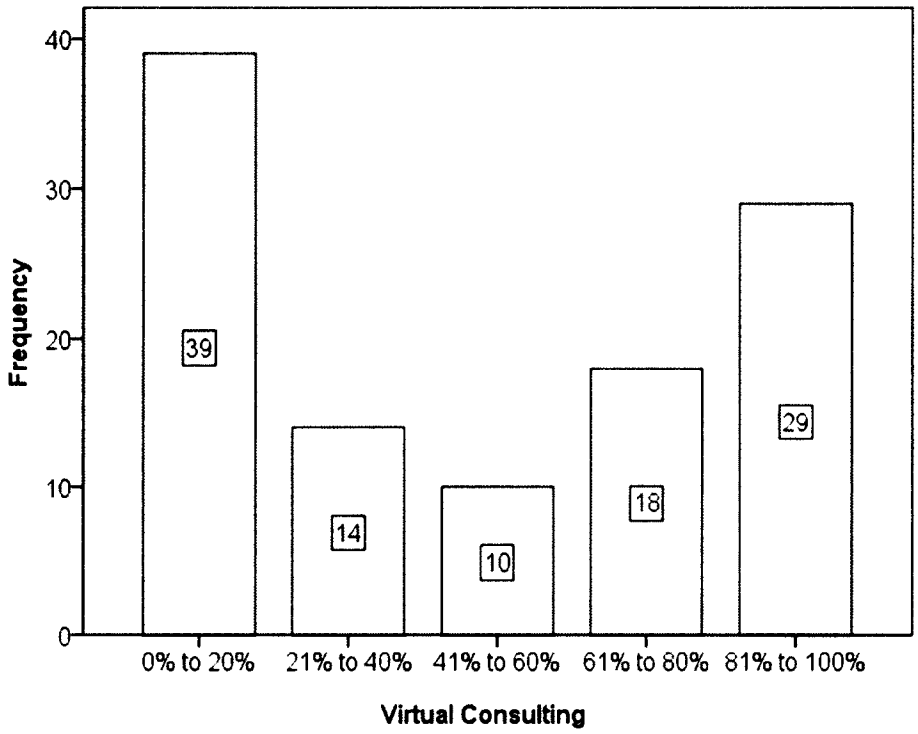


Figure 6. Frequency graph for virtual consulting

Workload

Workload was measured in one way. This was achieved by asking the respondents the number of clients they work with through their company or organization. The mean was 185.66 clients ($N = 107$) with a range from zero (less than one client) to 5000 clients and a mode of 0 clients with 10 respondents in this category. The median value was 28 clients. This distribution is depicted in Figure 7 and is positively skewed (6.20) with a floor effect since the mode is the lowest response of zero clients.

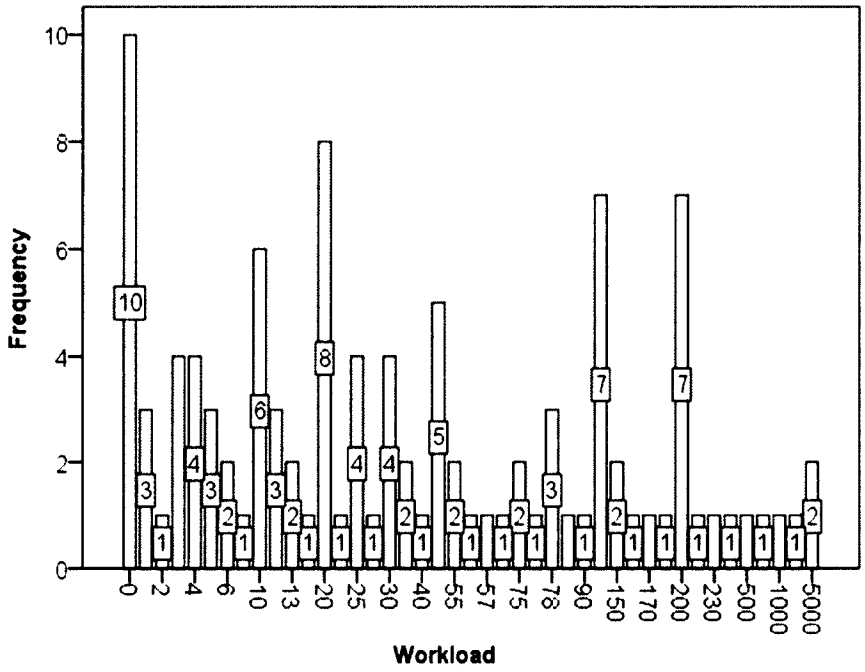


Figure 7. Frequency graph for workload

Ethnicity

Ethnicity was measured by asking the respondents to indicate their ethnicity as either Hispanic or Latino or Not Hispanic or Latino. We did create a category called "Other". This category was recommended by the committee. However, the responses in the Other category indicated the respondent's confusion between ethnicity and race. The 10 responses to the Other category were combined with the Not Hispanic or Latino category. The breakdown of the other responses was as follows; African American (1), Asian (1), Black (3), Caucasian (3), and White (2). The 117 usable responses included 28 Hispanic or Latino healthcare consultants representing 23.93% for the sample size. The remaining 89 respondents were Not Hispanic or Latino healthcare consultant responses characterizing 76.06% of the remaining sample population as illustrated in Figure 8.

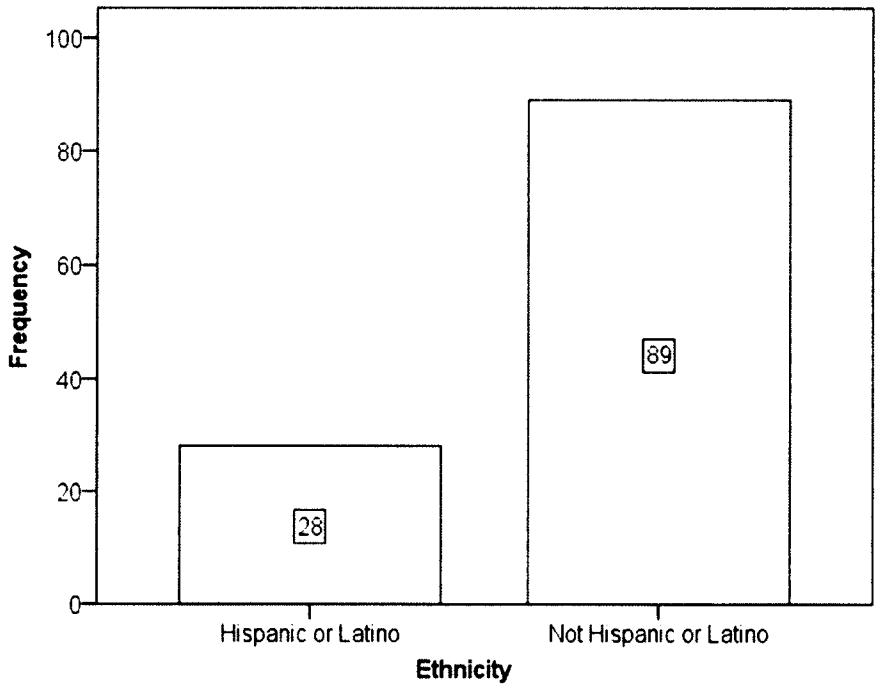


Figure 8. Frequency graph for ethnicity

Scored Measurement Instruments

Authentic Leadership

Figure 9 is a graphical representation of the self-rated Authentic Leadership Transparency scores for the respondents. The mean is 3.02, median is 3.20 and the mode is 4 ($N = 118$) with a minimum score of zero and a maximum score of four. This data is negatively skewed, -1.32. The negatively skewed distribution can lead to underestimated correlations and multiple regression results. The results of the Cronbach's alpha calculated for the study data was .81.

