Integrating Relational and Operational Leadership for Positive Patient Experience: A Qualitative Case Study in Behavioral Healthcare

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Leadership is widely recognized as an influence on organizational performance; however, less is known about the specific leadership characteristics and behaviors associated with positive patient experience in behavioral healthcare. This qualitative case study examined leadership practices associated with patient experience within the residential service lines of a multi-site, multi-regional behavioral healthcare organization serving adolescents and young adults. Data were collected through four semi-structured interviews with organizational leaders and contextualized using aggregated patient and family experience data, Predictive Index leadership profile information, and organizational artifacts. Interview data were analyzed using reflexive thematic analysis. Six interrelated leadership characteristics emerged: servant leadership, communication, leader visibility, accountability, adaptability, and responsiveness. These characteristics converged into two complementary dimensions: relational leadership and operational leadership. Findings suggest that participants perceived relational competencies, including empathy, trust, communication, and visibility, as important to workforce engagement and the care environment, while operational competencies, including accountability, consistency, execution, and responsiveness, supported the translation of organizational values into practice. The findings informed a preliminary, practice-oriented Integrated Leadership for Patient Experience (ILPX) framework. The framework proposes an integrated approach to leadership development that attends to both relational and operational competencies. This study contributes context-specific insight into leadership and patient experience in residential behavioral healthcare and identifies directions for future research and framework evaluation.

INTRODUCTION

Patient experience is increasingly recognized as a critical indicator of healthcare quality and organizational performance. The Beryl Institute (2025) defines patient experience as "the sum of all interactions shaped by an organization's culture that influence patient perceptions across the continuum of care." This definition positions patient experience beyond

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individual clinical encounters and emphasizes the broader organizational environment in which care occurs. Within behavioral healthcare, where trust, communication, therapeutic relationships, and continuity of care are central to treatment, understanding the organizational factors that shape patient experience is particularly important (D'Agostino et al., 2017; Wolf et al., 2021).

Leadership represents one such factor. Healthcare leaders establish organizational priorities, influence workforce culture, and shape the systems through which care is delivered. Empirical research has linked leadership with workforce engagement, teamwork, quality, and patient perceptions of care (Barden et al., 2024; Howell et al., 2024; Kelly & Hearld, 2020). Yet, despite growing recognition of leadership's influence, less is known about the specific characteristics and behaviors associated with positive patient experience outcomes in behavioral healthcare. This distinction is important because identifying that leadership matters provides limited practical guidance regarding how leaders should be selected, developed, and supported.

Leadership and Patient Experience

Leadership's relationship with patient experience extends beyond direct interactions between leaders and patients. Leaders influence the organizational conditions in which patient care occurs by establishing expectations, modeling behaviors, shaping culture, and determining how organizations respond to patient and workforce needs. Research on leadership and organizational performance similarly suggests that leaders influence outcomes by establishing vision, values, performance, expectations, and systems that shape care delivery and patient outcomes (Barden et al., 2024; Howell et al., 2024; Kelly & Hearld, 2020).

Research supports the importance of visible, relational, and responsive leadership in creating patient-centered environments. Barden et al. (2024) identified communication, empathy, adaptability, teamwork, presence, and relationship building among leadership characteristics associated with patient experience. Similarly, visible leadership engagement and relational presence have been associated with environments in which patient-centered behaviors are most consistently modeled and reinforced (Barden et al., 2024; Latvis et al., 2024). These findings suggest that patient experience is influenced not simply by organizational policies and clinical practices, but by the leadership behaviors that shape how those practices are implemented.

The relationship between leadership and patient experience also appears to operate through the workforce. Howell et al. (2024) found that teamwork significantly mediated the relationship between provider experience and patient experience, with high-functioning teams associated with lower burnout, greater intent to remain, and stronger

patient perceptions of care. Health-promoting leadership behaviors have similarly been associated with stronger teamwork and team mental health, particularly during organizational change (Paganin et al., 2023). Collectively, these findings position workforce engagement and team functioning as important mechanisms through which leadership may influence the patient experience.

Although existing research has begun to identify leadership characteristics relevant to patient experience, important distinctions remain in the scope and contribution of this work. Latvis et al. (2024) examined executive competencies relevant to patient experience, contributing insight into the leadership capabilities considered important at the organizational level. Barden et al. (2024) provided an organizational case description of patient experience structures and leadership characteristics. Related literature has also examined connections among leadership, workforce conditions, teamwork, and patient experience (Howell et al., 2024; Kelly & Hearld, 2020; Paganin et al., 2023). However, these contributions do not establish a validated combination of leadership behaviors that produce positive patient experience outcomes in residential behavioral healthcare. The present study extends this discussion by examining how leaders within a bounded residential service-line context described the leadership practices they perceived as relevant to workforce engagement, organizational functioning, and patient experience. Rather than testing the causal effect of leadership on patient outcomes, the study offers a context-specific examination of leadership characteristics and their perceived relationship to the conditions in which care is delivered.

For clarity, this study uses the terms leadership characteristics, behaviors, and competencies to describe related but distinct aspects of leadership practice. Characteristics refer to qualities or attributes participants associated with effective leadership. Behaviors refer to observable actions through which leaders demonstrate those characteristics. Competencies refer to the broader capabilities that enable leaders to apply these behaviors across organizational situations. The term dimensions are used to describe the two higher-order groupings developed through the analysis: relational leadership and operational leadership. Although these concepts are related, they are not treated as interchangeable; rather, they provide a progression from the attributes described by participants to the behaviors and broader competencies synthesized in the proposed framework.

Leadership in Behavioral Healthcare

Behavioral healthcare presents distinct leadership challenges because care is delivered within complex clinical, relational, and operational environments. Patients and families may encounter multiple professionals

across the continuum of care, making communication, consistency, trust, and coordination important components of the care experience (D'Agostino et al., 2017; Wolf et al., 2021). Leadership therefore operates within a system in which workforce conditions and organizational processes may affect how care is experienced.

Research in behavioral healthcare has identified relationships between leadership, workforce well-being, teamwork, and organizational climate (Kelly & Hearld, 2020; Paganin et al., 2023). However, limited research has examined which specific leadership characteristics and behaviors are associated with positive patient experience outcomes within behavioral healthcare settings. Greater specificity may provide organizations with more actionable information for leadership development, workforce engagement, and patient experience strategy.

Leadership Development in Behavioral Healthcare

Leadership development represents an important organizational consideration when seeking to translate leadership expectations into consistent practice. In behavioral healthcare, leaders must navigate the relational demands of treatment environments while maintaining operational standards, supporting multidisciplinary teams, and responding to changing patient and family needs. These responsibilities require more than an understanding of leadership theory; they require the ability to apply leadership competencies within complex and emotionally demanding care environments.

Existing research provides support for the relationship between leadership practices and workforce conditions that may contribute to patient experience. Kelly and Hearld (2020) examined relationships between leadership approaches and workforce outcomes in behavioral healthcare, while Paganin et al. (2023) identified relationships among health-promoting leadership, teamwork, and team mental health. Howell et al. (2024) further highlighted the relationship between teamwork and patient experience. Collectively, this literature suggests that leadership development may be relevant not only to individual leader effectiveness but also to the workforce conditions through which care is delivered.

However, evidence identifying specific leadership development programs that improve patient experience outcomes in behavioral healthcare remains limited within the literature considered in this study. Existing research provides insight into leadership characteristics, workforce engagement, and organizational conditions, but offers less direction regarding how relational and operational competencies may be intentionally developed together. This distinction is particularly important in residential behavioral healthcare, where leaders must support therapeutic relationships and workforce engagement while maintaining accountability, consistency, and responsiveness across daily operations.

The present study addresses this gap by examining leadership characteristics described by organizational leaders and considering how the resulting themes may inform leadership development. The proposed Integrated Leadership for Patient Experience framework is presented as a preliminary, practice-oriented response to this gap. It is not an evaluated intervention or a validated program; rather, it offers a structure for future leadership development and empirical evaluation.

Purpose of the Study

The purpose of this qualitative case study was to examine leadership characteristics and behaviors associated with positive patient experience within the residential service lines of a multi-site behavioral healthcare organization serving adolescents and young adults. Specifically, the study explored the leadership characteristics participants perceived as relevant to patient experience, how leaders described the relationship between their behaviors and the care environment, and how the findings might inform leadership development. The study was guided by three research questions addressing leadership characteristics, perceived influence of leadership behaviors, and the potential design of leadership development strategies to support patient experience. This study did not seek to establish causal relationships or directly measure patient perceptions through interviews; instead, it examined leaders' perspectives alongside de-identified organizational information used for contextual interpretation.

Research Questions

The study was guided by the following research questions:

RQ1: What specific leadership characteristics are most strongly associated with positive patient experiences in behavioral healthcare settings?

RQ2: How do organizational leaders perceive their behaviors as influencing patients' perceptions of care in behavioral healthcare facilities?

RQ3: How can leadership development strategies or programs in behavioral healthcare settings be designed to enhance patient experience outcomes?

A qualitative case study design was selected because it allowed for an in-depth examination of leadership practices within the real-world organizational context in which patient experience occurs. The design also supported the integration of multiple sources of evidence to develop a contextual understanding of the phenomenon (Creswell & Poth, 2018; Yin, 2018).

CONCEPTUAL FRAMEWORK

This study was informed by two complementary conceptual foundations: the Baldrige Excellence Framework (Baldrige Performance Excellence Program, 2021) and the Beryl Institute's (2025) definition of patient experience. These foundations were selected before data analysis because they provided complementary perspectives relevant to the study's purpose. The Baldrige framework offered an organizational systems perspective through which leadership, workforce engagement, operational processes, measurement, and organizational results could be considered together. The Beryl Institute's definition provided a patient-centered foundation by conceptualizing patient experience as the sum of interactions shaped by organizational culture across the continuum of care.

These frameworks informed the development and focus of the interview protocol and provided conceptual context for interpreting the findings. The Baldrige framework supported attention to leadership practices, workforce conditions, organizational processes, and performance information. The Beryl Institute's definition supported consideration of patient experience as an experience shaped by the organization rather than an outcome attributed solely to individual clinical encounters. Neither framework was used as a predetermined coding structure. Instead, the six leadership characteristics were developed inductively through analysis of participant interviews, after which the findings were considered in relation to these conceptual foundations.

Baldrige Excellence Framework

The Baldrige Excellence Framework provided a systems-oriented foundation for examining leadership, workforce engagement, organizational operations, and patient-focused outcomes. The framework emphasizes leadership, strategy, customers, workforce, operations, and results as interconnected components of organizational performance (Baldrige Performance Excellence Program, 2021). Within this study, particular attention was given to the relationship between leadership practices, workforce conditions, operational effectiveness, and patient experience.

The framework's emphasis on leadership accountability, strategic alignment, workforce engagement, and operational effectiveness supported examination of how leadership behaviors may shape the conditions in which patient care is delivered. Research examining the Baldrige framework in healthcare similarly supports its relevance to organizational performance and quality improvement (Strahan et al., 2022).

Beryl Institute Definition of Patient Experience

The Beryl Institute's definition of patient experience provided the foundation for how patient experience is defined in this study. The Beryl Institute (2025) defines patient experience as "the sum of all interactions shaped by an organization's culture that influence patient perceptions across the continuum of care." This definition emphasizes that patient experience extends beyond individual clinical encounters and includes the cumulative influence of organizational culture, relationships, communication, and interactions across the care continuum.

The definition was particularly relevant to the present study because participants described patient experience as extending beyond individual patient-provider interactions. Their responses emphasized the influence of workforce engagement, communication, leadership visibility, organizational consistency, responsiveness, and service recovery. The Beryl Institute framework therefore complemented the Baldrige framework by providing a patient-centered lens through which organizational leadership and performance could be considered.

Integration of the Framework

Together, the Baldrige Excellence Framework and the Beryl Institute's definition of patient experience provided complementary lenses for examining leadership within the broader organizational system. The Baldrige Excellence Framework provided the organizational and performance-oriented lens, while the Beryl Institute provided the patient-centered lens through which the experience of care was understood. This integration supported examination of how leadership characteristics and behaviors operate within organizational culture, workforce conditions, operational systems, and patient experience.