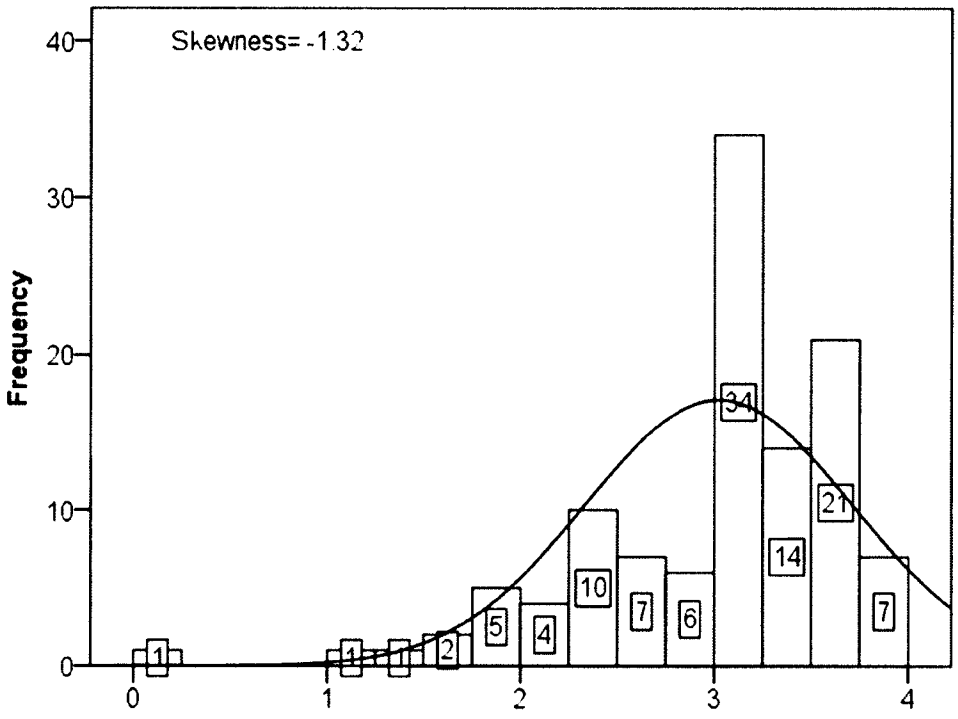


Figure 9. Frequency graph for self-rated AL Transparency scores

The self-rated Authentic Leadership Moral/Ethical scores are shown in Figure 10. This graph clearly demonstrates a ceiling effect of the scores with a mode of 4. The mean is 3.34 with a median of 3.67 ($N = 117$). The scores range from zero to four. This data is negatively skewed, -1.50. Since statistical tests assume the data exhibit a normal distribution, the negatively skewed distribution created by a ceiling effect may result in the correlations and/or the regression analysis being underestimated. The results of the Cronbach alpha calculated for the study data was .86.

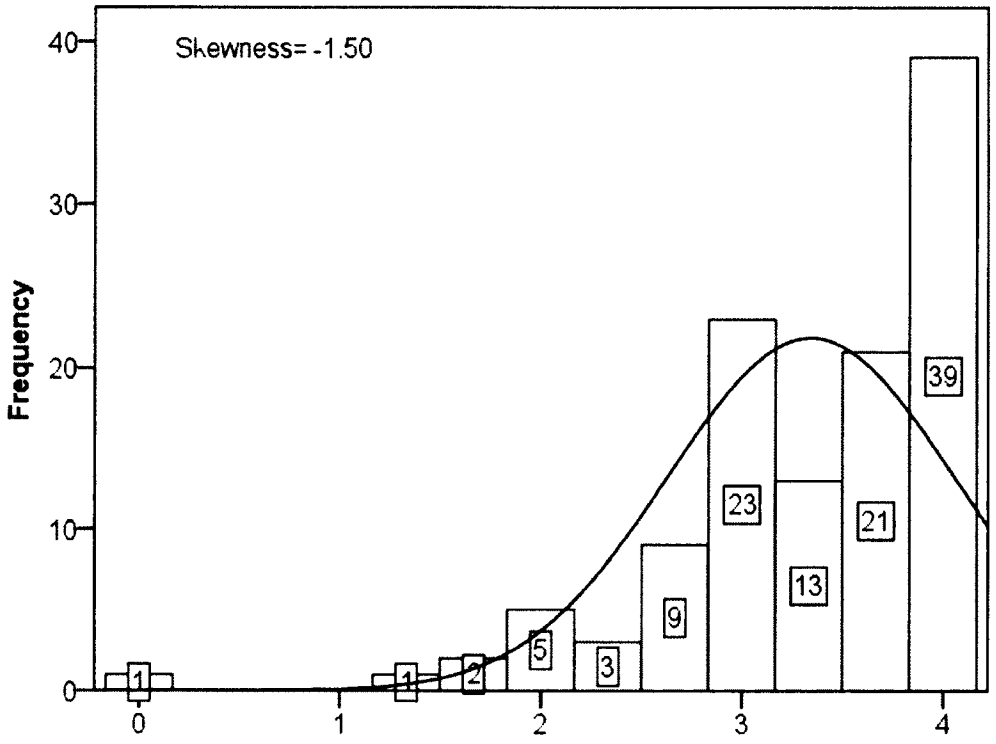


Figure 10. Frequency graph for self-rated AL Moral/Ethical scores

Self-rated Authentic Leadership-Balanced Processing scores are represented in Figure 11. The mean for the scores is 2.98, median is 3.00 and the mode is 3.00 (N = 117). The scores range from zero to four. This data is negatively skewed, -1.07. The negatively skewed distribution can lead to underestimated correlations and multiple regression results. The results of the Cronbach's alpha calculated for the study data was .50.

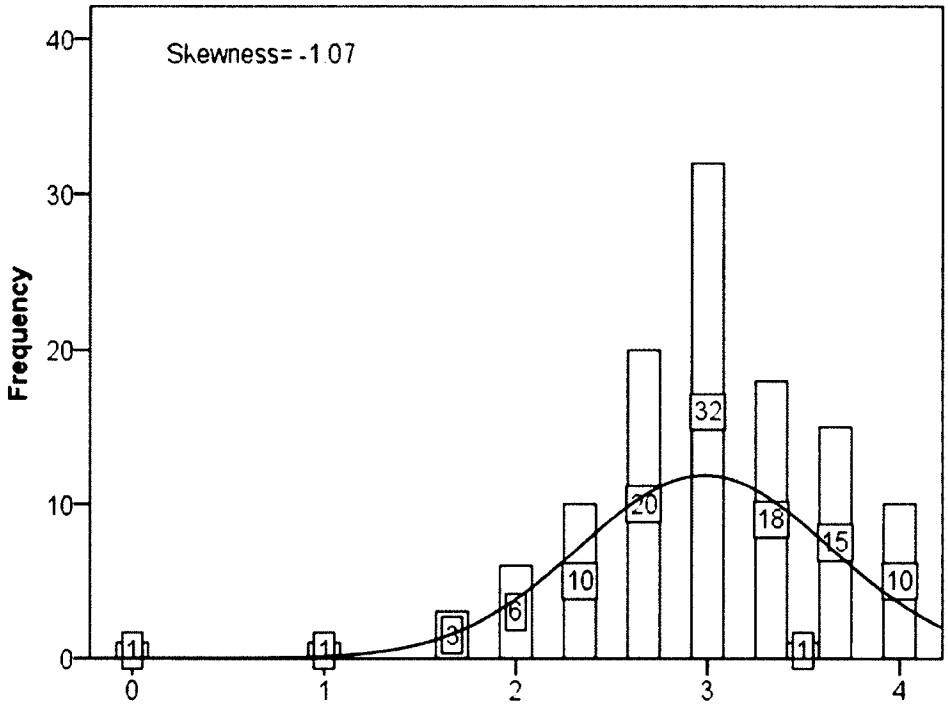


Figure 11. Frequency graph for self-rated AL Balanced Processing scores

The graphical representation of the self-rated Authentic Leadership Self-Awareness scores of the healthcare consultant is found in Figure 12. The mean is 2.84, the median is 3.00 and the mode is 3.00 ($N = 117$). The scores range from zero to four. This distribution is also negatively skewed, -1.17. The negatively skewed distribution can lead to underestimated correlations and multiple regression results. The result of the Cronbach's alpha calculated for the study data was .79.

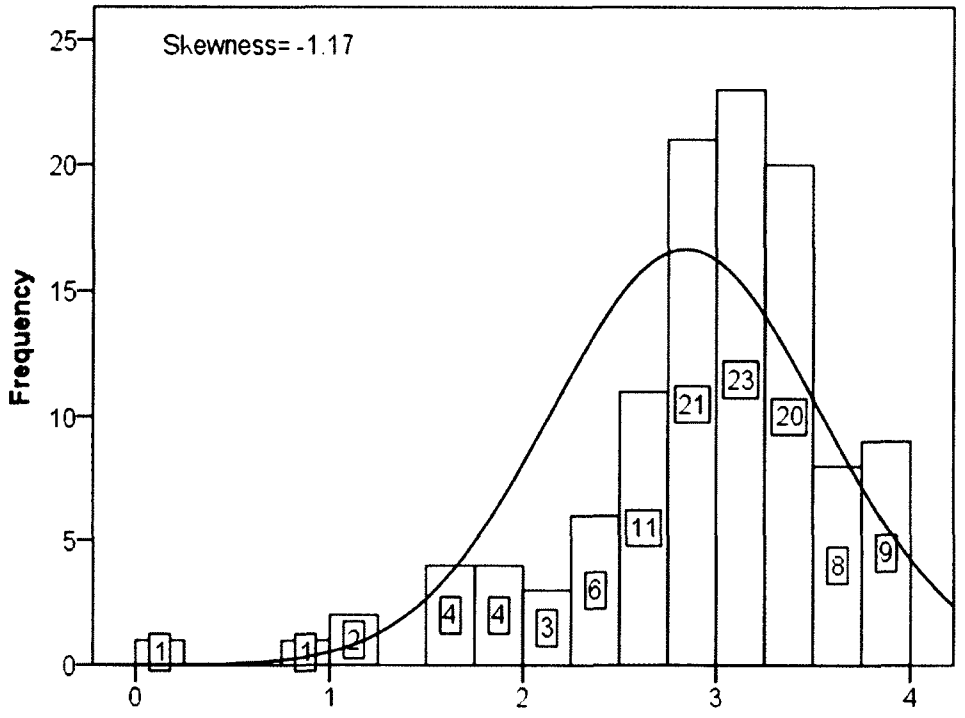


Figure 12. Frequency graph for self-rated AL Self-Awareness scores

The total score of all four subcomponents of Authentic Leadership is shown in Figure 13. The mean is 3.05, the median is 3.15 and multiple modes existing and the smallest value mode of 3.00 (N = 118). The composite Authentic Leadership graph is also negatively skewed with a negative skewness score of -1.66 and a positive Kurtosis score of 5.57. The negatively skewed distribution can lead to underestimated correlations and multiple regression results. The result of the Cronbach's alpha calculated for the study data was .92.

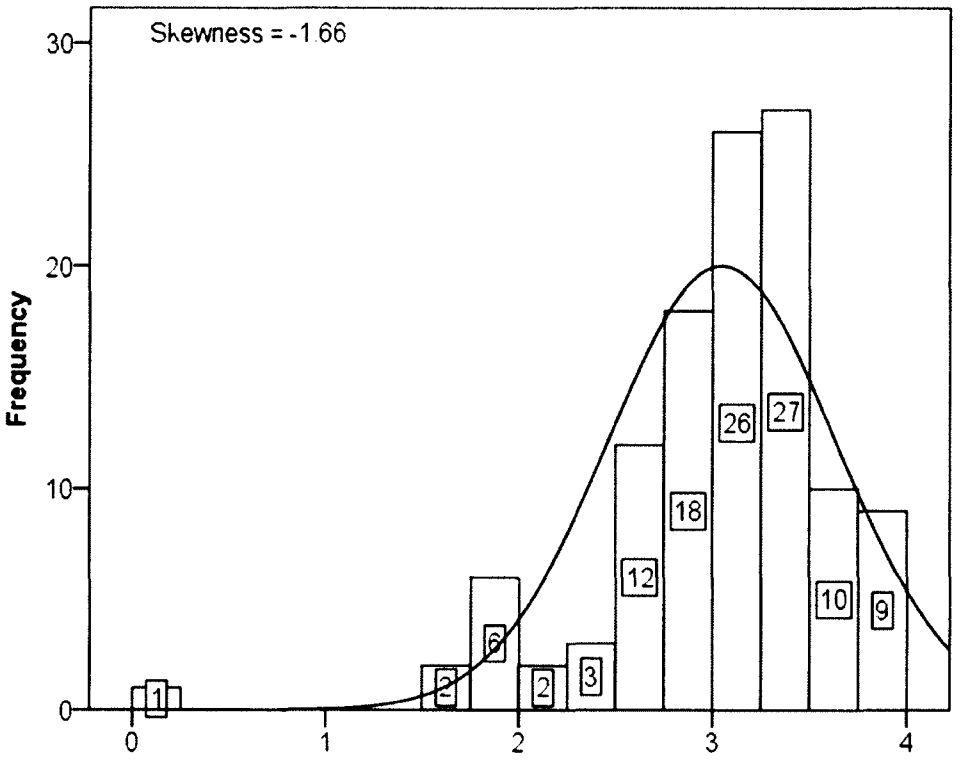


Figure 13. Frequency graph for self-rated Total Authentic Leadership score

Measurement of Brief Index of Affective Job Satisfaction

The *Brief Index of Affective Job Satisfaction* (BIAJS) scores are graphically represented in Figure 14. These scores are the result of the healthcare consultants self-rating their affective job satisfaction with the Thompson and Phua (2012) the Brief Index of Affective Job Satisfaction instrument. The BIAJS score is a sum of the responses to 7 items of which three responses are attenuated with a range from 1 to 5. The mean for the present study results was 3.84 with a median of 4.00 and a mode of 4 ($N = 118$). The minimum score recorded was 4 and the maximum score was 20. These results are negatively skewed. The negatively skewed distribution can lead to underestimated

correlations and multiple regression results. The results of the Cronbach's alpha calculated for the study data was .93.