The frameworks were used to guide the study rather than to impose predetermined findings on the interview data. The six leadership characteristics reported in the Findings section emerged inductively from participant interviews. The conceptual frameworks subsequently provided context for interpreting how those findings related to organizational performance and patient experience.

METHOD

Research Design

This study employed a qualitative case study design to explore the leadership characteristics associated with positive patient experience outcomes within a multi-site, multi-regional behavioral healthcare organization. A qualitative case study was selected because it allowed for an in-depth examination of leadership within its real-world organizational context while integrating multiple sources of evidence to develop a comprehensive understanding of the phenomenon (Yin, 2018). The study explored leadership characteristics, behaviors, and organizational

practices associated with patient experience rather than testing causal relationships.

Setting

The study was conducted within a multi-site, multi-regional behavioral healthcare organization. Although the partnering organization provides multiple levels of behavioral healthcare services, the study was bounded to its residential service lines serving adolescents and young adults. This boundary was selected to provide a defined organizational and care-delivery context in which leadership practices and patient experience could be examined. Residential behavioral healthcare involves sustained interactions among patients, families, clinical professionals, and operational teams. Family experience is particularly relevant in this setting because family members or other related contacts may participate in treatment-related communication and provide feedback at multiple points during care. The organizational setting therefore provided an appropriate context for exploring how leaders perceived the relationship among leadership practices, workforce conditions, and patient and family experience.

Participants

Purposeful sampling was used to identify four organizational leaders with direct knowledge of leadership practices and patient experience initiatives within the partnering organization. Participants included one senior organizational leader with responsibility for organizational experience strategy and three regional operational leaders overseeing residential service lines. Each participant has experience leading multidisciplinary teams and familiarity with organizational patient experience processes. Participant characteristics are summarized in Table 1.

The three regional operational leaders were identified by a senior organizational leader as representing different levels of regional patient experience performance. The organization used an internal benchmark of 80% for positive experience, with results below 80% categorized as below target and results at or above 80% categorized as at target or above target. Although these performance categories informed organizational interpretations of patient experience, the specific rationale and criteria used by the senior leader to select the regional participants were not communicated to the researcher. Therefore, the researcher cannot independently confirm the precise criteria used to assign or select the regional performance tiers.

To reduce the potential for deductive disclosure, participant roles are reported using broad organizational categories rather than specific titles or geographical identifiers. The sample was intentionally small and

selected for participants' direct knowledge of leadership practices and patient experience strategy rather than statistical representation. Aggregated patient experience data and Predictive Index profile information were treated as de-identified organizational artifacts and were not linked to individual participants in the reporting of findings.

Table 1

Participant Characteristics

Number	Participant category	General responsibility
1	Senior organizational leader	Organizational patient experience strategy and outcomes
3	Regional operational leader	Regional residential service-line operations and patient experience strategy

Note. Participant categories are intentionally broad to protect confidentiality and reduce the risk of deductive disclosure. Specific titles, geographical locations, and other potentially identifying characteristics are not reported.

Data Collection

Data were collected through semi-structured interviews guided by a standardized interview protocol. Prior to each interview, participants received an email containing the study purpose, informed consent information, interview procedures, and an overview of the interview protocol. Interviews explored participants' perceptions of leadership characteristics, leadership behaviors, organizational practices, workforce engagement, and patient experience outcomes. The interview protocol was designed to align with the study's research questions and conceptual framework and included questions addressing leadership behaviors, communication of patient experience strategy, use of patient experience data in decision-making, workforce engagement, and perceived drivers of patient experience outcomes. The semi-structured format provided consistency across interviews while allowing flexibility to explore participants' experiences and examples through follow-up questions (Creswell & Poth, 2018).

Four interviews were conducted virtually through Microsoft Teams, with each interview lasting approximately 1 hour. Interviews were recorded with participants' consent, and initial transcripts were generated using Microsoft Teams transcription capabilities. The researcher reviewed each recording alongside its corresponding transcript to verify accuracy and correct transcription errors before analysis. Interview transcripts were subsequently uploaded into NVivo for qualitative data management and analysis. Recordings and corrected transcripts were

retained on internal devices belonging to the partnering organization, which provided established confidentiality protections. Following completion of the doctoral study and submission of the doctoral manuscript, the interview recordings were electronically deleted. The corrected transcripts were retained for the purpose of preparing the journal manuscript and will be electronically discarded following its submission in accordance with the partnering organization's document-disposal guidelines and procedures intended to protect participant confidentiality.

In addition to the interviews, de-identified organizational artifacts were obtained through internal organizational honest brokers. These materials included an Excel data set containing third-quarter 2025 (Q3 2025) patient and family experience outcomes for eight organizational regions. Q3 2025 represented the most recent fully completed quarter of data available at the time of the study. The data set was intentionally compiled to present each region's experience outcomes alongside the Predictive Index profile type associated with the leadership of that region. The internal regional codes used by the organization were not disclosed to the researcher, and the data were provided without identifying information about individual leaders or regions. The honest brokers prepared and de-identified the information before providing it to the researcher.

The regional outcomes and corresponding Predictive Index profile types were intentionally presented together to provide contextual information for examining the qualitative interview findings and to support triangulation across data sources. The profile information offered an additional perspective on behavioral characteristics and tendencies commonly associated with each profile type, which could be considered alongside the leadership characteristics and behaviors described by interview participants. The purpose of this data arrangement was not to establish statistical relationships between leadership profiles and patient experience outcomes, compare individual leaders, or attribute regional performance to specific leadership characteristics. Rather, these organizational artifacts provided an additional contextual lens through which the researcher could consider patterns and points of convergence or difference across the available evidence. The PI Reference Profiles Guide was used to interpret the behavioral characteristics associated with the profile types (Predictive Index, 2022).

The experience outcomes included in the regional data set reflected information collected through the organization's internal patient experience processes. Family experience was captured through the Family Assessment of Treatment, previously referred to as the Family Experience Survey. This assessment was completed by a family member or related contact of the client and provided information about the family's experience during treatment. Additional family experience information

was collected at intervals throughout the treatment process and maintained in the organization's internal collaborative platform, RRDD. These measures were relevant to the study's residential behavioral healthcare context, where family involvement and communication are important components of the treatment experience for adolescents and young adults.

The organization uses an internal positive patient experience benchmark of 80% to evaluate performance. Regional outcomes below 80% were considered below target, whereas outcomes at or above 80% were considered at target or above target. Although this benchmark provided an organizational reference point for interpreting the aggregated outcomes, the specific criteria used to select the regional leaders who participated in the interviews were not disclosed to the researcher. Accordingly, the researcher did not assume that the regional outcome data established the rationale for individual participant selection or that a particular leadership profile explained a region's performance.

Together, the four leadership interviews and the de-identified organizational artifacts provided multiple sources of evidence for examining leadership within the organizational context. Interview data served as the primary source for identifying leadership characteristics and behaviors, while the regional experience outcomes and associated Predictive Index profile information provided contextual and triangulating evidence. These additional sources informed interpretation of the qualitative findings but were not treated as independent measures for statistical testing, quantitative inference, or causal analysis.

Data Analysis

Interview data were analyzed using reflexive thematic analysis following the six-phase approach described by Braun and Clarke (2006, 2021). The researcher reviewed the recording and corrected transcripts repeatedly to become familiar with the data. Transcripts were managed in NVivo, and reflexive memos were maintained throughout the analytic process to document initial impressions, assumptions, and developing interpretations.

Initial coding was conducted inductively, with codes assigned to meaningful segments of participant responses. Coding focused on leadership characteristics, observable behaviors, communication practices, decision-making, workforce engagement, patient experience strategy, and organizational constraints or enabling conditions. Codes were reviewed and refined through repeated engagement with the transcripts and comparison across the four interviews.

Related codes were then examined for patterns and grouped into preliminary themes. Themes were reviewed for internal coherence, distinction from one another, and consistency with the interview data. Six

themes were developed: servant leadership, communication, leader visibility, accountability, adaptability, and responsiveness. These themes were subsequently synthesized into two broader conceptual dimensions: relational leadership and operational leadership. Relational leadership encompassed servant leadership, communication, and leader visibility. Operational leadership encompassed accountability, adaptability, and responsiveness.

The themes were developed inductively from the interview data rather than imposed from an existing leadership model. Aggregated experience information, Predictive Index profile information, and organizational artifacts were reviewed as contextual and triangulation sources. These materials supported interpretation of the organizational setting but were not treated as independent evidence of causal relationships between leadership characteristics and patient experience outcomes. The resulting Integrated Leadership for Patient Experience framework represents a conceptual synthesis of the findings rather than a validated measurement model.

Table 2

Illustrative Coding Structure: Codes, Themes, and Dimensions

Illustrative code groupings	Emergent theme	Dimension
Empathy, support, coaching, employee development, trust	Servant leadership	Relational
Clear expectations, listening, information sharing, transparency	Communication	Relational
Presence, accessibility, engagement, connection with teams	Leader visibility	Relational
Follow-through, ownership, expectations, consistency	Accountability	Operational
Flexibility, problem-solving, adjusting to changing needs	Adaptability	Operational
Addressing concerns, acting on feedback, timely action	Responsiveness	Operational

Note. Code groupings are a representative example, not an exhaustive list of every initial code.

Trustworthiness

Trustworthiness was supported using a consistent semi-structured interview protocol, repeated review of interview recordings and transcripts, reflexive memoing, and comparison of themes across participant interviews. The researcher maintained an iterative analytic process in which initial codes and developing themes were revisited against the interview data. NVivo supported organization and management of the transcripts and analytic materials. The researcher reviewed the interview recording alongside corrected transcripts during the analysis process. Following completion of the doctoral study submission, the recordings were electronically deleted. Corrected transcripts were retained for preparation of the journal manuscript.

Contextual organizational artifacts, including aggregated experience information, provided additional context for interpreting the interview findings. These materials were used to examine areas of contextual convergence or difference rather than to establish statistical relationships. Reflexive memoing supported transparency regarding the researcher's developing interpretations and the potential influence of assumptions throughout the analytic process. Given the single-analyst design, findings represent the researcher's interpretation of the four interviews within the bounded organizational case.

Ethical Considerations

Prior to data collection, institutional approval was obtained from the Walden University Institutional Review Board (IRB), and research approval was granted by the partnering organization's internal research review committee. Participation was voluntary, and informed consent was obtained from all participants before interviews were conducted. Participants received written information describing the purpose of the study, interview procedures, anticipated use of the data, confidentiality protections, and their right to withdraw at any time without consequences. To protect participants and organizational confidentiality, all identifying information was removed from the data and organizational details were reported in a manner that preserved anonymity.

Interview recordings and corrected transcripts were retained on internal devices, including a computer owned by the partnering organization and subject to its confidentiality protections. Participant names and titles were removed during the analysis process and were not included in the manuscript or other written reporting. Following completion of the doctoral study's final submission the recordings were discarded, and the corrected transcripts were retained. Following the submission of this manuscript, corrected transcripts will be electronically discarded in a manner consistent with the partnering organization's document-disposal guidelines and confidentiality protections. Participant descriptions and organizational details were intentionally generalized to reduce the possibility of identifying individuals through their roles, responsibilities, or regional associations.

FINDINGS

The purpose of this qualitative case study was to explore leadership characteristics associated with positive patient experience within the residential service lines of a multi-site behavioral healthcare organization. Four organizational leaders participated in individual semi-structured interviews. Interview data were analyzed using reflexive thematic analysis and contextualized through aggregated experience information, Predictive Index leadership profile information, and organizational artifacts.

Six interrelated leadership characteristics emerged from the analysis: servant leadership, communication, leader visibility, accountability, adaptability, and responsiveness. The themes are presented as complementary findings rather than as a ranked hierarchy. Participants described these characteristics as interconnected aspects of leadership practice. For interpretive purposes, the six themes were synthesized into two broader dimensions: relational leadership, encompassing servant leadership, communication, and leader visibility; and operational leadership, encompassing accountability, adaptability, and responsiveness.