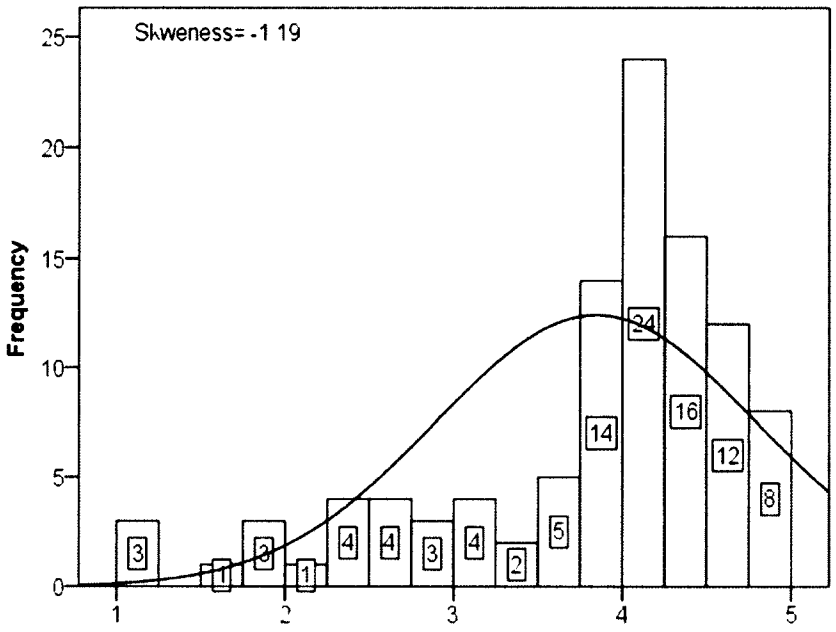


Figure 14. Brief Index of Affective Job Satisfaction score

Multiple Regression Analysis

This section presents the methodology for the research results and a discussion of the findings. Multiple regression was the primary statistical method used for the study. The analysis results were used to identify the relationships between the independent and dependent variables.

The dependent variable for the study was the affective job satisfaction score. This variable is a single score derived from the sum of the responses to the 4 questions in the instrument. The responses range from 1 to 5 therefore, the minimum possible score is 4 and the maximum possible score is 20.

The independent variable was authentic leadership, which has four subcomponents: transparency, ethical/moral, balanced processing, and self-awareness. The scoring for each subcomponent is an average of the responses for the questions in that component. The demographic independent variables of healthcare consultants were determined by gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity were all measured as continuous or dichotomous categorical variables.

The first step in the analysis was to run a Pearson's correlation to identify bivariate relationships between the continuous variables. The significant results are shown in Table 2. The Pearson correlation is a measure of the strength of a liner association between two variables and is denoted by r.

Correlation results range from negative one to positive one. A value of zero indicates there is no relationship between the variables. A value of positive one indicates a direct one to one relationship which means that for every unit the independent variable increases in value the dependent variable also increases by exactly the same amount. If the value is a negative one, the indication is an equivalent reduction in the dependent variable for each increase in the independent variable.

The data for the continuous variables was analyzed using a 1-tailed Pearson's correlation because the prediction was made that innovativeness would be increased by the leadership variables. This analysis produced several variables with strong correlations. Strong correlations are between the subcomponents of the ALQ, Transparency with moral/ethical ($r = .742, p < .01$), and self-awareness ($r = .675, p < .01$). Moral/ethical with balanced processing ($r = .614, p < .01$) and self-awareness ($r =$

.618, $p < .01$) also show a strong correlation. Balanced processing is also strongly correlated with self-awareness ($r = .854, p < .01$). There is a strong correlation between the total ALQ score and each of the four subcomponents: ALQ with transparency ($r = .879, p < .01$), moral/ethical ($r = .871, p < .01$), balanced processing ($r = .821, p < .01$) and self-awareness ($r = .854, p < .01$).

There is a moderate correlation between the healthcare consultants age and tenure ($r = .362, p < .01$) and transparency ($r = .363, p < .01$). Moderate correlations also exist between transparency and balanced processing ($r = .591, p < .01$). There is also a moderate correlation between the total ALQ score and age ($r = .311, p < .01$).

All other correlations are weak. Age has a significant weak correlation with multiple independent variable beginning with tenure ($r = .186, p < .05$). Weak correlations between age and the ALQ subcomponents exist; moral/ethical ($r = .262, p < .01$), balanced processing ($r = .219, p < .05$) and self-awareness ($r = .220, p < .05$). There is a weak correlation between tenure, years as a healthcare consultant, and workload ($r = .186, p < .05$), and ALQ self-awareness ($r = .165, p < .05$) likewise produced weak correlations in the 1-tailed correlation analysis.

The dependent variable, affective job satisfaction, has three statistically significant weak correlations. They are affective job satisfaction with age ($r = .166, p < .05$), transparency ($r = .298, p < .01$), and moral/ethical ($r = .281, p < .01$). The correlations with age is positive, which indicates the older the healthcare consultant the higher the jobs satisfaction score. The correlation with transparency is also positive, which indicates the higher the healthcare consultant rated his or her self in transparency, the higher the healthcare consultants own affective job satisfaction score.

	Age	Tenure	Workload	Transperancy	Moral/Ethical	Balanced Processing	Self-Awareness	ALQ	Job Satisfaction
Age	1								
Tenure	.362**	1							
Workload		.186*	1						
Transperancy	.363**			1					
Moral/Ethical	.262**			.742**	1				
Balanced Processing	.219*			.591**	.614**	1			
Self-Awareness	.220*	.165*		.675**	.618**	.629**	1		
ALQ	.311**			.879**	.871**	.821**	.854**	1	
Job Satisfaction	.166*			.298**	.281**	.308**	.387**	.372**	1

Weak .010 - .299 Moderate .300 - .599 Strong .600 - 1.00

** Correlations are significant at the .01 level (1 tailed)

* Correlations are significant at the .05 level (1 tailed)

Table 2: Correlation matrix of continuous variables

Multiple regression blocks were prepared after the correlation analysis. In Block 1, the continuous independent control variables of age, tenure, workload, and ethnicity were entered. Gender, a dichotomous categorical variable (female = 0, male = 1) was also entered in Block 1. The stepwise method of regression analysis was selected.

Block 1: Demographics (Stepwise)

- Age
- Gender
- Tenure
- Workload
- Ethnicity

In Block 2, the variables representing the healthcare consultant's education were entered with the enter method of analysis. Education descriptions required four dummy codes.

- Block 2: Education (Enter)
    - Education (categorical)

In Block 3, the variables representing the healthcare consultant's style of consulting were entered with the enter method of analysis. Virtual consulting descriptions required 3 dummy codes.

- Block 3: Virtual Consulting (Enter)
    - Virtual Consulting

In Block 4, the variables representing the healthcare consultant's management of others were entered with the enter method of analysis. Leadership role description required three dummy codes.

- Block 4: Leadership role (Enter)
    - Leadership Role

In Block 5 contains the four authentic leadership subcomponents of transparency, moral/ethical, balanced processing and self-awareness. The analysis method was stepwise.

- Block 5: Total ALQ (Enter)
    - Total ALQ

The multiple regression analysis was conducted using the block designs described above. The purpose of multiple regression analysis is to identify the independent variables which contribute a significant amount of variance to the change in the

dependent variable. The stepwise method evaluates each variable independently but the enter method evaluates all the variables entered in the block as one variable. The enter method is used for categorical variables and stepwise for continuous or dichotomous categorical. Block 2 and Block 4 in this multiple regression analysis contained the dummy coded variables for the healthcare consultant's education, and leadership role descriptions. The model summary from the multiple regression did not indicate statistical significance of healthcare consultant's education and leadership role variable. Because there was no statistical significance, or there was no indication any of the variables direct a significant amount to the variance of the dependent variable. This left two blocks of independent variables. Block 3 contained the control variables virtual consulting and Block 5 contained the independent variable subcomponents of authentic leadership. This arrangement allowed the analysis to be done by first looking at all of the contribution to the variance made by the control variables before evaluating the contribution to the variance of the dependent variable made by the independent variables in the study.

Analysis of the Null Hypothesis ($H_0 1$)

There is no relationship between total authentic leadership and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity.

The results depicted in Table 3 display the significant variance contributions identified by the regression analysis of the independent variables on the dependent variable, affective job satisfaction.