The findings reflect participants' descriptions and perceptions of leadership practices and their relationship to workforce conditions and patient experience. They should not be interpreted as direct assessments of patient perceptions or as evidence that particular leadership behaviors independently caused changes in patient experience outcomes. Participant quotations in the subsequent sections are presented with minimal editorial adjustments for readability. Filler words, simple verbal repetitions, and minor transcription artifacts were removed where they did not contribute to meaning. Quotations were not substantively rephrased or altered to change participants' intended messages.

Servant Leadership

Servant leadership emerged as a prominent leadership characteristic associated with positive patient experience outcomes. Participants consistently described leaders who "rely on servant leadership postures," who worked alongside their teams, remained accessible, invited feedback, supported employees, and demonstrated through their own behavior that no aspect of the work was beneath them. One participant described this approach as "leading alongside, as opposed to hierarchical leadership," emphasizing that strong leaders lead by example while remaining willing to step into the work when needed.

Taken together, the findings suggest that servant leadership represented more than an interpersonal preference among participants. It was described as a behavioral mechanism through which leaders create connection, trust, workforce engagement, and shared responsibility for patient care. This finding contributed to the broader distinction identified across the six themes between relational leadership, which emphasizes how leaders connect with and engage people, and operational leadership, which emphasizes how leaders create consistency, accountability, responsiveness, and execution within the organization.

Communication

Communication emerged as a central characteristic of effective leadership. Participants emphasized open communication, active listening, accessibility, and receptiveness to feedback. Leaders who were approachable and willing to consider ideas, suggestions, and constructive criticism were perceived as more effective in maintaining trust and engagement.

One participant explained:

> I think promoting a sense of belonging by inviting feedback and presenting as open to ideas and suggestions and being open to constructive criticism are always necessary. But probably openness. I would say openness is probably the most important thing.

Participants also connected communication with consistency and psychological safety. Leaders described the importance of maintaining clear messaging during difficult transitions, listening to concerns, and communicating expectations in a way that supported staff confidence and alignment.

Leader Visibility

Leader visibility emerged as closely related to servant leadership and communication. Participants described effective leaders as accessible and present within the environments where care was delivered. Visibility was not limited to physical presence; it also reflected leaders' willingness to remain connected to frontline experiences, understand operational realities, and engage directly with staff.

The overlap between servant leadership and visibility was evident in participant descriptions of leaders who "lead alongside" their teams. For analytic purposes, servant leadership reflected the orientation towards serving and supporting others, whereas visibility reflected the observed practice of remaining present and connected to the work.

Accountability

Accountability emerged as a leadership characteristic through participants' descriptions of follow-through, professionalism, consistency, and maintaining expectations. Participants emphasized that patient-centered leadership included the responsibility to ensure that commitments were carried through and that established standards were maintained.

One participant stated:

> We want the patients to understand that we care about them, that we're committed to their healing, that we're willing to work just as hard as they are, and that we prioritize their experience and their safety above all else. And then I think the other things that go hand in hand with that are accountability and professionalism. We're really big on making sure that is there's a session or a group or something scheduled that it's followed through with. If we say something to a patient about something that we're trying to do for them, we want to see follow-through. If we're not able to meet a certain need or something goes sideways, that there's communication about it and ownership.

These responses positioned accountability as more than employee performance management. Participants described accountability as the operational expression of organizational values, particularly when leaders were required to maintain safety, follow through on commitments, and communicate when expectations could not be met.

Adaptability

Adaptability emerged as an essential leadership characteristic within the dynamic environment of behavioral healthcare. Participants described effective leaders as remaining flexible, responsive to changing circumstances, and modifying approaches based on patient, workforce, and organizational needs.

Participants emphasized that adaptability supported decision-making during periods of organizational change while allowing leaders to balance competing priorities without compromising patient-centered care. Leaders who demonstrated flexibility while maintaining organizational direction were perceived as strengthening employee confidence and resilience.

One participant observed:

> One strategy does not fit every situation. Early on, I wanted to control the strategy because I thought I knew what needed to happen, but it wasn't moving the needle. We had to step back, look at the broader picture, and involve multiple departments in developing solutions. Sharing ownership ultimately produced stronger outcomes than a single leader directing the work.

Adaptability therefore differed from responsiveness in emphasis. Adaptability reflected a leader's willingness and ability to modify an approach as circumstances change, whereas responsiveness reflected the timeliness with which leaders acknowledged and acted on concerns and feedback.

Responsiveness

Responsiveness emerged as the final leadership characteristic associated with positive patient experience outcomes. Participants consistently described effective leaders as individuals who acted promptly on patient, family, and employee feedback while demonstrating commitment to continuous improvement.

Participants emphasized that responsiveness involved acknowledging concerns, implementing meaningful changes, and communicating outcomes to those affected. Leaders who responded quickly to feedback were viewed as reinforcing trust, demonstrating accountability, and strengthening confidence in organizational leadership.

One participant explained:

> The most important thing isn't the monthly data, it's how we respond in the moment. Every day, families call with concerns, and those conversations are opportunities for service recovery. The best time to resolve an issue is while the patient and family are still with us, not after discharge when survey results become available. That's why I'm excited about technology that allows us to respond in real time instead of waiting until the end of the month.

In this study, service recovery refers to the organizational response to a patient or family concern, including acknowledging the concern, taking appropriate action, and communicating follow-up. Participants' references to real-time feedback technology reflected perceived opportunities for more timely responses; the study did not evaluate a specific technology or service recovery system.

Responsiveness was closely associated with organizational learning and continuous improvement. Participants described leaders who used patient experience feedback not only to resolve individual concerns but also to identify broader opportunities to improve organizational systems, workforce performance, and care delivery.

Summary of the Findings

The six leadership characteristics identified through this study were consistently described as complementary rather than independent. Participants suggested that positive patient experience was influenced by leaders who balanced relational competencies, including servant leadership, communication, and visibility, with operational competencies such as accountability, adaptability, and responsiveness. Together, these themes suggest that leadership influences patient experience indirectly by shaping workforce engagement, organizational culture, and the systems through which care is delivered. The synthesis of these findings provided the foundation for the proposed Integrated Leadership for Patient Experience framework discussed below.

Although participants generally described relational and operational leadership characteristics as complementary, the interviews also reflected tensions in applying these competencies consistently. Participants described organizational demands, competing priorities, and operational constraints that could challenge leaders' ability to maintain relational presence while ensuring consistent execution. These tensions suggest that the integration of relational and operational competencies may be difficult to sustain under all organizational conditions. The findings therefore do not indicate that every leader consistently demonstrated both dimensions or that either dimension alone was sufficient in every circumstance. Rather, participants' descriptions highlighted the importance of attending to both relationship-centered leadership practices and the operational conditions required to support care delivery.

DISCUSSION

The purpose of this qualitative case study was to examine leadership characteristics and behaviors that organizational leaders associated with positive patient experience within residential behavioral healthcare. Six themes emerged from the analysis: servant leadership, communication, leader visibility, accountability, adaptability, and responsiveness. These themes converged into two complementary dimensions, relational

leadership and operational leadership. Taken together, the findings suggest that participants viewed effective patient experience leadership as requiring attention to both the quality of relationships within the organization and the operational practices that support consistent care delivery.

The findings extend existing discussions of leadership and patient experience by examining how these characteristics were described together within a bounded residential behavioral healthcare context. Prior research has identified leadership competencies and organizational practices relevant to patient experience (Barden et al., 2024; Kelly & Hearld, 2020; Paganin et al., 2023). The present study contributes a practice-oriented synthesis of six leadership characteristics into two dimensions that participants described as interconnected. This synthesis does not establish a new leadership style or demonstrate a causal relationship; rather, it offers a contextual interpretation of how established leadership competencies may operate together in behavioral healthcare.

Interpretations of Findings

The findings of this study suggest that positive patient experience in behavioral healthcare is not attributed to a single leadership style or isolated leadership behavior. Rather, the findings revealed an integrated pattern of leadership characterized by two complementary dimensions: relational leadership and operational leadership. Relational leadership encompassed servant leadership, communication, and leader visibility, whereas operational leadership encompassed accountability, adaptability, and responsiveness. Although these characteristics emerged as distinct themes during analysis, their convergence across participant perspectives suggests that effective leadership for patient experience requires both dimensions to function together.

The relational dimension reflects how leaders establish the human conditions necessary for positive experiences. Servant leadership, communication, and visibility enable leaders to build trust, understand the experiences of patients and employees, remain connected to frontline operations, and create an environment in which individuals feel heard and supported. The operational dimension reflects how leaders translate those relationships into consistent action through accountability, adaptability, and responsiveness. These characteristics enable leaders to establish expectations, respond to changing needs, address concerns, and sustain practices that support quality care.

The significance of the findings lies not in identifying either dimension as independently sufficient, but in the interaction between them. Relational leadership without operational follow-through may create strong relationships without consistent execution. Conversely, operational leadership without relational connection may produce

efficiency and accountability without the trust and engagement necessary for human-centered care. The findings suggest that participants perceived the integration of both dimensions as important to supporting the organizational conditions associated with positive patient experience.

These findings support prior research connecting leadership behaviors with workforce engagement, teamwork, organizational climate, and patient experience (Barden et al., 2024; Howell et al., 2024; Kelly & Hearld, 2020; Paganin et al., 2023). They extend this literature by suggesting that, within the behavioral healthcare context examined in this study, positive patient experience may be supported by the integration of relational leadership behaviors with operational leadership practices rather than by either domain in isolation.

Relational and Operational Leadership

The distinction between relational and operational leadership provides a useful lens for interpreting the leadership behaviors identified in this study. Participants described relational characteristics as foundational to the culture in which patient care occurs. Leaders who demonstrated servant leadership, maintained visibility, and communicated openly were perceived as more connected to both employees and patients. These behaviors appeared to strengthen trust and workforce engagement, creating conditions in which employees could more effectively contribute to positive patient experiences. This finding is consistent with research identifying communication, empathy, presence, relationship building, and teamwork as relevant components of leadership and patient experience (Barden et al., 2024; Latvis et al., 2024).

At the same time, participants emphasized that positive intentions and relationships alone were insufficient. Accountability, adaptability, and responsiveness were repeatedly associated with the leader's ability to translate organizational values into action. Leaders were expected to follow through on commitments, address concerns, respond to changing circumstances, and maintain standards even during periods of organizational disruption. This finding suggests that patient experience leadership requires both the capacity to build relationships and the capacity to operationalize those relationships through consistent leadership action. This operational emphasis is consistent with the Baldrige framework's focus on leadership, workforce engagement, operational effectiveness, and results (Baldrige Performance Excellence Program, 2021).

The complementary nature of these dimensions is particularly relevant within behavioral healthcare, where the patient experience is shaped by complex interactions among interdisciplinary teams, staff engagement, organizational systems, safety, and individual patient needs. Leadership therefore operates beyond a direct leader-to-patient

relationship. Leaders influence the workforce and organizational environment in which care is delivered, and those conditions subsequently shape how patients and families experience treatment.

Servant Leadership in Context

The findings are consistent with established descriptions of servant leadership, which emphasize serving others, developing people, listening, and supporting the growth and well-being of followers (Northouse, 2022). Within the broader healthcare leadership literature, transformational leadership has also been examined in relation to healthcare outcomes. Transformational leadership emphasizes vision, inspiration, intellectual stimulation, individualized consideration, and the development of followers (Northouse, 2022), creating meaningful overlap with the participants' descriptions of leaders who develop and support their teams. However, the findings in this study suggest a distinction in emphasis: participants did not primarily describe leadership in terms of articulating an inspirational vision or transforming organizational performance. Instead, they repeatedly emphasized the leader's willingness to work alongside employees, remain present, listen, support, and demonstrate through action that the workforce and the patient experience are shared responsibilities.

The National Society of Leadership and Success (NSLS, n.d.) similarly distinguishes among leadership approaches by describing different ways leaders influence, support, and develop others. Its discussion on servant leadership emphasizes the leader's orientation towards serving others and supporting their growth. In the present study, these characteristics were reflected in participants' descriptions of leaders who prioritized workforce support and engagement as part of creating the conditions necessary for positive patient experience.