Table 3: Significant predictors of Affective Job Satisfaction

Model	R	R Square	R Square Change	Beta	Partial	df1	df2	Sig. F Change
1	.289[a]	.083				3	114	.042
2	.470[b]	.221	.137	.374b	.387	1	113	.000

a. Predictors: (Constant), Virtual Consulting

b. Predictors: (Constant), Virtual Consulting, Total ALQ Score

The results found the virtual consulting style of the healthcare consultant contributed 8.4% of the variance to the model with a p value of .042. Total ALQ score accounted for another 13.7% of the variance with a p value of .001 and the beta is positive. The positive beta indicates the higher the healthcare consultants self-rated total authentic leadership score the higher the healthcare consultants self-rated affective job satisfaction score. Because the independent variable contributes a statistically significant percentage of the variance to the model the null hypothesis ($H_0 1$) was rejected.

Figure 15. This represents all the data points and the regression line for the relationship between the healthcare consultant's total authentic leadership and the self-rated job satisfaction score ($\Delta R2 = .137, p < .00$).

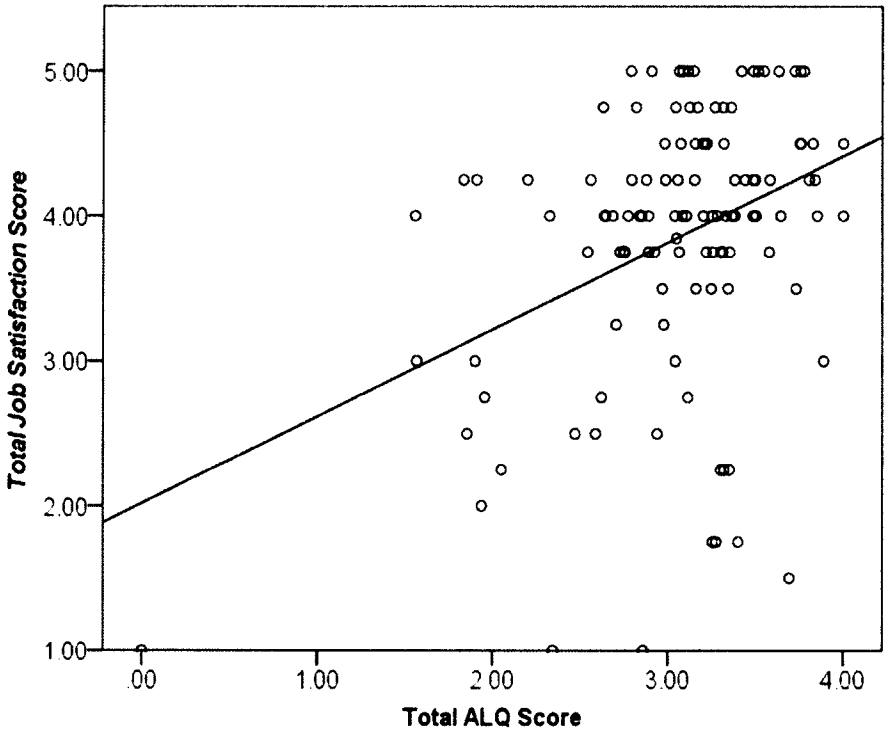


Figure 15. Scatter plot of total authentic leadership score and total job satisfaction.

Analysis of the Null Hypothesis ($H_0$2)

There is no relationship between authentic leadership and job satisfaction when controlling for gender, age, management of others, tenure, education, virtual consulting, workload, and ethnicity.

Multiple regression blocks were prepared after the correlation analysis to evaluate the variances in the models. The change in the setup from the first multiple regression blocks occurred in Block 5 with the individual evaluation of the subcomponents of ALQ (self-awareness, relational transparency, balanced processing, and moral perspective. The results depicted in Table 4 display the significant variance contributions identified by the regression analysis of the independent variables on the dependent variable, affective job satisfaction.

Table 4: Significant predictors of Affective Job Satisfaction

Model	R	R Square	R Square Change	Beta	Partial	df1	df2	Sig. F Change
1	.289[a]	.084				3	113	.043
2	.466[b]	.217	.133	.369b	.381	1	112	.000

a. Predictors: (Constant), Virtual Consulting

b. Predictors: (Constant), Virtual Consulting, Self-Awareness

The results found self-awareness to contribute 8.4% of the variance to the model with a p value of .043. The beta in the regression equation is positive, indicating the higher the self-awareness of the healthcare consultant higher the healthcare consultants self-rated affective job satisfaction score. Self-awareness accounted for another 13.3% of the variance with a p value of less than .000. Because the independent variable contributes a statistically significant percentage of the variance to the model the null hypothesis ($H_0 2$) was rejected.

Figure 16. Scatter plot representing all of the data points and the regression line for the relationship between the healthcare consultant's self-awareness score and the healthcare consultants self-rated affective job satisfaction score ($\Delta R^2 = .133, p < .001$).

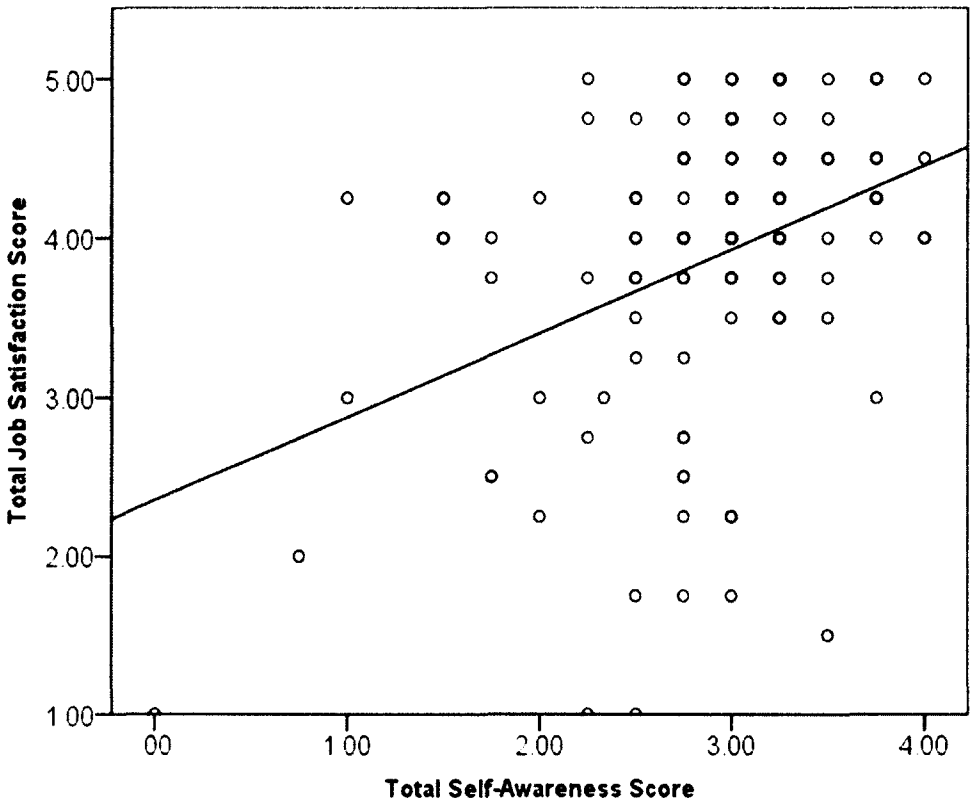


Figure 16. Scatter plot of self-awareness and affective job satisfaction

Summary of Results

Total ALQ and Affective Job Satisfaction. The greater the healthcare consultant's total authentic leadership score, the higher the healthcare consultants affective job satisfaction score.

Self-awareness and Affective Job Satisfaction. The greater the healthcare consultant's self-awareness the greater the affective job satisfaction score.

CHAPTER FIVE

Overview

The purpose of this study was to evaluate the relationships between the four subcomponents of authentic leadership and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity. This chapter includes a discussion of findings, limitations, implications, recommendations, and a conclusion.

The *Authentic Leadership Questionnaire* (ALQ) was used t0 assess leadership styles (self-awareness, relational transparency, moral/ethical, and balanced-processing) of the healthcare consultant. The ALQ was used to question 119 participants on how they perceived themselves about specific leadership behaviors using the self-rater questionnaire.

Total Authentic Leadership and Job Satisfaction

It was found that healthcare consultant's total authentic leadership score emerged as a significant predictor of affective job satisfaction. Total authentic leadership score accounted for 13.7% of the variance in affective job satisfaction. These findings are consistent with Banks, et al (2016) meat-analysis that found a strong positive relationship between authentic leadership and job satisfaction.

Self-awareness and Job Satisfaction

It was found that healthcare consultant's self-awareness score emerged as a significant predictor of affective job satisfaction. Authentic leadership, specifically self-awareness accounted for 13.3% of the variance in affective job satisfaction. Consistent with the literature this study found a weak positive relationship between self-awareness

and job satisfaction (Giallonardo et al., 2010). Additionally, this study affirms past peered reviewed literature further confirming the positive relationship between authentic leadership and job satisfaction.

Virtual consulting and Job Satisfaction

It was found that healthcare consultant's virtually consulting 61% of the time or higher were more satisfied than consultants working virtually 0% to 40% of the time. The findings are closely related to Jennings (2013) findings telecommuting is a form of work defined as telework; meaning work is pushed to the employee through the use of technology outside of in office or face to face. Telework is closely related to the aspects of virtual consulting.

Discussion

In this study, the following statistical techniques were used: descriptive statistics, Pearson Product Moment-Correlation to test whether participant self-collected demographics, authentic leadership style (self-awareness, relational transparency, moral/ethical, and balanced-processing), and job satisfaction scores were correlated along with multiple regression analysis to test two null hypotheses. Significant predictors of total authentic leadership and self-awareness explained a small percentage of variance, which indicated there may be other predictors for virtual healthcare consulting and job satisfaction that were not measured in the present study. If there is a predictor explaining a greater variance in for virtual healthcare consulting and job satisfaction it is not one included in the present study. These predictors of job satisfaction could be accounted for in relationships with clients, manager/director, and or organization and the healthcare consultant.

Other possible predictors for virtual healthcare consulting and job satisfaction could include leadership support, initiating structure, trust, and social support. Additionally, possible influential predictors could include, salary and/or travel away from organization home base leadership style, and attitudinal behavior of the leader over the healthcare consultant. Furthermore, the study collected self-evaluated data from the healthcare consultant in the form of self-rated questionnaires, authentic leadership, and job satisfaction. It is important to point out self-rated scoring questionnaires tend to be rated higher by the participant in the survey. Self-rating surveys do not yield a balanced perspective of the relationship. For example, a supervisor or client rating the authentic leadership style of the healthcare consultant as a counter balance to the self-rated score presented in the consultant.

Reevaluating the results from the variables examined during the study, the measure of relationship between the healthcare consultants and their direct supervisor, client, and the organizations culture. Within the context of general consulting research, specifically the relationship between the healthcare consultant, virtual consulting, and job satisfaction exist very limited peer reviewed and quantitative research. When reviewing other healthcare literature, specifically nurse providers, the literature explained 15% variance in job satisfaction was explained by work engagement and work engagement and authentic leadership accounted for 20% variance in job satisfaction (Giallonard, et al. 2010).

Outside of the healthcare industry, different variances were found in computer science and business industries. In Amazon's Mechanical Turk online marketplace for workers from India, dispositional variables (i.e. predictors skill variety, explained the

most unique variance in job satisfaction of 26%, but interactive variable (i.e. affect, contract fulfillment, intrinsic motivation, and pay satisfaction) explained the most unique variance in job satisfaction 27% with positive events for US workers (Brawley and Pury, 2016, p. 537).

These variance examples in varied industries illustrate the influence of multitude of variable that predict job satisfaction. The addition of new variable to a second study.

Overall Implications

A healthcare consultant leader ranked high in total authentic leadership is perceived as being one who is characterized as having a "pattern of leader behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" (Walumbwa et al., 2008, p. 94). Healthcare consultant leaders act as a temporary leader in their capacity with the client. If the relationship between the two parties is fostered in an open positive exchange (Avolio and Gardner, 2005) it would suggest that the healthcare consultant leader's positive moderate relationship to job satisfaction found in this study may be related to the relationship between the healthcare consultant leader and their client. Moreover, the authentic healthcare consultant can promote positive self-development to foster greater client self-awareness strengthening the relationship between client and consultant. Dirks and Ferrin (2002) acknowledge perceived leader integrity is related to job satisfaction.

As a temporary leader, healthcare consultants are involved in job related tasks for organization revenue and performance increases. The outcomes are associated with direct trust of the healthcare leader.

Additionally, emerging in this study was self-awareness as a predictor of job satisfaction. Walumbwa et al (2008) referred to authentic leaders are perceived how others see the leader impacts or influences other. Self-awareness is characterized as a person who is aware of their strengths and weaknesses. In terms of the applying the self-awareness' characterization to healthcare consultant leader. Self-awareness could be understood in a real world setting as how clients see the healthcare consultant ability to influence the clients with advice and the consultant's emotional stability when dealing with high level changes to the organization. We can infer from the characterization of a consultant, those with greater self-awareness will understand both their strengths and limitations of their ability to offer sound knowledge advice grounded in the remaining subscales of authentic leadership (relational transparency, balanced processing, moral/ethical). Moreover, the study revealed moderate strength correlations between the composite authentic leadership, self-awareness, and job satisfaction. This is consistent with the results of the meta-analysis conducted by Banks, McCauley, Gardner, and Gule (2016). Additionally, Giallonardo et al., (2010) found a weak positive relationship between self-awareness and job satisfaction. Both studies further strengthen the inference this study eludes to; the correlational relationship exists between the self-awareness, and job satisfaction.

The literature also leads us to the idea of charismatic leaders may be more self-aware. House et al (1992) described and found positive correlation with charismatic

leadership and job satisfaction. The healthcare consultant can be characterized as a leader with strong internalized values and goals which in turn could serve to gain deeper trust of the client more quickly to influence change of the organization the healthcare consultant is assigned to.

Another interesting finding was the result of virtual consulting 61% of the time indicated higher job satisfaction than those consulting 40% of the time or less. While correlations do not equal causation, higher job satisfaction for virtual consulting may be explained by spurious variables not fully examined in this study. For example, the consultants working in a telecommuting, where telework is being pushed to the employee using technology outside of the office or outside of face-to-face visits (Jennings, 2013). Contributing variables that lead to the relationship between virtual consulting and job satisfaction could be the influence of a balance between work and family for not traditional families, disabled employees, or the ability to work from other locations other than the home office. The flexibility of the telework in these scenarios may lead to higher level of job satisfaction. Organizations expanding the search for new hires outside the local talent pool area already versed in the aspect of working virtually may lead to higher morale and retention.

Limitations

A convenience sample was used for this study. There are limitations in generalizing the results of a convenience sample back to the entire healthcare consultant population. Participants in this study did not solely represent healthcare consultants but through the snowball sample potentially, other areas of the healthcare industry not offering advice as service. Furthermore, the sample lacked ethnic diversity; most of the

participants were primarily Non-Hispanic. Race categories were not represented within the study and may have provided a clearer representation of the ethnic and race if these categories were used.