This distinction is important because the findings do not suggest that servant and transformational leadership are competing or mutually exclusive approaches. Rather, the participant accounts suggest meaningful conceptual overlap while highlighting a different behavioral emphasis. Servant leadership, as described by participants, was particularly evident through proximity to the work, responsiveness to employees, willingness to help, and attention to individual and team needs. These behaviors were subsequently connected to patient experience through participants' repeated descriptions of the workforce as a primary pathway through which organizational culture and leadership are experienced by patients and families.

This relationship was particularly evident in participants' descriptions of employee experience. One participant stated, "Our staff drive patient experience and if our staff are feeling comfortable and competent in their role, if they're engaged, if they're satisfied, that will naturally lead to

increased patient experience." Another participant similarly described the importance of ensuring that employees feel supported rather than "just another number" within the organization.

The connection between leadership, teamwork, and organizational outcomes is also reflected in existing research. Paganin et al. (2023) found that leadership behaviors were associated with teamwork and team mental health, supporting the broader proposition that leadership influences organizational functioning through its effects on teams. Howell et al. (2024) likewise identified teamwork as an important pathway connecting workforce experience with patient experience. In the present study, participants described this relationship in practical terms: leaders influence the conditions experienced by employees, those conditions shape how teams function and engage in their work, and the resulting behaviors are experienced by patients and families.

Leadership as a Pathway to Patient Experience

The findings further suggest that leadership influences patient experience primarily through its effect on the workforce, organizational culture, and care delivery processes. Participants repeatedly connected employee engagement and satisfaction with the quality of patient experience, describing staff as central to the delivery of compassionate, responsive, and consistent care.

This finding provides an important distinction between leadership and patient experience outcomes. Leaders do not necessarily create patient experience through direct interaction with every patient. Instead, leadership behaviors shape the conditions in which patient experience is produced. Leaders who establish trust, communicate clearly, remain visible, hold teams accountable, adapt to changing needs, and respond to feedback influence how employees experience their work. Those employee experiences can subsequently influence engagement, team culture, and the consistency of care delivered to patients and families.

This distinction is supported by research identifying teamwork and workforce conditions as important links between leadership and patient experience. Howell et al. (2024), for example, found that teamwork was associated with patient experience, while Paganin et al. (2023) identified relationships between health-promoting leadership, teamwork, and team mental health. The findings therefore position workforce experience as an important pathway connecting leadership to patient experience.

The data suggest that organizations seeking to improve patient experience may benefit from considering leadership development and workforce experience as interconnected components of patient experience strategy rather than separate organizational priorities.

Leadership Development Implications

The findings have implications for leadership development in behavioral healthcare. Participants' descriptions suggest that leadership development may benefit from addressing relational and operational competencies together rather than treating them as separate areas of development. Leaders who demonstrate empathy, communication, and visibility may also require support in accountability, execution, adaptability, and responsiveness. Similarly, leaders with strong operational capabilities may benefit from development focused on trust-building, listening, communication, and relational engagement.

The proposed Integrated Leadership for Patient Experience framework offers a preliminary structure for considering these developmental needs. A leadership development approach informed by the findings could include competency assessment, individualized development goals, applied learning, observation and feedback, and ongoing evaluation of leadership practices. Experiential activities such as leadership shadowing, structured feedback, coaching, and application of learning to real organizational situations may provide opportunities for leaders to practice the integration of relational and operational competencies. These strategies are proposed implications of the findings rather than interventions evaluated in the present study.

Organizations may also consider incorporating patient and family experience information, workforce feedback, and operational performance indicators into leadership development discussions. Such information may help leaders examine how their behaviors are experienced by teams and how leadership practices align with organizational expectations. Future research is needed to determine whether development approaches informed by the proposed framework produce measurable changes in leadership behavior, workforce conditions, or patient experience outcomes.

Integrated Leadership for Patient Experience

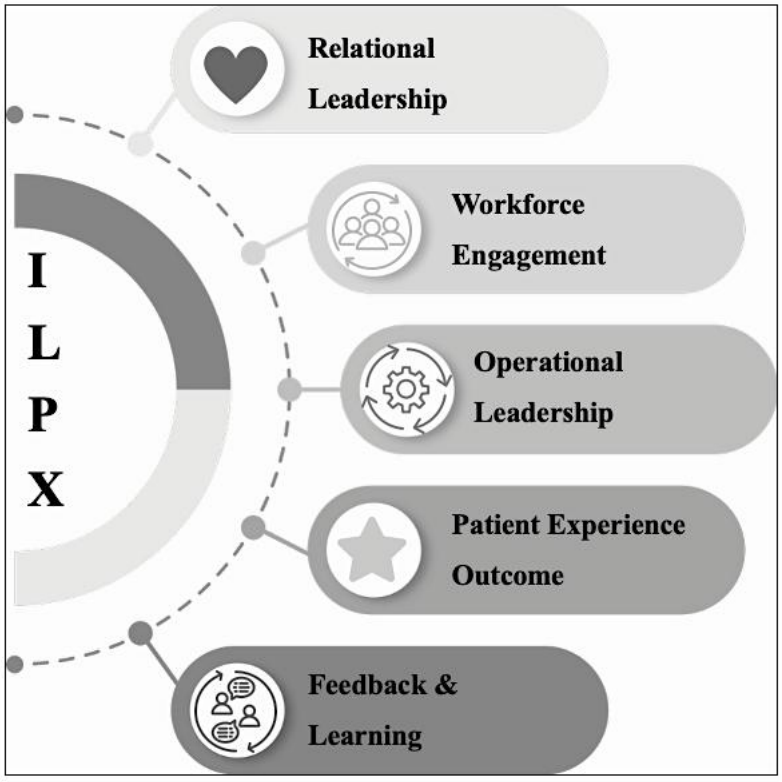
The Integrated Leadership for Patient Experience (ILPX) framework represents a preliminary, practice-oriented conceptualization developed from the findings of this qualitative case study. The framework synthesizes the six emergent leadership characteristics into two complementary dimensions: relational leadership and operational leadership. Relational leadership encompassed servant leadership, communication, and leader visibility, while operational leadership encompassed accountability, adaptability, and responsiveness.

The central premise of ILPX is integration. Relational competencies support connection, trust, communication, and engagement, while operational competencies support accountability, consistency, execution, and responsiveness. Refer to Figure 1. The framework proposes that leadership development for patient experience should address both

dimensions and consider how they function together within the organizational environment. Its contribution is not the introduction of a new leadership style, but the integration of established leadership competencies into a patient-experience-focused framework for behavioral healthcare.

Figure 1

Proposed Integrated Leadership for Patient Experience (ILPX) Pillars.



Note. The ILPX framework is a preliminary, practice-oriented conceptualization developed from the findings of this qualitative case study. It has not yet been empirically validated.

The proposed development process includes assessment of leadership strengths and opportunities, individualized learning goals, applied practice, observation and feedback, and ongoing evaluation. Refer to Figure 2. This process is intended to support continued development rather than a one-time training intervention. The framework has not yet been implemented or empirically validated. Its current value is as a

preliminary structure that organizations and researchers may examine, refine, and evaluate through future application.

Figure 2

Proposed Integrated Leadership for Patient Experience (ILPX) Developmental Cycle.



Note. The ILPX framework is a preliminary, practice-oriented conceptualization developed from the findings of this qualitative case study. It has not yet been empirically validated.

Implications for Leadership Practice

At the individual leadership level, the findings suggest that patient experience leadership may require development across both relational and operational competencies. Leadership development may be strengthened through opportunities for leaders to assess their current practices, receive feedback, and apply learning within the context of daily operations. The findings also suggest that development needs may differ across individuals; some leaders may benefit from greater emphasis on relational engagement, while others may require additional support in accountability, adaptability, or responsiveness.

Implications for Organizations

At the organizational level, the findings suggest that patient experience should be considered within broader leadership expectations and organizational systems rather than as the responsibility of a single department or function. Organizations may consider integrating relational and operational competencies into leadership development, performance discussions, succession planning, and patient experience strategy. The use of patient and family feedback alongside workforce and operational information may also support more comprehensive organizational learning.

Implications for Behavioral Healthcare Systems

At the system level, the findings highlight the importance of considering the conditions through which behavioral healthcare is delivered. Leadership practices operate within complex environments shaped by workforce capacity, clinical priorities, operational demands, and patient and family needs. A patient experience strategy informed by the findings may therefore benefit from attention to both the interpersonal quality of care and the organizational processes that support consistency, communication, and responsiveness.

Limitations

Several limitations should be considered when interpreting the findings. First, the study was conducted within a single multi-site, multi-regional behavioral healthcare organization and was bounded to residential service lines. Although the organization provided a diverse operational context, findings reflect the experiences and practices of one organizational system and are not intended to be directly generalized to other behavioral healthcare organizations or healthcare settings. Transferability depends on the degree to which other settings share relevant organizational, clinical, workforce, and patient experience characteristics.

Second, the purposeful sample consisted of organizational leaders with direct knowledge of leadership practices and patient experience initiatives. The perspectives of patients, families, and frontline employees were not directly collected through interviews. Although aggregated patient experience data and organizational artifacts were used to triangulate participant perspectives, the findings primarily reflect the experience and interpretations of leaders. This limits the extent to which the findings can speak directly to how patients, families, or frontline employees themselves perceive leadership behaviors.

Third, the qualitative case study design was intended to provide contextual understanding rather than establish causal relationships. The findings identify leadership characteristics and organizational practices that participants associated with positive patient experience outcomes but do not establish that specific leadership behaviors independently caused those outcomes.

Finally, patient experience is influenced by multiple factors beyond leadership, including clinical outcomes, patient characteristics, treatment setting, workforce conditions, organizational processes, and external circumstances. The findings should therefore be interpreted within the broader complexity of behavioral healthcare rather than as evidence that leadership characteristics alone determine patient experience outcomes.

Recommendations for Future Research

Future research may build on these findings through several approaches. First, a multi-site comparative case study could examine leadership characteristics across behavioral healthcare organizations with differing patient experience performance. Such a design could explore whether the six leadership characteristics and the two proposed dimensions are reflected across organizations, service lines, and performance contexts.

Second, future studies should incorporate the perspectives of patients, family members, and frontline employees. Interviews or focus groups with these groups could provide a more direct understanding of how leadership behaviors are experienced throughout treatment and how those experiences relate to perceptions of care. Including multiple stakeholder perspectives would also allow researchers to examine whether leaders' perceptions align with the experiences of those receiving and delivering care.

Third, a Delphi study could be used to obtain expert consensus regarding the leadership competencies most relevant to patient experience in behavioral healthcare. This approach may help refine the proposed ILPX dimensions and identify competencies appropriate for inclusion in a leadership development model.

Finally, future research could focus on developing and evaluating an ILPX assessment instrument. Initial instrument development could include expert review, pilot testing, and examination of reliability and validity. Subsequent intervention studies could evaluate whether leadership development informed by ILPX is associated with changes in leadership behaviors, workforce engagement, organizational practices, and patient and family experience outcomes. These approaches would provide opportunities to determine whether the preliminary framework has practical utility and measurable value across behavioral healthcare settings.

CONCLUSION

This qualitative case study explored leadership characteristics and behaviors that organizational leaders associated with positive patient experience within residential behavioral healthcare. Six interrelated characteristics emerged from the analysis: servant leadership, communication, leader visibility, accountability, adaptability, and responsiveness. These characteristics were synthesized into two complementary dimensions: relational leadership and operational leadership.

The findings suggest that participants perceived both dimensions as important to the organizational conditions that support patient experience. Relational leadership emphasizes trust, communication, presence, and connection, while operational leadership emphasizes

accountability, adaptability, responsiveness, and consistent execution. Together, these dimensions provide a foundation for considering leadership development as an integrated rather than isolated set of competencies.

The proposed Integrated Leadership for Patient Experience framework offers a preliminary, practice-oriented conceptualization developed from the findings of this qualitative case study. Although additional research is necessary to evaluate and validate the framework, the findings provide a basis for further examining how leadership development, workforce experience, and operational practice may be considered together in efforts to support positive patient experience in behavioral healthcare.

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