Another limitation of the study is the floor effect seen with the tenure and workload variables measured by the number of years as a healthcare consultant and the number of clients a healthcare consultant gives advice. These positively skewed distributions may have led to a Type II error. Additionally, a ceiling effect was found on the authentic leadership subcomponent moral/ethical which may have led to underestimated correlation in the multiple regression. Furthermore, the initial email release to the convenience sample within TMF-QIO may have been biased. The close working relationship with the other consultants, program managers, managers, and directors may have influenced the self-rated scores of the participating healthcare consultants to select responses possibly higher because of the relationship with the principle investigator.

Recommendations for Future Research

There are limited number of quantitative studies focusing on authentic leadership and healthcare consulting. Healthcare investigators should continue to contribute to further advance knowledge in these areas of healthcare consulting. Future research should measure the healthcare consultant's clients' satisfaction with their temporary healthcare leader to evaluate further the leadership style and delivery of advice services from the healthcare consultant to client. The client's relationship with the healthcare consultant is another area to measure using leadership theories and tools such as, Leadership Member Exchange or Leadership Practice Inventory. The future orientation of healthcare

consulting research may include the characteristics of telecommuting and their impact on job satisfaction of healthcare consultants in various areas the healthcare industry. Additionally, new areas of research should include the utilization of online technology on virtual consulting practices in the delivery of advice services along with the impact those technologies have on job satisfaction.

Healthcare consulting is a complex dynamically changing field. Future research may provide better insight on the adaptive authentic leadership practices within the healthcare industry. The healthcare environment is highly regulated with nationwide changes occurring in 18 month intervals mandated on healthcare organizations by federal agencies through the Office of National Coordinator and Centers for Medicare and Medicaid. Research dedicated to adaptive leadership style, such as authentic leadership, may provide a clearer guide to a deeper understanding of the relationship of the authentic leadership style to job satisfaction.

Conclusion

This study accomplished its purpose, to evaluate the relationships between total authentic leadership, the four subcomponents of authentic leadership, and job satisfaction when controlling for gender, age, leadership role, tenure, education, virtual consulting, workload, and ethnicity. Three significant variables were identified as contributing to the model and therefore the null hypothesis' were rejected.

In this study, total authentic leadership, self-awareness, and virtual consulting were identified as a significantly contributing factors to job satisfaction. The moderate correlation in the authentic leadership literature between the four subcomponents has led to the idea a composite score of authentic leadership may be a more accurate measure

than the individual subcomponent scores. However, this study indicated a relationship between the subcomponent of self-awareness and job satisfaction that was not identified with the other three unique subcomponents of authentic leadership. Additional research is needed to identify other contributing factors to the relationship between leadership and job satisfaction for virtual healthcare consultants.

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Appendices

Appendix A

Email Script

***Dissertation Title*: Artisan Leadership: Exploring the relationship of Authentic Leadership and Job Satisfaction of the Virtual Healthcare Consultant**
The survey link is: **https://www.surveymonkey.com/r/ArtisanLeadership**

My name is Edgar A. Gonzalez and I am currently a PhD Candidate in Leadership Studies in the School of Business at Our Lady of the Lake University in San Antonio, TX. I am conducting research for my dissertation.

You are invited to take part in this research study by filing out a basic demographic questionnaire, leadership questionnaire, and a job satisfaction questionnaire. All the surveys used in this research study are specific to you and your perceived role in the organization. All questionnaires have been validated and are used regularly in professional research. The questionnaires are brief and should take no longer than 5 -10 minutes to complete. The survey link is: **https://www.surveymonkey.com/r/ArtisanLeadership**

If you decide to participate, your participation is completely voluntary and anonymous. If you choose to participate, you may stop participation at any time without penalty. Before participating, you will be given a consent form with more detailed information about the study, as well as points of contact for any questions you may have.

The research is being conducted because I believe this study will contribute to the overall understanding of the relationship between Authentic Leadership and Job Satisfaction. The results of this study will be included in my dissertation and potentially presented at scholarly conferences or published in scholarly journals. The data collected will be confidential and no individual will be identifiable. Meaning, data will be coded in such a manner that not even the researchers will be able to identify data associated with particular participants.

I would like this survey to include as many healthcare consultants as possible. Please forward this email to any consultant colleagues in any organization setting. I appreciate your participation and your assistance with forwarding this opportunity to your colleagues.

You may forward this survey link: **https://www.surveymonkey.com/r/ArtisanLeadership**

Respectfully,

Edgar A. Gonzalez
PhD Candidate
Our Lady of the Lake University
San Antonio, TX 78207
(210) 413 – 0539
eagonzalez2@lake.ollusa.edu

Appendix B

TMF Approval

RE: Guidance on permission to conduct a Dissertation Project
Jennifer Markley
You replied on 2/1/2016 8:38 AM.
Sent: Monday, February 01, 2016 7:31 AM
To: Gonzalez, Edgar
Cc: Swoboda, Tracy

Morning Edgar –

You have approval to survey the QIO teams as outlined below. Please let me know what I can do to assist you when your proposal is approved by your dissertation committee.

Regards,

Jennifer

Division Director, Quality Improvement

QIN-QIO IDIQ Director

TMF Health Quality Institute| 5918 West Courtyard Dr, Suite 300| Austin, TX 78730| http://TMFQIN.org

From: Gonzalez, Edgar
Sent: Thursday, January 28, 2016 11:42 AM
To: Jennifer Markley
Cc: Tracy Swoboda
Subject: RE: Guidance on permission to conduct a Dissertation Project

Jennifer:

Thank you for your response. Let me address the first concern *Provider Surveys*. Although this would be an interesting collection of data contributing to the literature I can complete this collection through different venues thus keeping the obligations intact with QIO and CMS. In anticipating a challenge such as this, I purposefully chose to compartmentalize the research question in two areas of interest.

Your second concern, Staff Surveys; *how often* and how long a period? The Staff Survey, will be conducted one time there is not a pre- or post-test survey. The complete survey will be released and completed through Survey Monkey. The complete survey will combine demographic questions (10 questions) followed by the Authentic Leadership Questionnaire (16 questions), and the Brief Index Job Satisfaction Questionnaire (7

questions). The survey should take about 30 minutes to complete and will be collected once from staff with anonymity and without obligation to participate in survey.

As to the second part of the question, *how long a period.* I will answer this way. Once I have permission to move forward from TMF leadership, I will make the necessary adjustments to my concept proposal and resubmit to my dissertation committee for concept defense. Once I have dissertation committee approval then I submit to the International Review Board (IRB) for data collection approval. This time line may vary but my best guess would be to being collecting data in early March. I would propose to leave the survey open for a minimum of 30 days with at least a reminder once a week to participate. However this last point would have to be balanced with TMF leadership to ensure it is not intrusive or counter-productive to staff and to the mission of TMF.

Jennifer, thank you again in opening the door of discussion and support. If can answer or provide you with additional information please let me know.

Your humble servant,

Edgar A Gonzalez

Quality Improvement Consultant

TMF Health Quality Institute

5918 West Courtyard Drive | www.TMFQIN.org

Appendix C

Instrument Approvals

Per permission agreement between the researcher and publishers of the *Authentic Leadership Questionnaire,* includes 16 items that measure leadership behaviors on the subscale of self-awareness, rational transparency, moral perspective, and balanced processing. The *Brief Index of Affective Job Satisfaction Survey,* includes 7 items that measure the overall emotive job satisfaction. Both permissions are included in this appendix.

Edgar Gonzalez

mind garden

To whom it may concern,

This letter is to grant permission for Edgar Gonzalez to use the following copyright material for his/her research

Instrument: ***Authentic Leadership Questionnaire (ALQ)***

Authors: ***Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa***

Copyright: ***2007 by Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa***

Three sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published materia

Sincerely

Mind Garden, Inc.
www.mindgarden.com

The Brief Index of Affective Job Satisfaction (BIAJS)
Scoring guide

We, Edmund R Thompson and Florence TT Phua, authors of the Brief Index of Affective Job Satisfaction (BIAJS), hereby give, without prejudice, permission for its use by academic researchers for their own academic, non-commercial research. The appropriate citation is

> Thompson, E. R. and Phua, F. T. T. 2012. 'A Brief Index of Affective Job Satisfaction,' *Group & Organization Management*. 37(3), 275-307

Instructions to respondents

> *Thinking specifically about your current job, do you agree with the following?*

Items in administered order

> I find real enjoyment in my job
>
> My job is unusual*
>
> I like my job better than the average person
>
> My job needs me to be fit*
>
> Most days I am enthusiastic about my job
>
> My job is time-consuming*
>
> I feel fairly well satisfied with my job

Interval measure

1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

* Distracter items used to help attenuate method variance. These are optional, and are removed from analyses if used

Professor Edmund R Thompson, PhD
Bath, England 2012

Appendix D

OLLU Approval

OUR LADY OF THE LAKE UNIVERSITY

NOTICE OF APPROVAL TO BEGIN RESEARCH

EXEMPT STATUS

Approval Date: May 6, 2016

PI Name: Edgar A. Gonzalez

Faculty Advisor: Dr. Jared A. Montoya

Title of Study: Artisan Leadership: Exploring the relationship of Authentic Leadership and Job Satisfaction of the Virtual Healthcare Consultant

The application you submitted for IRB review has been reviewed and determined to be Exempt from further review. Your study qualifies for exemption based on federal guidelines and no follow up with the IRB is required. You may begin data collection.

CHANGES – The PI must receive approval from the IRB before initiating any changes, including those required by the sponsor, which would affect human subjects. Such changes include changes in methods or procedures, numbers or kinds of human subjects, or revisions to the informed consent document or process. In addition, co-investigators must also receive approval from the IRB.

UNANTICIPATED RISK OR HARM– The PI will immediately inform the IRB of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects.

Note: Your IRB training certificate needs to be renewed for another three years.

CC: IRB

IRB Chair

Appendix F

Survey Monkey® Complete Questionnaire

Documentation of Adult Informed Consent

This project is for dissertation.

The Title of the Research Study: Artisan Leadership: Exploring the relationship of Authentic Leadership and Job Satisfaction of the Virtual Healthcare Consultant.

Invitation:

You are invited to take part in this research study if you work or participate in the healthcare industry. The information in this form is meant to help you decide whether or not to take part. IF you have any questions, please ask. Participation is voluntary. All data collected in this study is anonymous. No names will be recorded during the study. There is no way to connect your identity with your responses. If you choose to participate, you may stop participation at any time without penalty.

What is the reason for doing this research study?

This study will examine factors that contribute to job satisfaction of the healthcare industry consultants/workers/participants, including the relationship between authentic leadership and job satisfaction.

What will be done during the research study? You will be asked to consent to participate in this study by selecting "I agree" at the end of the informed consent form. Then, you will take a demographic survey, as well as two additional surveys. Authentic Leadership Questionnaire 1.0 Self (Avolio, Gardner, Walumbwa, 2007) and the Brief Index Affective Job Satisfaction questionnaire (Thompson and Phua, 2012). All surveys will be administered online and will take no longer than 5-10 minutes to complete.

What are the possible risks of being in this research study?

There are no known risks to you from being in this research study.

What are the possible benefits to you?

Although there is no direct compensation for your participation, the information you provide may further understanding of how authentic leadership may contribute to job satisfaction.

What will participation in this research cost you?

There is no cost to you for participating in this research study.

How will the information about you be protected?

All data collected in this study is anonymous. No names will be recorded during the study. There is no way to connect your identity with your responses.

What will happen if you decided not to be in this study or if you decide to stop?

Participation in the study is completely voluntary. You may select "I do not agree" at the end of the consent form and the survey will be terminated. If you initially choose to participate, you may stop participation at any time without penalty by exiting the survey.

What should you do if you have questions or concerns about this research study?

If you have any questions or concerns during or after this study, you may contact the researcher, Edgar Gonzalez, (210) 413-0539, eagonzalez2@lake.ollusa.edu. You can also contact the Our Lady of the Lake Institutional Review Board Chair, Dr. Christine Carmichael: ccarmichael@ollusa.edu or (210) 434-6711 x 2402.

Who can you contact if you have questions about your rights?

If you have any questions or concerns during or after this study, you may contact the researcher,

Edgar Gonzalez, (210) 413-0539, eagonzalez2@lake.ollusa.edu. You can also contact the Our Lady of the Lake Institutional Review Board Chair, Dr. Christine Carmichael: ccarmichael@ollusa.edu or (210) 434-6711 x 2402

Institutional Review Board Approval Notice
This research study has been reviewed and approved by the Our Lady of Lake University San Antonio.

* I have read the above Adult Informed Consent form, I understand the contents of the form and have the information needed to make a decision about participation in the research study described.

I agree

I do not agree

Demographic Questions

Answer the following questions about yourself.

* What is your gender?

- Female
- Male

* What is your age as of your last birthday? Please enter a number value only,(i.e. 25)

* Describe your management position of others?

- Consultant
- Team Lead
- Manager/Project Manager
- Director
- Other (please specify)

* How many years have you worked as a consultant? Please enter a number value only, (i.e. 25).

* Identify the highest level of education you have obtained

- Associates
- Bachelors
- Masters
- Doctorate
- Any Degree plus certifications/licenses

* Indicate your ethnicity.

- Hispanic or Latino
- Not Hispanic or Latino
- Other (please specify)

* At the company or organization level, enter the number of clients you currently work with as a consultant?

* To the best of your ability describe the percentage of time spent consulting clients in each category, using the scale below

	0% to 20%	21% to 40%	41% to 60%	61% to 80%	81% to 100%
Face to Face (Office visits)					
Combination Consulting (Face to Face and virtual)					
Virtual Consulting (Any technology other than face to face to deliver knowledge services)					

Authentic Leadership Questionnaire Version 1.0 Self
Bruce J. Avolio, PhD.

Instructions:
The following survey items refer to your leadership style, as you perceive it.Please judge how frequently each statement fits your leadership style using the following the following scale
As a leader I....

* 1. say exactly what I mean

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 2. admit mistakes when they are made

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 3. encourage everyone to speak their mind

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 4. tell you the hard truth

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 5. display emotions exactly in line with feelings

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 6. demonstrate beliefs that are consistent with actions

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 7. make decisions based on core values

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 8. ask you to take positions that support your core values

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 9. make difficult decisions based on high standards of ethical conduct

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

Authentic Leadership Questionnaire Version 1.0 Self
Bruce J. Avolio, PhD.

Instructions:

The following survey items refer to your leadership style, as you perceive it.Please judge how frequently each statement fits your leadership style using the following the following scale

As a leader I...

* 10. solicit views that challenge my deeply held positions

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 11. analyze relevant data before coming to a decision

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 12. listen carefully to different points of view before coming to conclusions

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 13. seek feedback to improve interactions with others

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 14. accurately describe how others view my capabilities

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 15. know when it is time to reevaluate my position on important issues

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

* 16. show I understand how specific actions impact others

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
○	○	○	○	○

The Brief Index of Affective Job Satisfaction Questionnaire
Edmund R.Thompson, PhD.

Instructions to respondents:
Thinking specifically about your current job, do you agree with the following?

* 1. I find real enjoyment in my job

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 2. My job is unusual

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 3. I like my job better than the average person

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 4. My job needs me to be fit

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 5. Most days I am enthusiastic about my job

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 6. My job is time-consuming

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

* 7. I feel fairly well satisfied with my job

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree