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Leadership Strategies to Influence Employee Engagement in Health Care

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Abstract

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MS, California Coast University, 1999

BA, Hiram College, 1994

Doctoral Study Submitted in Partial Fulfillment

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Abstract

Hospitals are in a precarious financial position with declining reimbursement, eroding profit margins, and low patient satisfaction. The Patient Protection and Affordable Care Act of 2010 reform may decrease hospital reimbursement by $500 billion from 2010 to 2020, while low patient satisfaction may decrease profitability for hospitals by 27%. Employee disengagement may decrease patient satisfaction and consumer loyalty. The purpose of this phenomenological study was to explore the lived experiences of health care leaders as they worked to engage employees and provide better patient care. Improving patient care provides opportunities to capture new market shares, which increases sustainability of health care organizations. Expectancy theory shaped the conceptual framework of this study. Inquiry consisted of personal interviews with 23 mid-level hospital managers. Data analysis occurred with a modified Van Kamm data analysis process, which entailed descriptive coding and sequential review of the interview transcripts. Member checks and data saturation ensured trustworthiness of the findings. The findings from these personal interviews led to discovery of 4 themes of leader-employee engagement to include psychological commitment, expectation realization, trust actualization, and reduction in the leadership power distance. By applying employee engagement strategies aligned with these themes, leaders may influence patient care. This study contributes to social change by increasing health care quality for patients leading to a positive influence on medical care and societal health.

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Dedication

This doctoral study is dedicated to my wife Jenny, sharing 25 years of happiness, sadness, forgiveness, humility, empathy, love, laughter, and salvation.

Acknowledgments

I would like to acknowledge my family, past and present coworkers, fellow students, and faculty members for the support and encouragement in meeting my personal and professional goals.

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Section 1: Foundation of the Study

Health care reforms have led to financial uncertainty in health care organizations (Aslin, 2011). Leaders, physicians, and patients await changes in health care reimbursement practices that may lead to an economic shift from a focus on health care volume to value in health care (Bennett, 2012). With these new reimbursement guidelines, health care consumers have the ability to choose health care services based on price and quality metrics (Cassalty, 2011). This creates a competitive environment for health care organizations while decreasing the overall cost of health care (Aslin, 2011). Employee engagement and patient satisfaction now influence consumer loyalty (Albdour & Altarawneh, 2014). Patient dissatisfaction places the sustainability of health care organizations at risk (Bonias, Leggat, & Bartram, 2012).

Background of the Problem

Historically, health care delivery systems in the United States have lacked oversight in cost management and customer service (Aslin, 2011). In 2011, health care costs represented 12% of the gross national product (GNP) with no sign of cost reduction (Roehrig, 2011). Improving financial performance for health care organizations depends on cost containment, increased market share penetration, and improving the patient experience (Roehrig, 2011). The Patient Protection and Affordable Care Act, otherwise known as ACA by the federal government, creates an opportunity for health care reform and improvement in consumer health care experiences (Devore & Champion, 2011). The federal government created health care coverage for all citizens, which provided incentives for health care organizations to lower costs and improve the quality of care.

Health care organizations that do not become customer-focused may be at risk of market share loss because health care consumers have choices and have become cost sensitive (Devore & Champion, 2011). Market share loss may also occur due to demand changes in health care delivery and decreases in the total cost of care (Lowe, 2012). Legacy operational processes and price insensitively creates an environment for market loss and health care consolidation (Devore & Champion, 2011).

Health care organizations face economic pressure to decrease cost while improving quality of care. The Baby Boomer segmentation, which represents the segment of the population born from 1946 to 1964, will increase the retirement population through 2029 (Chiesl, 2012). This will lead to a flood of educated consumers using health care. Health care leaders must provide high-quality services at the lowest possible cost or risk market erosion. Improved customer satisfaction and loyalty drives sustainability.

Meeting employee expectations positively affects employee motivation, which increases employee engagement and job effort (Lunenburg, 2011). These expectations trigger either personal satisfaction or dissatisfaction, and influence the emotional connection between employee satisfaction and organizational goals. Employee engagement is the connection between the emotional well-being of the employee and organizational commitment (Nasomboon, 2014). Employees who are positively engaged in their jobs are more likely to excel in their work; these satisfied employees perform and work well with patients, which can improve consumer satisfaction and loyalty (Dikkers, Jansen, De Lange, Vinkenburg, & Kooji, 2010). Emotional connectivity and employee

engagement increase productivity, which improves profit margin and consumer satisfaction (Dikkers et al., 2010).

The role of employee engagement in health care is critical in maintaining quality care. Employees must engage patients at an emotional level to increase satisfaction and create an optimized patient experience (Wessel, 2012). Patients may face uncertainty, a lack of medical knowledge, financial insecurity, and life and death decisions when using health care services. These patient experiences may make it more difficult for health care workers to create a positive experience for the patients. With the onset of new health care delivery options, it is important for health care organizations to engage their employees and provide a positive work environment that can lead to increased patient satisfaction.

Problem Statement

Hospitals are in a precarious position with declining reimbursement, eroding profit margins, and low patient satisfaction (Alrubaiee & Alkaaida, 2011). ACA reform may decrease hospital reimbursement by $500 billion from 2010 to 2020 (Petasnick, 2011), while low patient satisfaction may decrease profitability for hospitals by 27% (Alrubaiee & Alkaaida, 2011). As of 2013, Medicare paid out $850 million in incentive payments on an annual basis to hospitals that improve quality and patient satisfaction (Petrullo, Lamar, Nwankwo-Otti, Alexander-Mills, & Viola, 2013). Employee engagement, the display of commitment between employees and their work environment, can influence patient satisfaction (Hewison, Gale, Yeats, & Shapiro, 2013). The general business problem is that health care organizations face decreasing Medicare reimbursement funding due to low patient satisfaction. The specific business problem is

that some health care leaders lack strategies to engage their employees in order to provide better patient care.

Purpose Statement

The purpose of this qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care. The population for this study consisted of 23 health care leaders in Midwestern U.S. hospitals. This population was appropriate to this study because health care leaders influence health care employees.

This study may lead to positive social change by influencing the quality of health care services. Improving employee engagement may increase the likelihood of improving patient satisfaction, which directly influences financial stability of health care organizations while improving a manager's ability to lead (Alrubaiee & Alkaaida, 2011). Contributions to the business environment may involve improved sustainability of health care organizations.

Nature of the Study

This study was a qualitative, phenomenological exploration. A qualitative research method is a research strategy for exploring cognitive views, social interaction, and interpersonal perspectives (Moustakas, 1994). Uncovering personal experiences through the interview process provides researchers with a unique perspective on the participants' lived experiences (Moustakas, 1994). Qualitative research provides an opportunity to capture a wide diversity of population characteristics (Anyan, 2013). Through questionnaires, interviews, and focus groups, qualitative researchers provide

data reflecting personal perspectives, experiences, and cultural backgrounds. A qualitative research design offered the best method to grasp the social impact of meeting employee expectations on an organizational level.

For this study, the phenomenological design provided an opportunity to review and understand employee experience as it pertains to meeting employee expectations in a health care environment. The importance of gathering the personal experiences of the participants eliminated other designs. I did not consider grounded theory since my study would not generate or discover a theory. Case study design includes the entire group dynamic, but this may leave out the perspective of the individual (Yin, 2009). Ethnographic researchers focus on behaviors and language of culture, which were beyond the scope of my study (Sangasubana, 2011).

Quantitative researchers provide insight into correlations between variables (Frels & Onwuegbuzie, 2011). In my study, I focused on strategies necessary for health care leaders to improve employee engagement. Employee perspectives and experiences created a foundation for research analysis. However, quantitative researchers cannot provide a personal base of information, thus eliminating the use of a quantitative research approach.

Mixed method research includes a combination of aspects of quantitative and qualitative research in an attempt to answer how and what affects a topic (Heyvaert, Maes, & Onghena, 2011). Mixed method research is an extension of quantitative research and focuses on a complex matrix of variables and experiences (Heyvaert et al., 2011).

The complexity of using both quantitative and qualitative methods was beyond the scope of my research intent, thus eliminating the use of the mixed method research process.

Research Question

The major research question in this study was: What strategies should health care leaders implement to engage employees and enhance patient care? Through a phenomenological study design, I analyzed the personal experiences of leaders to describe strategies that influenced employee engagement. Personal demographic, targeted research questions, and follow-up questions provided an opportunity for data collection and analysis.

Interview Questions

In the following questions, *PQ* preceding the number indicates the question relates to personal demographic information:

PQ1. What is your name?

PQ2. What is your job title?

PQ3. What is your age?

PQ4. How long have you been in the health care field?

PQ5. What is your educational background?

PQ6. How many jobs in health care have you had in your career?

PQ7. What do you do in your job?

PQ8. What does health care reform mean to you?

In the following questions, *C* preceding the number indicates the question refers to conceptual information, and *F* designates follow-up questions related to the research inquiry:

C1. How do you define employee engagement?

C2. How does employee engagement affect the day-to-day operations of your department?

C3. What expectations do you have as an employee?

C4. How does your attitude affect you meeting employee expectations?

C5. How does your personal ownership of the workplace influence your performance as a leader?

C6. How does trust influence your employees' engagement within the organization?

C7. How does leadership influence engagement in your workplace?

C8. How is your motivation affected by your leader meeting your expectations?

Targeted follow-up questions relating to the conceptual questions were as follows:

C1F1. What examples do you have of employee engagement?

C1F2. What are the components of employee engagement that influence your employees?

C2F1. What are your key operational tasks?

C2F2. What are the specific drivers of employee engagement that influence the job tasks of your employees?

C3F1. What expectations do you have that are reasonable?

C3F2. What expectations do you have that are not reasonable?

C4F1. How can the attitudes of employees be improved?

C4F2. How can you improve your attitude to improve engagement?

C5F1. How do you improve your personal ownership of your work environment?

C6F1. How do you improve trust between you and your employees?

C6F2. How might a decrease in job security affect your engagement?

C7F1. How can your leadership skills improve the likelihood of meeting the expectations of your employees?

C8F1. How does communication affect your relationship with your supervisor?

C8F2. How does a strong interpersonal relationship with your employees affect your desire to meet organizational goals?

Conceptual Framework

The basis for this study was expectancy theory. Vroom (1964) developed the expectancy theory in 1965 in an attempt to understand personal motivation of people in the workplace. According to expectancy theory, a relationship exists between personal effort, performance, and rewards (Bembenutty, 2012). Workers join organizations with expectations, make behavioral choices, and create life goal options to maximize personal outcomes (Faleye & Trahnan, 2011). Expectancy theory has associations with employee satisfaction and engagement. Influence of an environmental context, organizational culture, and social interactions affect employee expectations, which increases or decreases employee engagement (Chou & Pearson, 2012). The purpose of this

qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care.

Operational Definitions

Definitions create a basis for understanding the information contained in a doctoral study. In this definition section, I focus on health-care-related terms. However, some word meanings can be contextual.

Accountable care organization (ACO). ACO is an organization accepting reasonability for cost-savings programs in health care reform (Bennett, 2012).

Employee engagement. Employee engagement is the act of an employee emotionally connecting to the success of the organization (Nasomboon, 2014).

Expectancy theory. Vroom suggested that performance increases when workers understand the job requirements and predicted outcomes occur (Lunenburg, 2011).

Fee-for service. Fee-for-service is a reimbursement method that provides health care organizations with a fee per unit of service rendered (Bennett, 2012).

Psychological ownership. Psychological ownership is the ability of a person to take an ownership view of work related tasks (Avey, Wernsing, & Palanski, 2012).

Transformational leadership. Transformational leadership is a leadership style that focuses on positive feedback and interpersonal relationships, while recognizing follower performance and contribution (Yuan & Lin, 2012).

Assumptions, Limitations, and Delimitations

Assumptions

In this study, assumptions included the thought that the influence of leadership on employee engagement plays an important role in increasing organizational productivity, efficiency, and financial success. A further assumption focused on improving employee engagement may create an environment for improving patient satisfaction in health care while participants view employee engagement as a positive driver for organizational performance. A final assumption was that all participants would respond to the interview questions in a forthright manner.

Limitations

The limitations of this study included (a) lack of ancillary stakeholders, (b) geographical limitations, and (c) shift variability. I focused on health care leaders. Ancillary stakeholders in health care such as commercial payers, suppliers, and vendors may provide perspectives on challenges in health care but is not included in this study. Lack of ancillary stakeholder perspectives limited the scope of this study because their services may influence patient satisfaction and employee engagement. There were geographical limitations with the selected population. The sample size represented leaders from several health care organizations. This limits the ability to view perspectives from other organizations. Views and perspectives of the employees focused only on one employer.

An additional limitation was shift variability. Interview scheduling might have led to limited access to off-shift workers. Hospitals operate day, evening, and midnight shifts

of employees creating different work environments, which may create different employee experiences. These variations in experience may limit a complete understanding of the full range of employee expectations (Nasomboon, 2014).

Delimitations

Delimitations help clarify the focus of a study by indicating the areas that are included and excluded from the study. For example, a delimitation of this study was to select participants with direct patient care duties. This ensured that interview responses would provide data from employees who had influence on patient satisfaction. It is conceivable that employees without patient contact might provide different perspectives. The final delimitation was excluding employees with less than one year of service. Research was dependent upon reliable, credible, and accurate presentations of data from participants. This exclusion increased the likelihood that the participants had an understanding of the organization and a familiarization with the management team.

Significance of the Study

Understanding the impact of meeting employee expectations is necessary for improving the social impact of health care on patients. Many health care organizations fail to meet the requirements of consumers, which hampers service quality in health care (Angelova & Zekiri, 2011). The findings of this study may contribute to positive social change by enhancing employee engagement and improving service quality in health care. In turn, this may improve medical outcomes.

Value to Business

Employee engagement in health care provides value for businesses by improving profitability, productivity, and customer satisfaction (Marini, 2013). Improving patient satisfaction increases consumer loyalty while improving the quality of health care services. Improvements in financial performance provide value in improving shareholder return and organizational sustainability (Nasomboon, 2014).

Contribution to Business Practice

Health care reform creates an environment in which consumers will have more choices on who provides their health care. With this competition among health care providers, health care organizations must find ways to ensure patient satisfaction to increase revenue for health care organizations. Increasing employee engagement and psychological ownership creates opportunities for organizations to improve their competitive advantage, gain market share, and improve patient satisfaction, as well as increase consumer loyalty. Improvement in engagement provides more opportunities for patient satisfaction (Lowe, 2012).

Implications for Social Change

Employee engagement plays a role in supporting the continuum of care, which may improve patient satisfaction. Health care employees work in a unique continuum of care, being present from birth to death (Dorval, Rey, Soufflet, Halling, & Barthelemy, 2011). Consumers may emotionally connect with health care providers during life and death situations. In addition to better meeting patient needs, improving patient satisfaction may also increase financial stability in health care (Metha, 2011).

Successful health care organizations provide a wide range of services that meet the needs of the community. Low employee engagement may negatively affect the sustainability of health care organizations, which may decrease service offerings, limit access, and lower the quality of services (Lowe, 2012). Decreases in access and quality of care may have a negative influence on medical outcomes, which would impact society as a whole.

A Review of the Professional and Academic Literature

The purpose of this qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care. Employee disengagement may increase the likelihood of financial distress. The research question for this proposed research was: What strategies should health care leaders implement to engage employees and enhance patient care?

The literature review involved conducting content searches using a search strategy focused on Walden University Library Databases and Google Scholar by reviewing peer-reviewed journal submissions in the following health care databases: Business Source Compete, ABIFORM, Premier, and ProQuest. The following keywords guided database searches: *expectancy theory*, *psychological ownership*, *leadership, employee engagement*, *patient satisfaction*, and *hospital reform*. Research information from the literature review included articles from 124 academic journals. The review included 204 references (see Table 1). Of the 196 journal articles examined, 174 were peer-reviewed sources

published within the last 3 to 5 years, representing 86.20% of the literature review (see Table 2).

Table 1

Subject Matter Review

References	Books	Journal Articles
Health Care Reform	1	27
Research	5	15
Leadership	0	36
Psychological Ownership	0	19
Expectancy Theory	1	7
Employee Engagement	0	54
Patient Satisfaction	0	38
Total	7	196

Table 2

Numbers of Sources for Literature Review

Category	Books	Peer Review 3-5 Years	Not Peer Reviewed	Total
Books	7	N/A	N/A	7
Journal Articles	N/A	175	22	197
Total	7	175	22	204

Expectancy Theory

Employees meet performance goals when organizations meet or exceed employee expectations. According to Vroom's (1964) expectancy theory, there is a link between effort and the expected outcome. Organizations that meet employee expectations influence employee motivation (Lunenburg, 2011). Organizations have a duty to create a culture that provides an environment in which leaders can foster clear expectations for

their employees (Faleye & Trahan, 2011).

Expectancy is an estimate of the effort that results in a desired level of performance (Lunenburg, 2011). Vroom (1964) suggested that motivation is the product of expectancy. A collaborative culture creates an environment for clear communication and expectations (Spurgeon, Mazelan, & Barwell, 2011). An organization that does not promote a collaborative culture may not meet employee expectations.

Researchers applied the expectancy theory to study workplace motivation (Bembenutty, 2012). Westover, Westover, and Westover (2010) found that the work environment creates opportunities for both employee work motivation. Bembenutty (2012) found that students scored higher test results by focusing on understanding the expected goals, as opposed to those in the control group not having knowledge of the general expectations. When an individual understands and meets expectations, he or she is more likely to have increased engagement. Leaders who do not encourage goal setting with employees may negatively influence employee engagement and motivation (Bushra, Usman, & Naveed, 2011).

Psychological Ownership

Psychological ownership is the act of feeling emotional ownership of work tasks and responsibilities (Avey et al., 2012). Shuck, Rocco, and Albornoz (2011) commented that interpersonal relationships of the employees played a role in their emotional ownership or commitment to the organization. The leader-employee relationship plays a role in organizational commitment (Yuan & Lin, 2012).

Organizations should value fairness, respect, and emotional connectivity in the

workplace (Avey et al., 2012). Psychological ownership occurs when the value of equity exceeds expectations (Avey et al., 2012). A high organizational value for equity, combined with respect for the employee's ideas, creates psychological ownership (Avey et al., 2012).

Transformational leaders provide employees with the opportunity to communicate problems they are experiencing, or any other input within the workplace, which fosters psychological ownership (Yuan & Lin, 2012). Sieger, Zellweger, and Aquino (2013) suggested that a shared mindset among employees created the sense of ownership for the group. All employees in high-performing organizations experience psychological ownership collectively. The genesis of ownership feelings begins at the individual level. However, employees may experience difficulty with individual commitment and being motivated in their jobs without strong leadership, decreasing their likelihood of taking psychological ownership of their positions (Ghafoor, Qureshi, Kahn, & Hijazi, 2011).

Feelings of ownership emerge at the interpersonal level when there is personal motivation and self-identity with a job (Sieger et al., 2013). Work structure, job design, and improved communication create an environment that promotes psychological ownership. Bushra et al. (2011) believed that transformational leaders provided employees with vision, clear communication, and support. This created an environment in which to foster psychological commitment. When an employee feels psychological ownership, group dynamics converge to create a sense of possession and ownership of the environment, organization, and outcomes (Avey et al., 2012). Dollard and Bakker (2010) defined the personal safety climate (PSC) as policies, practices, and procedures

for protecting workers' emotional wellbeing. An improved sense of security and a decreased risk of job loss influence employee psychological commitment (Nasomboon, 2014). Workers who feel anxiety about job loss are more likely disengaged from meeting expectations of the customers (Dollard & Bakker, 2010).

Increased PSC and an efficient organizational climate lead to employee engagement and psychological ownership. Organizations should allow employees to share their perceptions of organizational policies and procedures in an effort to create a safe emotional work climate (Dollard & Bakker, 2010). Shuck et al. (2011) claimed that the environmental climate alone does not create engagement. Shuck et al. looked for a correlation between resources, demands, psychological well-being, emotional exhaustion, and employee engagement and found that there was a significant correlation between psychological stress and work demands with $p < .01$. Engagement can only happen when an employee and a leader create a safe climate together.

Power sharing between leaders and employees increases employee satisfaction and an employee's sense of control over his or her personal workspace. Psychological ownership and transformational leadership affect employee decision-making (Han, Chiang, & Chang, 2010). Transformational leaders can create an environment in which to increase employee motivation (Muchiri, Cooksey, & Walumbwa, 2012). A motivated employee is more likely to have a personal investment in the organization (Zhu, Chen, Li, & Zhou, 2013). Perceived ownership provides employees with an incentive to achieve successful results. Han et al. (2010) found that workers who felt psychological ownership demonstrated a positive association with the organizational commitment, $p < .01$.

Individual informational sharing correlated with psychological ownership, organizational commitment, and personal knowledge with $p < .01$ (Han et al., 2010). Psychological ownership and transformational leaders positively influence overall employee attitudes and job performance.

Stewardship is the mental commitment from an employee to the company (Hernandez, 2012). According to the stewardship construct, psychological ownership influence behaviors that change the organizational governance from an agency model toward a stewardship model (Hernandez, 2012). Psychological ownership ultimately influences stewardship (Hernandez, 2012). Employees who are emotionally connected demonstrate stewardship to the organization. Stewardship leads to improved engagement between the employee and the organization (Caspi & Blau, 2011).

Emotional connectivity increases the likelihood of improved consumer loyalty. There is a relationship between psychological capital, employee engagement, and organizational identity (Liu, Wang, Hui, & Lee, 2012). Lowe (2012) suggested that employee engagement created opportunities for improved customer-supplier relationships. Psychological capital is the ability of an employee to develop emotional ownership of his or her job (Liu et al., 2012). Psychological capital and organizational identity influence positive organizational behavior (Liu et al., 2012). However, employee deviance can affect psychological capital and organizational identity (Baumard, Andre, & Sperber, 2013). Organizational performance and positive behavior ultimately result from the attitudes and personal choices of the employee. Rothmann and Welsh (2013) studied the psychological conditions for employee engagement in the developing country of

Namibia. Rothmann and Welsh found that work-role fit, job satisfaction, and available resources affected employee engagement through psychological availability. Work engagement improves customer loyalty, employee productivity, and profitability (Rothmann & Welsh, 2013). Psychological commitment is the first step in the process of employee engagement.

Leadership

Transformational leadership. There is a connection between transformational leadership, employee engagement, and employee performance (Ghafoor et al., 2011). Transformational leaders meet the needs of employees by offering employee incentives for meeting organizational goals. Psychological ownership creates belongingness, self-identity, and responsibility at a personal level, while transformational leaders provide a foundation of trust, expectations, and an environment for psychological ownership (Avey et al., 2012). A relationship exists between transformational leadership and employee engagement (Krishnan, 2012). Transformational leaders develop a connection with their employees, encouraging employees to become engaged in their jobs. Mozes, Josman, and Yaniv (2011) suggested personal responsibility was an essential part of employee motivation, regardless of environmental situations.

Ineffective leadership influences engagement, but employees still have a social responsibility to meet job expectations (Mesu, Riemsdijk, & Sanders, 2013). Transformational leaders influence work engagement over time (Warrick, 2011). An increase in employee engagement influences service performance, productivity, and improved customer relations (Simola, Barling, & Turner, 2012). Improvement in

customer relationships leads to customer loyalty.

A leader's most valuable commodity is his or her ability to engage employees (Bushra et al., 2011). Transformational leaders promote employee commitment and respect. Employees treated with respect feel more attached to the organization (Bushra et al., 2011). Welch (2011) determined increased company communications influenced employee engagement, creating opportunities for building trust between employees and senior leadership (Bushra et al., 2011).

Bushra et al. (2011) used a Likert-like scale questionnaire consisting of 35 items designed to measure the effect of trends from transformational leadership on employee engagement and found that transformational leadership had a positive impact on job satisfaction in the commitment of employees. Decreased job risk and fear fosters psychological ownership (Dollard & Bakker, 2010). Transformational leaders create an environment to enhance interpersonal relationships and psychological ownership (Birasnav, Rangnekar, & Dalpati, 2011).

Transformational leaders influence employee engagement at the interpersonal level, which includes increased empathy, interpersonal relationships, and effective communication (Tims, Bakker, & Xanthopoulou, 2011). Psychological empowerment creates higher employee engagement (Karkoulian, Mukaddam, McCarthy, & Messarra, 2013). Leadership has the responsibility for the development of a stable emotional work domain. Day-level transformational leadership has a significant, positive correlation between work engagement and optimism of employees (McKnight, 2013). Overall, transformational leaders have a positive effect on employee engagement.

Other leadership attributes. New age leaders should understand and shape employee engagement, shareholder perceptions, and customer requirements (Baird & Gonzalez-Wertz, 2011). Organizations focusing on understanding consumer insights in the digital era have value in a virtual marketplace. Leadership styles should align with the mission of the organization (Darbi, 2012). Centered leaders create a mission for innovation and organizational adaptability. New business models should include business units focused on the changing demands of consumers, information relevance, and innovation (Meng & Berger, 2011). Effective leadership provides vision and direction for market-driven development (Souba, 2011).

Middle-manager leadership is crucial to the overall success of health care organizations (Birken, Lee, & Weiner, 2012). Effective leadership creates positive team environments (Guay, 2013). Middle management should use senior leadership approaches in everyday work duties (Birken et al., 2012). Darbi (2012) suggested that successful leadership at all levels in an organization should include a focus on both the mission and vision statements, which created a culture of accountability. Middle managers work closer with frontline employees (Birken et al., 2012). With this proximity, middle managers have the opportunity to create strong work-related relationships. The relationship between a middle manager and his or her employees affects employee engagement.

Authentic leaders influence the engagement of employees (Nichols & Erakovich, 2013). Leaders balance moral perspectives with interpersonal relationships to create a dynamic leadership personality. Improved employee engagement is a by-product of the

direct relationship with the leadership (Lowe, 2012). Authentic leaders focus on improving interpersonal relationships (Nichols & Erakovich, 2013). Proactive leaders positively influence work engagement and increase an employee's sense of empowerment (Nichols & Erakovich, 2013). Authentic leadership plays a role in ensuring work engagement and empowerment (Nichols & Erakovich, 2013).

Ethical leaders support the development of task importance, job autonomy, and job performance (Krishnan, 2012). A leader with a strong moral center can enhance employee engagement and job performance (Kottke & Pelletier, 2013). Employees with ethical leaders are more likely to place more effort into their jobs, leading to better job performance (Krishnan, 2012). Leaders with an ethical code of conduct influence employee engagement by developing trust (Den Hartog & Belschak, 2012).

Ethical leaders offer personal initiatives to their employees (Den Hartog & Belschak, 2012). Ethical leadership is the expression of a moral identity. Ethical leaders send clear messages to followers and stand by an internal code of ethics, which may make an employee more engaged with the organization (Den Hartog & Belschak, 2012). Employee engagement is a strategic objective for organizations (Lowe, 2012). Improved employee engagement leads to increased financial performance. Ethical leaders have the ability to influence the engagement of employees (Derr, 2012).

Employee Engagement

Stakeholder development. Communication plays a role in employee engagement (Welch, 2011). The focus on employee engagement developed over time through interval waves. The first wave of engagement occurred in 1980 where businesses examined the

need to engage employees in organizations (Welch, 2011). During the second wave, (1990-1999) academics began defining employee engagement as a movement to promote employee satisfaction and organizational success (Welch, 2011). In Wave 3 (2000-2007), researchers defined how an engaged employee could lead to increased productivity, which results in decreased costs and an improved the financial foundation for organizations (Welch, 2011). The ability of leadership to communicate effectively creates a basis for employee engagement. Ghafoor et al. (2011) defined engagement as a positive psychological attitude. Transformational leaders support this approach to improve engagement.

Psychological engagement begins at the board of director leadership level within organizations (Guerrero & Seguin, 2012). The board of directors should provide motivation for the management of the organization. Guerrero and Seguin (2012) examined engagement at the board level and found that organizational motivation achievement, self-motivation, identification, and engagement had a significant relationship to achievement.

Employees, leadership, and shareholders should hold a general interest in the stability and success of the organization (Adelman, 2012). Faleye and Trahan (2011) examined the relationship between stakeholders and shareholders and found that the creation of business-friendly environments promoted improved relationships. Leaders created a psychologically safe workplace, which creates a culture of psychological ownership and engagement (Dollard & Bakker, 2010). The ultimate goal should be a focus on improving shareholder return while improving the stakeholder's work life.

According to the stakeholder theory, stakeholder and shareholder relationships are necessary for creating value for the corporation (Faleye & Trahan, 2011). Faleye and Trahan (2011) reviewed four measures of operating performance: employee productivity, firm-level factor productivity, return on assets, and Tobin's q. Faleye and Trahan found that the return on assets increased from 2.15% to 3.89% over a 4-year period because of increased productivity in a labor-friendly environment. Employee engagement provides a return on investment for shareholders while increasing the prospect of sustainability (Nasomboon, 2014).

Employee engagement influence on outcomes. Employee engagement is the individual's feeling of satisfaction and enthusiasm in work-related activities for the organization (Nasomboon, 2014). There is a statistical correlation between high employee engagement and improvements in productivity, profitability, and job satisfaction (Nasomboon, 2014). Job involvement and trust are the primary determinants of organizational effectiveness (Nasomboon, 2014). Trust in expectations creates employee motivation (Swarnalatha & Prasanna, 2013). Problems arise in employee engagement when there is dysfunctional leadership and dissatisfaction with the workplace.

Employees dissatisfied in their work domain produce less and may have decreased customer service skills. The work environment can affect employee job satisfaction and engagement (Westover et al., 2010). Work domains should be places where employees can build trust and communication without fear of losing their job (Dollard & Bakker, 2010). Satisfied employees support the mission of the company.

Westover et al. (2010) used an ordinary leased square correlation with descriptive statistics to examine employee satisfaction and commitment and confirmed a statically valid connection between work domain and employee satisfaction. Organizational trust, passion, and gender had a relationship with $p < .01$(Westover et al., 2010).

Employee engagement has a U-shaped relationship with job requirements and demands (Sawang, 2011). Job demands place stressors on employees. Companies need to have healthy environments to improve employee satisfaction while achieving organizational goals. Karkoulian et al. (2013) suggested job demands combined with job insecurity created difficulties in engagement. Significant correlations exist between psychological empowerment, job demand, job insecurity, and employee engagement. Social drivers and work demands are predictors of higher engagement (Sawang, 2012). However, the longer the employee works, the more likely their relationship is going to erode, which suggests that trust fades with tenure. Employee engagement is the ability to harness emotionally cognitive attributes to improve organizational performance. Consistent and honest communication is an essential requirement for employees (Sawang, 2012). Leader-follower relationships affect levels of engagement in an organization (Shuck et al., 2011). Changes in employee empowerment, recognition, and training affect employee engagement.

Employee engagement positively influences business outcomes (Hynes, 2012). Hynes (2012) claimed that improved communication and interpersonal relationships between leaders and employees provided a foundation that fostered engagement. Nasomboon (2014) suggested increased communication and employee empowerment

increased employee engagement. Increased engagement positively influences organizational performance and psychological ownership (Nasomboon, 2014). Leaders must identify skills that influence employee performance and engagement, such as interpersonal communication, flexibility, corporate culture, team skills, and proactive problem solving (Hynes, 2012). The organization should develop training programs focused on improving these elements. Employees who enroll in this training program experience improved engagement levels. Coca-Cola's leadership believed that engaged frontline employees influenced customers daily (Fritz, Kaestner, & Bergmann, 2010). Coca-Cola's leaders invested capital funds and technology to improve the onboarding process for new employees. Kompaso and Sridevi (2010) determined engaged employees have an emotional connection with the organization. Increased emotional connections influence consumer satisfaction. Learning solutions create opportunities for frontline employees to understand communication tactics, vision collaboration, and self-study (Kompaso & Sridevi, 2010).

Employees who interact with customers must have a sense of engagement with the organization to be effective (Slatten & Mehmetoglu, 2011). Job autonomy, role benefit, and strategic attention influence employee engagement (Slatten & Mehmetoglu, 2011). Garg (2014) examined additional factors that influence engagement in frontline workers. Slatten and Mehmetoglu (2011) found employee engagement had a positive correlation with strategic awareness with a path correlation of .250 while innovation behavior had a positive correlation of .636. Companies that stressed role importance had better employee engagement.

Individuals who take the initiative for improving their current situations create new learning environments (Sieger et al., 2013). Organizations that focus on interpersonal attitudes allow psychological ownership to take hold, grow, and develop into a team-oriented mentality (Sieger et al., 2013). The Dutch government examined a proactive personality as it relates to employee engagement and job demands and found that a proactive personality increased employee engagement after an 18-month interval (Dikkers et al., 2010). Employees with improved social support demonstrate higher engagement scores. An employee with a proactive personality defines his or her job demands, while improving his or her engagement (Dikkers et al., 2010).

Joint goal setting and understanding of on-the-job requirements provides a foundation for a positive relationship. Employee engagement in a recognized organization, known as a preferred employer, demonstrates improved worker productivity (Shuck et al., 2011). Management should encourage open lines of communication, employee recognition, and goal setting (Shuck et al., 2011). Rashid, Asad, and Ashraf (2011) demonstrated that the manager-employee relationship influenced job satisfaction and engagement. The leader-employee relationship plays a role within the organization. Leadership philosophy and hiring practices create an environment for employee engagement.

Workplace interpersonal injustice and workplace deviance negatively affects employee engagement (Cheng, Huang, Li, & Hsu, 2011). Low self-esteem can also affect the attitude of employees. Nasomboon (2014) suggested that engagement had a direct relationship with improved organizational performance. Decreased employee morale

influences engagement. Cheng et al. (2011) found a negative relationship between daily interpersonal injustice and workplace defiance, while daily interpersonal injustice had a negative relationship with self-esteem. Overall, increased interpersonal injustice decreases self-esteem and increases workplace deviance (Cheng et al., 2011).
Real or perceived unfairness between employees leads to employee disengagement outcomes (Cheng et al., 2011).

Improved employee development strengthened employee engagement and work performance. Pendleton and Robinson (2011) examined the relationship between employee shared ownership and employee development. Service quality influences patient satisfaction (Metha, 2011). Service quality depends on employee engagement and employee psychological ownership improves the likelihood of employee satisfaction (Metha, 2011). Pendleton and Robinson claimed that the involvement in ownership plans influences employee training. Improved training increases the likelihood of employee satisfaction and engagement. In direct focus groups, Granatino, Verkamp, and Parker (2013) demonstrated that service training increased engagement to 77% and increased customer satisfaction to 82%. Improved engagement has a direct effect on customer satisfaction.

There is a relationship between employee satisfaction and increased efficiencies (Fearon, McLaughlin, & Morris, 2013). Satisfied employees decrease labor costs, increase efficiency, and influence customer satisfaction (Abel, 2013). Fair compensation, available resources, and fair treatment influence employee satisfaction (Abel, 2013). Ghadi, Fernando, and Mulla (2013) suggested leadership plays a role in employee

satisfaction. Trust influences interpersonal leader-employee relationships, which leads to improved communication, work performance, and employee retention (Xu & Thomas, 2011). Organizations must create strategic objectives focused on increasing employee satisfaction and engagement. Transformational leaders provide an effective environment that fosters inspirational motivation, which increases employee engagement (Abel, 2013). These leaders focus on improving employee relationships and building trust.

Improved operational efficiency occurs when employees engage (Lee, Lee, & Kang, 2012). Companies that provide a high quality of service create consumer loyalty. Lee et al. (2012) demonstrated a significant relationship with $p < .01$ for an efficient relationship with an employee's well-being, a positive influence on service quality, and customer loyalty. Kompaso and Sridevi (2010) suggested meeting employee expectations provided the best opportunity to increase engagement. Engagement directly influences operational performance.

Sutharjana, Thoyib, Taroena, and Rahayu (2013) described organizational citizenship behavior (OCB) as positive personal behaviors that supported the mission of the organization and service quality. OCB has a relationship with service quality, while service quality has a positive relationship with patient satisfaction and loyalty (Sutharjana et al., 2013). OCB directly affects service quality, which improves the overall patient experience. Self-motivated employees have organizational attitudes, leading to better outcomes (Shahid & Azhar, 2013).

Motivation. Many people work to feel motivated and satisfied (Abadi, Jalilvand, Sharif, Ali Salimi, & Khanzadeh, 2011). Improved training techniques can affect

employee motivation, increasing employee satisfaction. Shorbaji, Messarra, and Karkoulian (2011) examined the correlation between the Core-Self Evaluation (CSE) instrument and employee engagement. CSE is useful when examining how self-esteem plays a part in employee engagement. In a three-part survey answered by 150 people focused on aspects of CSE and employee engagement, Shorbaji et al. (2011) found that individuals with high CSE scores for self-esteem demonstrated high employee engagement. Kompaso and Sridevi (2010) also described a significant correlation between employee engagement and the organizational citizenship of the employee. As employee self-respect increases, so does the organizational commitment (Kompaso & Sridevi, 2010). Employees with higher self-esteem, self-efficacy, and an internal focus are more satisfied with their organizations (Kompaso & Sridevi, 2010).

Corporate social responsibility (CSR) influences employee engagement, satisfaction, and motivation. CSR is the business of monitoring corporate compliance with ethical standards (Mozes et al., 2011). Eisele, Grohnert, Beausaert, and Segers (2013) examined intrinsic motivation and employee engagement. Employees committed and engaged improve operational performance. Intrinsic motivations develop within a contextual environment (Eisele et al., 2013). Employees who have a sense of pride have an increased personal motivation to succeed. Improving motivation creates opportunities to better employee engagement (Eisele et al., 2013). CSR is important for ensuring ethical behavior and connects integrity with personal actions (Mozes et al., 2011). Psychological connections create employee commitment and improved employee motivation that enhanced the culture of the company (Van Rooy, Whitmen, Hart, &

Caleo, 2011). Motivational drivers included skill use, relationship to leadership, work duties, meaningfulness, and job flexibility (Van Rooy et al., 2011). Meaningfulness of work and self-worth influenced employees' overall motivation improves CSR.

The manager-employee relationship is necessary to foster employee satisfaction and engagement. Performance management influences employee engagement and motivation (Mone, Eisinger, Guggenheim, Price, & Stine, 2011). Performance awareness provides an environment for setting goals, expectations, recognition, and development (Mone et al., 2011). Understanding expectation and relationship requirements provided a solid foundation for employee engagement (Mone et al., 2011). Lunenburg (2011) found a link between expectancy theory attributes and positive employee motivation. Motivated employees who understand expectations met goals and became more engaged in the organization (Robertson, Birch, & Cooper, 2012).

Human resource activities such as performance appraisals influence employee engagement (Jose, 2012). Jose (2012) suggested the social exchange theory described the process of social exchanges between parties in an effort to create and foster relationships. These social exchanges affected employee engagement because interpersonal relationships affected attitude and commitment (Jose, 2012). In 2011, 90,000 workers from India took an employee engagement survey with only 21% demonstrating positive engagement (Jose, 2012). Overall, engagement is declining globally by 4% on an annual basis (Jose, 2012). Bushra et al. (2011) dismissed workplace influences on engagement because direct leadership drove engagement. Leaders of organizations must develop sound human resources functions. These functions create a foundation for

communication and trust.

Non-health care employee engagement. Coca-Cola employs more than 73,000 people on an international basis (Fritz et al., 2010). Employee engagement was a major issue for Coca-Cola due to the size and logistics of the employee base (Fritz et al., 2010). The hiring process of Coca-Cola failed to provide the necessary information on expectations creating disengagement. The Coca-Cola management changed the on-boarding process by providing peer-coaching support for new employees. The learning process focused on reinforcing learning through reflection while increasing the knowledge base. The onboarding process does not end after employment but continues with support from leadership. The onboarding process lowered training costs and increased employee retention rates. Increased employee turnover increases organizational cost and decreases employee productivity (Chat-Uthai, 2013).

In 2007, 58% of Ritz-Carlton employees lacked engagement in the success of the organization (Gallup, 2007; Timmerman, 2009). Ritz-Carlton developed an approach to leverage employee engagement (Timmerman, 2009). Leadership fostered an environment that inspired vision, stimulated ideas, and touted ideas for effectiveness. Ritz-Carlton developed employee focus groups to concentrate on increasing employee engagement and innovation. These focus groups described drivers that influenced employee engagement. Employees suggested that empowerment, use of best practices, leadership involvement, and inspiring vision influenced employee engagement (Erkutlu & Chafra, 2013).

The Gap is an international retailer that focused on employee and stakeholder engagement in an attempt to increase sustainability and social responsibility (Smith, Ansett, & Erez, 2011). Increased stakeholder engagement directly influenced economic performance (Smith et al., 2011). Stakeholder engagement created opportunities to improve trust, communication, and political influence (Smith et al., 2011). Lack of supplier engagement resulted in reduced labor results, environmental pollution, and tarnished company image (Smith et al., 2011). The Gap developed an engagement strategy by creating objectives such as developing leadership collaboration, resolving material problems, and increasing transparency. This created an increased level of stakeholder engagement.

Employee engagement is the act of an employee or group becoming more enthusiastic and passionately committed to the best interests of the organization (Vaijayanthi, Shreenivasan, & Prabhakaran, 2011). Sieger et al. (2013) suggested that psychological ownership existed in a group setting, and groups of employees created a positive influence on engagement. Vaijayanthi et al. (2011) studied the effects of employee engagement at General Electric (GE) Water and Process Technologies. Personal interviews and self-reflection questionnaires provided a method to collect data (Vaijayanthi et al., 2011). The results demonstrated a significant relationship with $p <$ .001 between engagement and specific drivers (Vaijayanthi et al., 2011). Drivers included communication, workforce management, work environment, accountability, and lack of training (Vaijayanthi et al., 2011).

There is a relationship between employee engagement and financial performance

in the banking industry in Pakistan (Rashid et al., 2011). Researchers used a five-part Likert-like scale questionnaire and structured equation modeling to survey 250 bank employees (Rashid et al., 2011). The instrument included topics of engagement, training, positive reinforcement, and development. There is a powerful connection between employee involvement and performance reward systems with $p < .001$ (Rashid et al., 2011). A significant correlation exists between employee appraisals and training with $p < .05$ (Rashid et al., 2011). Recognition and rewards supported expectations of employees while increasing personal motivation (Ugah, 2011). Employees perceived engagement as a positive factor in the profitability of the organization.

Employee engagement in health care. Improving engagement increases employee satisfaction, which directly improves patient satisfaction (Spurgeon et al., 2011). Medical engagement is a critical part of operational performance in health care (Spurgeon et al., 2011). Medical engagement decreases mortality ratios, raises safety standards, and improves medical outcomes (Freeney & Fellenz, 2013). Spurgeon et al. (2011) reviewed a systematic approach and found that engagement-improved performance. The main thrust of engagement is in the hands of the stakeholders of the organization (Guerrero & Seguin, 2012).

There is a connection between patient satisfaction and employee engagement (Gemmel & Verleye, 2010). More than 1,000 patients and employees took a survey, which demonstrated strong emotional connections within a health care organization (Gemmel & Verleye, 2010). This emotional connection created increased loyalty from both patients and employees (Gemmel & Verleye, 2010). Jose (2012) suggested the

emotional bond between the employee and customer created long-term sustainability for organizations. Employee engagement delivers the necessary drivers to create consumer and employee loyalty.

Customer-organization linkage is the degree of loyalty between a service organization and their customer base (Handa & Gulati, 2014). Customers and employees share common drivers of pride, integrity, confidence, and emotional attachment (Gemmel & Verleye, 2010). Correlation for employees demonstrated that confidence significantly connected to integrity with $p = .000$ (Gemmel & Verleye, 2010). The trust and confidence between patients who had prior contact with the hospital versus those new to the system was not significant (Gemmel & Verleye, 2010). This suggested that the hospital delivered a less-than-optimal patient experience. Granatino et al. (2013) developed a secret shopping method designed to measure employee engagement in health care. Employee engagement and satisfaction directly affected the effort of the employee (Granatino et al., 2013). Welch (2011) ascertained that good communication created opportunities for employee empowerment and engagement. Feedback information pathways develop leader-employee trust.

Work environment, job characteristics, and organizational support increase with employee engagement (Lowe, 2012). Employee engagement is a strategic goal for health care organizations (Lowe, 2012). Nasomboon (2014) demonstrated the connection between meeting customer expectations and increased consumer satisfaction. Employees consistently met expectations when engagement existed (Timms, Brough, & Graham, 2012). Lowe (2012) surveyed health care workers on several dimensions of engagement

drivers, which built a unique engagement scale. Low engagement employees represented 33% of the sample total with 39% in the medium range of engagement (Lowe, 2012). High levels of engagement correlated with high increases in service quality, which directly influenced patient satisfaction (Springer, Clark, Strohfus, & Belcheir, 2012). Increased employee engagement directly influenced improvement in organizational performance (Lowe, 2012).

Low engagement decreases worker productivity and lowered profitability. Burnout and high work volume negatively affects employee engagement (Poulsen, Poulsen, Khan, Poulsen, & Khan, 2011). One-third of the workers surveyed reported significant burnout and decreased engagement (Poulsen et al., 2011). Spurgeon et al. (2011) demonstrated that decreased engagement negatively affects an organization. Survey data provided insight into the drivers of burnout (Poulsen et al., 2011). These drivers included shift work, 40-hour-plus workweeks, and marital status. Health care organizations can create better work environments to decrease burnout and improve employee engagement.

Patient-centered health care can create an improved patient experience by placing the patient in the center of the health care process. Nursing experienced a gap between engaged and disengaged employees; leadership influenced this gap (Rivera, Fitzpatrick, & Boyle, 2011). Nursing engagement directly affected the patient experience in this process. Nurse longevity has a significant relationship with engagement with $p < .001$ (Rivera et al., 2011). Shift, manager, and tenure at the hospital all had significant relationships with nursing engagement with $p < .01$ (Rivera et al., 2011). Improved

engagement created an environment for better care by focusing resources on the patient experience.

Psychological empowerment was important to both nurses and patients (Rivera et al., 2011). Purdy, Laschinger, Finegan, Kerr, and Olivera (2010) used a multilevel study questionnaire to collect data from 679 nurses and 1000 patients. Researchers focused on work and patient environments (Purdy et al., 2010). Opportunity for personal development, work challenge, and employee empowerment influences overall structural employee empowerment (Purdy et al., 2010). Avey et al. (2012) described psychological ownership as the feeling of ownership over the work domain and environment. Psychological ownership motivates employees to strive to achieve both personal and organizational goals.

Ideals of change such as communication, vision, urgency, and collaboration create opportunities for employees to engage in meaningful ways (Gerst, 2013). There is a connection between engagement in health care and aspects of change in management (Bleicher et al., 2012). Leadership roles within a hospital setting connected with the development of engagement (Bleicher et al., 2012). A review of top talent identified the top three employees from a salary perspective who had the biggest challenges of engagement (Bleicher et al., 2012). Darbi (2012) suggested leadership has a direct role in promoting a healthy work environment. Organizational leaders went through an eight-step process to improve change management and goal setting (Bleicher et al., 2012). Overall, operational performance and patient satisfaction increased in these areas (Bleicher et al., 2012). Leadership influences the opportunities for increasing the

likelihood of improved employee empowerment.

Strong leadership creates an atmosphere of trust. According to Shuck et al. (2011), an atmosphere of trust created positive employee engagement, which all minimized a negative personality influence. Health care executives, patients, providers, and health care employees provide a wide range of views on employee engagement in health care (Luxford, Safran, & Delbanco, 2011). Interview groups focused on aspects of information that included technology, engagement, service delivery, communication, and work environment (Luxford et al., 2011). Luxford et al. (2011) identified several characteristics that create a patient-centered environment. These attributes focused on strong senior leadership, clear communication, active employees, engagement, focus on staff satisfaction, and patient satisfaction. The primary goal for health care organizations is to focus on transforming from provider-focused care to patient-centered care.

Patient Satisfaction

Patient-centered care. Attention to the feelings of the patient results in an increase in patient satisfaction (Blakley, Kroth, & Gregson, 2011). Patient-centered care meets the emotional needs of the individual by placing the patient first (Pelzang, 2010). This care methodology started with engagement from the board of directors and the senior leadership of health care organizations. Senior leadership created the vision of patient-centered care and clearly communicated employee requirements in the delivery of care (Andrew & Sofian, 2011). Health care organizations created supportive work groups, measurable benchmarks, and focused on service quality (Pelzang, 2010). Lack of employee resources, miscommunication, and low employee engagement creates barriers

to implementation of a patient-centered care model (Pelzang, 2010).

Stakeholders in a primary care practice should focus on creating educational models focused on improving patient awareness. Patient-centered care begins with the primary care practice setting (Farin & Nagl, 2013). Communication creates the ability to make emotional connections with patients (Tims et al., 2011). Improvements in communication, outreach services, and service quality provide a basis for patient compliance to medical treatment plans. The physician-patient relationship improves the opportunity for improving care (Farin & Nagl, 2013). Communication skills on both sides of the physician-patient relationship improve the likelihood of emotional connectivity. Improving the care plan improves medical outcomes.

Strong leadership is necessary for transitioning to a patient-centered care model. Patient-centered delivery health care systems rely on delivering all services based on the needs of the patient (Cliff, 2012). Historically, delivery systems focused on operations around providers and hospital systems. Transition to patient-centered care creates a cultural shift in health care systems (Cliff, 2012). The nucleus of the patient experience centers on employee engagement (Needham, 2012). Employee engagement creates an environment that fostered consumer satisfaction.

In 2011, the Institute for Healthcare Improvement focused on understanding drivers that transform health care into a patient-centric model (Cliff, 2012). Leadership, communication, and employee engagement created the best possibility to change to the new paradigm. Patient satisfaction flourished in the patient-centered design (Cliff, 2012). Cliff (2012) concluded that the key factor to achieve a patient-centered experience is the

ability of leadership to establish a patient centric culture. Patient-centered design places the patient in the center of the hospital operational focus with the intention of meeting the consumer's requirements (Cliff, 2012).

Service quality. High valued services in health care organizations positively influence financial sustainability (Angelova & Zekiri, 2011). Increased patient satisfaction increases profitability in hospitals (Shoemaker, 2010). This connection occurred regardless of medical outcome. Improved customer satisfaction facilitated volume growth and improved profitability (Shoemaker, 2010). Researchers collected data based on customer expectations, satisfaction degree, and comparison to similar services (Angelova & Zekiri, 2011). One-sample *t* test demonstrated $p < .05$, which reflected the significance of the relationship between satisfaction and customer expectations, while service quality had a significant relationship to customer expectations with $p < .001$ (Angelova & Zekiri, 2011).

Drivers of service quality in patient satisfaction are empathy, response, access, and safety; these drivers influence the perception of service quality for patients (Atta, 2012). Degrees of service quality influence patient satisfaction (Atta, 2012). Improved service quality created opportunities to influence consumer behavior (Leicht, Honekamp, & Ostermann, 2013). Shuck et al. (2011) determined that engaged employees consistently met key drivers that increased consumer satisfaction and improved service quality. Improved consumer satisfaction increases the likelihood of increased consumer loyalty (Detsky & Shaul, 2013). There is a distinct relationship between service quality and customer satisfaction with $p < .01$ while responsiveness, safety, empathy, and

facilitations all had a significant relationship to service quality with $p < .01$ (Atta, 2012). Service quality was a key driver in influencing patient satisfaction.

Metha (2011) focused research resources on attempting to find a correlation between service quality and patient satisfaction. Patient satisfaction had a better correlation with service quality than the degree of the medical outcome (Shoemaker, 2010). Patient satisfaction related to meeting the expectations of the patient (Metha, 2011). Patients and employees shared common drivers that overlapped between satisfaction and engagement (Lowe, 2012). Metha used regression modeling between patient satisfaction and service quality. The sample size consisted of 400 patients in a hospital located in India (Metha, 2011). Promptness of service had the highest total variance of 35.738, while drivers such as problems with emotional handling, courtesy, response to questions, and physician availability all scored high (Metha, 2011). Overall linear regression demonstrated $p < .001$ between patient satisfaction and service quality (Metha, 2011). Collaboration between employee engagement and service quality provides a stable environment for improved patient satisfaction (Yousapronpaiboon & Johnson, 2013).

In Bahrain, service quality and patient satisfaction had an interesting relationship (Ramez, 2012). Ramez (2012) focused on the behavioral intentions of patients. A sample of 235 patients participated in a survey questionnaire that collected data about the patients' perceptions and insights (Ramez, 2012). Insights from the surveys revealed relationships between tangibles, reliability, responsiveness, and empathy.

Engaged employees demonstrate skills that affected overall service quality

(Storch, Makaroff, Pauly, & Newton, 2013). Improved service quality increased consumer satisfaction (Slatten & Mehmetoglu, 2011). There were significant differences between service quality and the four insights (Ramez, 2012). Responsiveness had the biggest impact with a coefficient value of .364, while service quality had a significant correlation with patient satisfaction and a correlation value of .779 (Ramez, 2012). Improved patient satisfaction increases the likelihood of consumer loyalty and organizational profitability.

Service quality influences patient satisfaction and loyalty (Ramez, 2012). Service quality, customer satisfaction, and customer loyalty interconnect with each other (Chahal & Kumari, 2011). More than 400 inpatients answered survey-structured questions through a personal contact approach (Chahal & Kumari, 2011). Chahal and Kumari (2011) used structured equation modeling for data interpretation. Physical environment, expertise of the staff, and communication provided a significant relationship to consumer satisfaction and loyalty (Chahal & Kumari, 2011). Improvements in the physical environment and improved service quality give the best opportunity for increasing consumer loyalty and satisfaction (Chahal & Kumari, 2011).

Patient satisfaction can be a vague ill-defined concept with low validity, reliability, and standardization (Amin & Nasharuddin, 2013). Amin and Nasharuddin (2013) reviewed aspects of patient satisfaction research and literature in an attempt to compare patient satisfaction with service quality. Amin and Zahora compared and contrasted patient satisfaction theories on aspects of service quality and focused on patient satisfaction perception versus service quality issues. The correlation between

patient satisfaction and quality of care is vague.

Health care organizations continue to focus on patient satisfaction rather than improving aspects of perceived service quality issues (Shannon, 2013). Alrubaiee and Alkaaida (2011) described health care quality as the perceived quality of care by patients. This perceived quality focused on metrics of communication, respect, cost, and empathy but not medical outcomes. Improved patient satisfaction leads to improved financial performance (Alrubaiee & Alkaaida, 2011).

Improvement in quality and service offerings increases the likelihood of improved patient satisfaction (Irfan & Ijaz, 2011). There was a difference between quality and patient satisfaction of public and private health care systems in Pakistan (Irfan & Ijaz, 2011). Improved service quality perceptions increased the likelihood of improved patient satisfaction (Irfan & Ijaz, 2011). Empathy had a significant relationship with $p < .000$ in the private sector hospitals while public sector hospitals demonstrated $p < .000$ for tangible benefits for quality service (Irfan & Ijaz, 2011). Private hospitals provided more assurance in service quality and timeliness of services with $p < .000$ (Irfan & Ijaz, 2011). Private hospital systems in Pakistan created a better environment for overall service quality.

Drivers of patient satisfaction. There is variability in the drivers of the patient health care experience (Holzer & Minder, 2011). Holzer and Minder (2011) used the Picker Institute Methodology of data collection while reviewing information from 24 acute care hospitals. Information consisted of six classifications in communication, care, respect, discharge, cooperation, and the organizational process. Patient demographics of

age, gender, and educational level were variables that influenced the classification scores (Holzer & Minder, 2011). The six classifications created a better mechanism for measuring of patient satisfaction. Classifications covered the spectrum of provider-patient interactions. Respect for patients and discharge management had a significant correlation with patient satisfaction (Holzer & Minder, 2011).

There is a connection between patient satisfaction and improved communication in the patient-physician relationship (Holzer & Minder, 2011). Holzer and Minder (2011) created a cross-sectional questionnaire study to evaluate the extent to which continuity of care influences patient satisfaction. Psychological ownership builds a foundation of trust between people (Avey et al., 2012). Increased trust and longevity is dependent on the patient-provider relationship (Dorval et al., 2011). People who reported seeing their provider on a regular basis had a mean patient satisfaction 17.3 points higher than the average patient satisfaction score (Dorval et al., 2011). Relationship building provided a foundation team structure that fostered engagement for both parties (Ncube & Jerie, 2012). A strong continuum of care improves patient satisfaction. Improved patient-physician relationships create positive health care environments.

Community clinicians and providers are essential for producing quality health care services to the local population. The continuity between medical providers and quality outcomes influenced patient satisfaction (Beal & Hernandez, 2010). Community health care centers are more likely to provide services to low income and uninsured populations. Low-income patients are less likely to seek preventive care in a community health care clinic when compared to a private physician practice (Beal & Hernandez,

2010). Community health care centers struggle with communication with patients with only 53% of the patients expressing satisfaction with instructions, communication, and satisfaction with treatment plans (Beal & Hernandez, 2010). Community health care centers struggle with patient satisfaction, because of inconstancy with provider coverage and communication.

Different climates influence patient satisfaction on many levels. The orientation of managers in an organizational climate contributes to increasing patient satisfaction (Ancarani, Di Mauro, & Giammanco, 2010). Leadership provides key engagement drivers that influenced meeting the expectations of customers (Bushra et al., 2011). Human relationship climates augment patient satisfaction.

Communications, employee engagement, and shared values improve patient satisfaction (Kompaso & Sridevi, 2010). Ancarani et al. (2010) indicated that improved patient satisfaction occurs when the orientation of managers coincided with a perceived organizational climate by both the medical and nursing staff. Kompaso and Sridevi (2010) focused their research on strong predictors of communication, employee commitment, and positive behavior in employee engagement and customer satisfaction.

Health care conditions dictate consumer needs. There is a difference in patient satisfaction between critically ill patients and non-critically ill patients (Otani, Waterman, & Dunagan, 2012). Customer requirements changed based on the overall medical condition of the patient. Patient satisfaction was the goal for health care organizations. Data from five, large health care systems in St. Louis, Missouri, provided a sample of participants in the study (Otani et al., 2012). Participants provided a dependent variable

rating on quality of care and the possibility of recommending of services to other people (Otani et al., 2012). An independent, variable mix consisted of room accommodations, nursing care, and the overall admission process (Otani et al., 2012). Nursing care, physician communication, and room cleanliness had a significant relationship with $p = <$ .001 for quality of care while quality of staff service, physician interaction, and nursing care was $p < .001$ for likelihood to recommend (Otani et al., 2012). Severity of illness did have a significant relationship with satisfaction (Otani et al., 2012).

Clinician communication plays a main role in promoting patient satisfaction (Oliveira et al., 2012). Physician communication and interaction, patient education, and service quality influences patient satisfaction within health care (Oliveira et al., 2012). Improved communication creates the possibility of improving customer service and meeting the needs of the consumer (Johansen, 2014). Oliveria et al. (2012) suggested that 38 communication factors consistently improved patient satisfaction ratings in health care. Verbal and nonverbal communication creates style interactions with patients.

Effective triage of patients marginally increases patient satisfaction for emergency room patients. Crane, Yerman, and Schneider (2012) compared patient satisfaction scores between days with and without physicians. Gemmel and Verleye (2010) suggested physicians create emotional connections with patients. The results did not demonstrate any significant difference in mean patient satisfaction scores based on the availability of a physician (Crane et al., 2012). Crane et al. suggested short examination times affected the strength of the patient-provider relationship. Improving provider-patient relationships depends on the amount of time for social interaction between the physician and patient

(Crane et al., 2012). However, provider-patient relationships differed between types of specialties (Holzel, Kriston, & Harter, 2013). Primary care physicians have a much stronger and longer bond with patients than emergency physicians have because of the time and frequency of the provider-patient relationship (Mercer, Jani, Maxell, Wong, & Watt, 2012).

There is a relationship between proactive communication and patient satisfaction while admitting patients from the emergency room (Gemmel & Verleye, 2010). Ferguson, Ward, Card, Sheppard, and McMurtry (2013) used convenience sampling on adults and pediatric patients in an effort to gain an understanding of the relationship between communication and patient comprehension of health issues. Ferguson et al. used analysis variances to gain an understanding of the significant differences between patient satisfaction and the ability of a patient to understand his or her medical treatment. Oliveria et al. (2012) studied communications between medical providers and patients. Verbal and nonverbal communication creates pathways for the transfer of data. Researchers focused on a central hypothesis that increased dialogue translated into increased patient satisfaction.

Verbal communication improves direct communication with patients improving patient satisfaction (Oliveria et al., 2012). Oliveria et al. (2012) reviewed a wide range of studies associated with reviewing the influence of communication in health care. Nonverbal drivers of time spent, body position, facial expressions, and tone of voice influences the perception of patients on the delivery of their health care (Oliveria et al., 2012). Information demonstrated that 90% of patients rated their care as excellent

(Oliveria et al., 2012). A total of 22% of the patients did not understand the reasons for admissions, medical tests or results (Oliveria et al., 2012). Slatten and Mehmetoglu (2011) suggested that frontline employees formed the first line of communication for customers. Communication developed early in the patient experience. Errors in communication created issues through the cycle of medical care. Paired *t* test demonstrated $p < .01$ between understanding and patient satisfaction, which demonstrated a significant correlation (Slatten & Mehmetoglu, 2011). Lack of understanding creates negative perceptions with patient satisfaction.

There is a relationship between high nurse-to-patient ratios and patient satisfaction. Organizations with a nursing ratio of seven patients to one nurse had higher patient satisfaction when compared to a ratio of 10 patients to one nurse (Fujimura, Tanii, & Saijoh, 2010). Fulimura et al. (2010) compared profitability between these same organizations. Health care environments with high nurse to patient ratios influenced high nursing turnover (Purdy et al., 2010). Smaller nursing-patient ratios created a more manageable nursing care environment that improved job demands and nursing engagement, which in turn led to improved patient satisfaction (Fujimura et al., 2010). The mean patient satisfaction score for 10:1 ratio was four on a scale of one (low) and five (high) while the mean patient satisfaction score for a 7:1 ratio was 4.38 on the same scale (Fujimura et al., 2010). Employee satisfaction scores were slightly higher for the 7:1 nurse ratio model. A lower patient-to-nurse ratio increased patient satisfaction (Fujimura et al., 2010).

The Consumer Assessment of Healthcare Providers and Systems (CAHPS), which

created surveys to measure drivers of the patient experience (Hays et al., 2014), provided data from patients on aspects of the care delivery system. Driver metrics on appointment scheduling, wait times, communication, and provider engagement focused on indicators of the patient experience (Lis, Rodeghier, & Gupta, 2011). There was a connection between meeting customer demands and service quality (Ali & Ndubisi, 2010). Drivers of consumer needs created opportunities to meet consumer demands. Health care organizations can efficiently use CAHPS as a management tool (Hays et al., 2014). Data use can focus on health care operational issues, set-up provider incentive plans, and improving the quality of patient care.

The Dutch Health Care System underwent dramatic changes in 2006 with changes in quality standards, processes, and delivery of medical care (Ikkersheim & Koolman, 2012). The Dutch system adopted pay-for-performance based on quality metrics (Ikkersheim & Koolman, 2012). Ikkersheim and Koolman (2012) studied drivers of health care quality factors from 2006 to 2007 in the Dutch delivery system. Factors included infection rates, patient satisfaction, communication, safety, and discharge data. Hospitals improved overall quality outcomes by .034 ($p < .05$) to .060 ($p < .01$) (Ikkersheim & Koolman, 2012). Hospitals that agreed to publish their data increased quality scores higher than those who did not (Ikkersheim & Koolman, 2012). Pay-for-performance, consumer-oriented services and increased competition improved the patient experience. Stephens and Ledlow (2010) suggested improving the patient experience increases financial stability.

Patient satisfaction is an international objective. Camgoz-Akdag and Zineldin

(2010) examined the factors that affect patient perceptions of health care quality in Turkey. Baird and Gonzalez (2011) concluded organizations that focused on meeting the requirements of the consumer-increased sustainability. Improvement in consumer loyalty influences long-term viability. The quality of the infrastructure, atmosphere, and medical service ranked at the top of the scale for patient-perceptions (Camgoz-Akdag & Zineldin, 2010). The primary problem in health care in Turkey is the lack of a sense of well-being. Over 32% of patients in Turkey perceived the health care system as needing improvements in food quality, family accommodations, and communication (Camgoz-Akdag & Zineldin, 2010). Improved patient satisfaction is an indicator of quality of care.

Relationship quality and rapport create opportunities for building strong consumer relationships. Health care organizations must establish an interpersonal relationship with patients to increase their market share (Ali & Ndubisi, 2010). This emotional connection increases satisfaction. Respect and rapport building had a significant relationship to interpersonal relationship building with $p < .001$, while results also indicated a significant relationship with responsibility, report building, and the quality of the relationship with $p < .001$ (Ali & Ndubisi, 2010). There was not a statistical difference between attention and valuing with the quality of the relationship (Ali & Ndubisi, 2010).

Health Care Reform and Sustainability

In 1965, President Johnson signed the Social Security amendments, which created Medicare. Medicare legislation created a provision that would provide health care for senior citizens (Petasnick, 2011). Petasnick (2011) also suggested that Medicare created social change in the role that government played in the health coverage of its citizens.

Robinson (2011) analyzed the fundamental idea of Medicare because of the significant inability of Medicare to keep up with growth in medical expenses. The mission of Medicare faced questions as health care changed. The role of senior citizens in society changed with the passage of the law.

Through the years, Medicare transformed from being a simple medical coverage to becoming a more inclusive health care coverage. Approximately 77 million, or one-third of the people in the United States, will retire by 2029 (Chiesl, 2012). Baby Boomer retirees represent the single largest population segmentation in history (Chiesl, 2012). Medicare accounted for 15% of the federal budget (Petasnick, 2011). Health care reform predicted reducing provider payments by $500 billion by 2020 (Petasnick, 2011). An increase in the Medicare population may increase health care costs while reimbursements decline creating sustainability issues for health care organizations.

A current challenge for Medicare lies in the expanding constituency, with an estimated 53 million beneficiaries enrolling by 2015 (Petasnick, 2011). Successful Medicare transformation occurs by implementing appropriate safeguards, linking reimbursement to quality results, and adjusting the age eligibility (Petasnick, 2011). Early government intervention provided a basis for future health care changes. Life expectancy in 1965 was 67 years for men and 74 years for women (Petasnick, 2011). In 2015, experts predict to see a life expectancy of 76 years for men and 82 years for women (Petasnick, 2011).

The ACA created an environment for health care reform by creating the Accountable Care Organization (ACO) (Bennett, 2012). An ACO is an organization that

combines primary care physicians, hospitals, and specialists into an entity to focus on managing health care services for a patient population. The main goals of an ACO are increasing quality, decreasing cost, and improving patient satisfaction. Bennett (2012) articulated that shared saving programs provide ACOs opportunities to save money and improve profits. Shared savings programs provided incentives to any businesses that participate in lowering the cost of health care. Certain incentives decrease costs and increase competitive advantages for an ACO. In addition, reform created health care exchanges that provided all citizens with health care coverage. Kaufman (2013) agreed that health care reform provided universal coverage, but the central goal focused on improving the quality of care, lowering costs, and improving the patient experience.

Quality outcomes and patient satisfaction determine payment schedules for health care services. The ACA transformed the historic in-patient reimbursement methodology to pay for performance (Cliff, 2012). Patient satisfaction results affected 30% of the reimbursement exposure in the new payment model (Cliff, 2012). Lowe (2012) determined high performing hospitals created environments that fostered employee engagement that supported the eventual outcome of improving the patient experience. Improved patient satisfaction directly affects the profitability of health care systems (Cliff, 2012).

The federal government planned to reduce reimbursement to health care organizations by $600 billion over the next 10 years (Orszag & Emanuel, 2010). The goal of ACA was to reduce federally covered health care expenses (Orszag & Emanuel, 2010). Reducing expenses alone would not increase the economic stability of health care (Singh,

Wheeler, & Roden, 2012). Improvements in revenue cycle management provided a balanced approach to fiscal health for health care organizations. Capital investment in information technology has become a strategic objective for hospitals (Singh et al., 2012). The development of the electronic medical record provides an opportunity to recover overpayments because of medical necessity for decreasing revenue (Singh et al., 2012).

Unhealthy patients with severe health care conditions create an uneven expense distribution with 10% of patients representing 64% of overall health care costs (Orszag & Emanuel, 2010). Cassalty (2011) claimed that health care reform would even out the distribution of payments for services by changing the reimbursement model from fee-for-service to quality-driven metrics. Healthy wellness programs develop methods for dealing with the health of the person before chronic concerns could persist in an attempt to lower the overall cost (Cassalty, 2011).

ACOs review information technology for meaningful use, value management, payment policy, and garnishing arrangements in an attempt to develop cost-sharing activities (Devore & Champion, 2011). Lack of institutional knowledge, practical experience, and proven results inhibits the process of collaboration, which increases the likelihood of sustainability issues in health care. ACOs provide opportunities to increase hospital profitability, decrease costs, and improve quality metrics (Devore & Champion, 2011). Devore and Champion (2011) suggested creating an ACO is difficult because of a host of legal issues that create reasonable concerns. Aslin (2011) recommended that hospital leaders must understand the criteria for success as ACOs continue to influence

health care delivery systems.

Bennett (2012) suggested ACO models focus on improving patient satisfaction while decreasing costs. ACOs focus on sharing cost savings with health care consumers. ACOs must provide a wide range of services to patients in order to control quality and cost of the services (Bennett, 2012). ACO development created patient loyalty with over 75% of patients staying within an ACO environment (Antos, 2014). Service variety, cost savings, and provider confidence influence the success of the ACO model.

Primary care development is the initial step in creating health care reform and cost control (Stephens & Ledlow, 2010). Zwanziger, Khan, and Bamezai (2010) suggested that lowering the overall cost of care would reduce the overall quality of health care delivery systems. New technology and services create an increased cost associated with improving overall patient care. Primary care physician networks provide oversight for patient care while lowering the cost of health care by improving patient wellness services (Stephens & Ledlow, 2010).

Health care insurance coverage and increases in deductibles negatively influence patients. Woolhandler and Himmelstein (2011) reviewed aspects of health care reform in the United States and suggested that more than 45,000 Americans die annually because of lack of health care insurance coverage (Woolhandler & Himmelstein, 2011). Americans with insurance are unable to pay the deductibles of their medical bills (Woolhandler & Himmelstein, 2011). Troubling economic factors, low literacy rates, and service quality negatively influenced the health care environment in the United States (Woolhandler & Himmelstein, 2011). The Massachusetts health care system provided a snapshot of the

new health care model. Some residents in Massachusetts still cannot afford the care offered by the state (Woolhandler & Himmelstein, 2011).

Patient loyalty translates into improved profit margins (Kaufman, 2013). Patient satisfaction and loyalty are the ultimate goals for health care leaders (Kaufman, 2013). An emotional connection exists between employee engagement and patient satisfaction when service quality meets the expectations of the patients (Kaufman, 2013). Ali and Ndubisi (2010) suggested health care organizations must differentiate their service quality from other health care firms in an effort to improve patient loyalty. Service quality produces an environment in which health care organizations must capture market share.

Hospital ownership models have an impact on hospital service offerings and profitability (Horwitz & Nichols, 2011). Nonprofit hospitals offer fewer services than for-profit organizations (Horwitz & Nichols, 2011). Data used and gathered from the American Hospital Association provided key financial ratios for Horwitz and Nichols's analysis. Cassatly (2011) explained irreversible changes in health care reform influenced how hospitals receive payment creating cash collection issues that led to negative cash flow and financial distress. In addition, nonprofit hospitals are more likely to give unprofitable services to patients. For-profit hospitals are less likely to provide unprofitable services, such as psychiatric emergency room services and home care (Horwitz & Nichols, 2011). Increasing patient satisfaction lowered the overall risk while improving revenue (Horwitz & Nichols, 2011). Nonprofit and for-profit organizations need changes in consumer offerings and service quality.

Researchers between 1990 and 2009 gathered data on the attributes and deficits of paying businesses based on meeting performance goals. Pay-for-performance will affect health care organizations (Emmert, Eijkenaar, Kemter, Esslinger, & Schoffski, 2012). Cliff (2012) suggested patient-centered health care provided the best opportunity to meet the needs of customers and influence performance metrics. Researchers found the current payment system in the United States had a minimal effect on clinical effectiveness, cost-effective operations, and continuity (Emmert et al., 2012). Effects varied based on program design and payment methodology. Pay-for-performance systems work best when the organization demonstrates stakeholder engagement, development of core metrics, payer collaboration, and team-based financial incentives (Emmert et al., 2010). Researchers compared hospital profitability with corresponding patient satisfaction scores. A 20% increase in patient satisfaction produced an 85% increase in hospital profitability without a correlation to the medical outcome, which creates a connection between patient satisfaction and financial stability of hospitals.

Engaged employees have an inherent desire to be productive members of the organization while increasing productivity and improving profitability. Employee engagement increases organizational performance and service quality (Kompaso & Sridevi, 2010). Service quality and innovation play a significant role in organizational efficiency in the delivery of health care services (Barnett, Vasileiou, Djemil, Brooks, & Young, 2011). Improved service quality influences consumer loyalty and satisfaction.

Barnett et al. (2011) suggested four fundamental themes exist in regards to service quality and innovation. Barnett et al. described these themes as organizational

partnerships, human-based influence, impact of contextual factors, and the rule of evidence affecting organizational service and innovation. Interaction between intrapersonal and intra-organizational networks facilitates the four central themes. Dollard and Bakker (2010) suggested the failure of leaders to create an environment supporting psychological ownership decreases human-based influence. Improvements related to increasing the impact of the four themes create an opportunity to meet the expectations of the health care consumer (Barnett et al., 2011).

Gregorio and Cronemyr (2011) used the Kano Model to categorize product and service standards by focusing on consumer requirements. Understanding the requirements of the consumers increases the likelihood of consumer loyalty (Gregorio & Cronemyr, 2011). Alrubaiee and Alkaaida (2011) suggested improved customer satisfaction and loyalty increased hospital profitability. Hospital sustainability depends on increasing consumer loyalty and thus, improving financial performance (Rao, 2012).

Improvement in the quality of service creates opportunities for increasing patient satisfaction (Weinberg, Avgar, Sugrue, & Cooney-Minor, 2013). Improvements in the work environment, team performance, and service quality create positive financial outcomes (Weinberg et al., 2013). Shoemaker (2010) connected increased patient satisfaction with hospital profitability. High-performance teams had a significant correlation with employee satisfaction with $p < .000$, while low retention demonstrated a significant relationship with a high performance work climate with $p < .012$ (Weinberg et al., 2013). The work climate demonstrated a significant correlation with patient satisfaction with $p < .008$, while improved work performance and work climate positively

influenced overall patient satisfaction (Weinberg et al., 2013). Increased profitability provides opportunities for organizational investment and improved sustainability.

Safety-net hospitals provide care for the low income, uninsured patient population. Kane, Singer, Clark, Eeckloo, and Valentine (2012) collected financial data from 5,299 hospitals and demonstrated three critical financial benchmarks. Kane et al. reviewed total patient revenue, average total margin, and negative margin operations that determined safety net hospital status. More than 50% of the 526 safety net hospitals operated in metropolitan statistical areas (Kane et al., 2012). Safety net hospitals focus on providing care to those individuals without insurance coverage. Many publicly owned health care organizations received subsidies covering the cost of health care services. Graduate medical education is also a major component of safety net hospitals. The combination of medical education and federal subsidy offset portions of uncompensated care for safety net hospitals.

Retaining and attracting new customers creates strategic objectives for sustainability. Starting in 2007, the safety net hospital system in San Francisco, California transformed itself into fully integrated health care delivery system (Katz & Brigham, 2011). By 2010, the health care system enrolled 89% of the uninsured population with a 94% patient satisfaction score (Katz & Brigham, 2011). Healthy San Francisco created a competitive advantage by increasing information technology, establishing primary care base, and improved customer service (Katz & Brigham, 2011). Strong medical engagement and a clear vision created an opportunity for a financially successful delivery of community health care coverage. Healthy San Francisco created a

formula for employee engagement, medical leadership, and community involvement that improved health care coverage.

Medicaid patients' choice of provider increased because of the ACA. Safety net organizations face increased pressure to keep costs under control while attracting low-risk Medicaid patients (Zwanziger et al., 2010). Zwanziger et al. (2010) used the Annual Survey of Hospitals as the primary data source for analysis of financial performance of safety net health care organizations. Safety net activities have little to no effect on profit margins (Zwanziger et al., 2010). Overall, expenditures were lower for safety net organizations, which created a perception that safety net hospitals provide a decrease in service quality.

Kane et al. (2012) reviewed data that supported how safety net hospitals financially thrived before the last recession. Health care organizations with significant Medicaid discharges demonstrated healthy profit margins in competitive environments. Devore and Champion (2011) suggested that health care reform created opportunities for businesses to thrive. Increased market share produced improved profitability while overall revenue decreased. Medicaid payment systems and subsidies are vulnerable to decreases in challenging economic environments (Kane et al., 2012). A stressed economic climate created an opportunity for issues with sustainability for safety net hospitals. Decreased political support and increased population created a situation in which medical care comes with higher costs and decreased reimbursement.

The federal government reviewed the reimbursement shift between nonprofit and privately owned hospitals by studying cost versus reimbursement rates. Medicare planned

a reduction in reimbursement rates as patients signed up for ACA insurance plans (Robinson, 2011). The ultimate goal of the legislation is to decrease cost while improving quality. Robinson (2011) indicated that health care organizations in concentrated markets attempted to increase reimbursement from private insurance companies while health care organizations in competitive marketplaces focused on cutting operational costs. Decreased cost improves profit margins, which provides capital for reinvestment.

Grants, gifts, and contributions affect the profitability of hospitals (Bailey, 2013). Fiscal ratios determined fiscal viability. Urban and rural health care facilities created a sample pool of data to examine the impact of grants and contributions. Kane et al. (2012) demonstrated that contributions, gifts, and grants did not play a significant role in the total hospital revenue. However, these items did have a more positive impact on urban hospitals than for rural hospitals. Kompaso and Sridevi (2010) suggested employee engagement created a solid foundation for positive operating performance. Increased employee engagement is a predictor of increased productivity and profitability. Motivated employees develop opportunities for gifts and grants. In addition, the impact of non-operating revenue was greater for larger-sized facilities.

Transition and Summary

Low employee engagement in health care is a business problem because employee engagement negatively influences consumer satisfaction. Health care reform mandates improvements in cost control, improving quality, and increasing patient satisfaction. The new strategic objective of hospitals and health care systems focuses on improving the patient experience to increase consumer loyalty. The general research

question for this study focused on how meeting employee expectations influenced employee engagement in health care.

The literature review was focused on aspects of health care reform, expectancy theory, psychological ownership, transformational leadership, employee engagement, and patient satisfaction. In the literature review, I confirmed that specific drivers influence employee engagement. Enhanced psychological ownership developed strong emotional connections to the organization. In Section 2, I provide detailed information regarding research design and methodology for approaching the problem statement while, in Section 3, I present the findings of this study and the significance of the study as it relates to a business practice.

Section 2: The Project

In this section, I provide information on the research method and design, and I chose to address the business problem that some health care leaders lack strategies to engage their employees in order to provide better patient care. I describe the role of the researcher and the participants, and provide justification for the selected research methodology and design, as well as information about the population and the sampling. I also cover ethical concerns, data collection instruments, and steps taken for the assurance of reliability, and validity.

Purpose Statement

The purpose of this qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care. Increased employee engagement may influence patient satisfaction in health care. The population for this study consisted of 23 health care leaders in Midwestern hospitals. Improvements in patient satisfaction create opportunities to improve revenue, consumer loyalty, and sustainability. This study may provide insight into understanding engagement from the perspective of the employee, which ultimately could lead to creating strategies focused on increasing patient satisfaction, improving business sustainability, and increasing the quality of care. Improvements in the quality of health care may have a positive effect on social change by improving the overall health of the members of the community.

Role of the Researcher

In this qualitative phenomenological study, I had a direct role in the research

design, data collection, and analysis of the study findings. I was the data collection instrument. My interest in understanding strategies that increase work motivation came from my personal experience as an engaged employee. I chose qualitative phenomenological research based on the nature of my topic and main research question.

Bias is the influence of a particular culture, background, and experience that may influence personal and external views (Bernard, 2013). I mitigated bias through my understanding of the presence of a personal lens related to my personal views and work experiences. This facilitated an objective interpretation of responses. The interview protocol was the same for each participant by (a) holding the interviews in a safe, off-site location, (b) allowing adequate time for a response and, (c) conducting the second interview to document response validity. This consistency prevented my personal bias from entering into the interview process.

As the researcher, in an effort to mitigate bias, I selected health care systems in which I had no contact with the leaders ensuring that my leadership views would not influence the participants. Bracketing is a useful technique used to separate the research topic from the contextual world (Patton, 2002). I used bracketing to eliminate external influence by taking the research topic out of the environmental context by using well-written questions and focusing conversations on topic analysis as research orientation instead of corrective action. Covell, Sidani, and Ritchie (2012) suggested that an interviewer has an obligation to protect participants from interviewer interference and ensure confidentiality in the data collection process.

Bracketing also assists with reducing interviewer interference by putting aside my

own beliefs on the research topic (Chan, Fung, & Chien, 2013). It was important to find hospitals that provided an environment where employees interact with patients. This provided the necessary environmental context in which to study employee engagement in health care. Employee engagement played a major role in my personal experience and success as a leader. Increasing patient satisfaction had been a major focus of my career goals and job expectations.

Epoche is the process by which a researcher takes on a phenomenological attitude to eliminate personal bias by looking at internal personal involvement in the subject matter (Patton, 2002). In epoche, researchers set aside personal knowledge, judgments, and general perceptions (Moustakas, 1994). I was able to obtain epoche by withholding judgment and personal ego on the research topic in a search for knowledge from lived experiences of leaders.

Participants

Twenty-three health care leaders of hospitals located in the Midwestern United States participated in this study. The participants managed and led employees in health care, holding the responsibility of meeting the expectations of employees. Leadership approval for employee participation in my research study created an environment for development of a working relationship with the participants. I accessed participants by working with department management and developed a system for volunteer participation.

I applied a snowballing sampling technique to select participants who could offer in-depth insights and information-rich data about this topic (Jawale, 2012). An

appropriate sample size for a qualitative phenomenological study is 20 participants (Bernard, 2013). I selected a sample size of 23 health care leaders. This sample size met the Walden University DBA requirement.

I ensured a good working relationship with participants by providing a statement of purpose and intended results in an effort to share the importance of their engagement to increase the validity of the research. I discussed the ethical issues pertaining to the participants' confidentiality and rights. I selected numbers instead of names to identify the participants and present the results of this study meeting confidentiality guidelines. I provided an informed consent document (see Appendix A) to ensure confidentiality. I ensured that the environment would provide a safe, nonthreatening atmosphere that allowed for each participant's comfort by providing comfortable chairs, soft lighting, and use of a soundproof room. All information and consents will reside on an external hard drive and a separate flash drive stored in a locked and secured place for a period of 5 years. I will destroy all information after the 5-year period.

Research Method and Design

In this section, I describe the research method and design and provide justification for using the selected approach. The decision to apply qualitative phenomenology stems from a need for an in-depth understanding of the triad of health care leader actions, employee expectations, and employee engagement. A qualitative research method allows for in-depth discovery of individual perceptions and motivations.

Research Method

Qualitative research is an appropriate method to explore the perceptions and lived

experiences of health care leaders improving employee engagement (Moustakas, 1994). Employees create interpersonal and emotional connections to an organization that builds personal perspective and knowledge (Nasomboon, 2014). A qualitative study provides an opportunity to interview health care leaders to gain perspective, understand emotional connectivity, and view an organization through the eyes of the health care leaders.

Qualitative researchers expose important points surrounding a topic (Anyan, 2013). Strong employee engagement positively influences consumer loyalty and increases revenue (Abel, 2013). Discovering why employees engage in their work environment may influence positive changes in the workplace. Qualitative researchers use conversation, active listening, and the merging of thought in an attempt to gain understanding (Branthwaite & Patterson, 2011). Interviews with health care leaders may create an environment to foster truthful dialogue about how meeting expectations affects work motivation. Personal experience gathered by interviewing individuals provides a unique perspective not found in the quantitative or mixed method research.

A quantitative approach would not have provided the necessary investigation style and form needed to capture the nature of an employee's experience (Moustaka, 1994). Quantitative researchers use statistical correlations in an effort to explain how variables interact in an effort to document what happens. The goal of my research was to focus on understanding how health care leaders' strategies affect employee engagement, which eliminated quantitative research.

A mixed method approach combines both qualitative and quantitative methods. I eliminated the mixed methodology because of research found in the literature review.

There was no need for the quantitative portion of the mixed method approach because of the past documented research in the literature review.

Research Design

I selected a phenomenological design for this study. A phenomenological approach allowed me to focus on how meeting employee expectations influences employee engagement. Phenomenology is a science that focuses on understanding the subjective perceptions of participants (Eberle, 2012). A focused phenomenological approached develops an understanding of employee engagement from health care leader experiences. Moustaka (1994) suggested seven qualities of phenomenological design: (a) combining and clustering of ideas and themes from experiences, (b) observation through listening with connection to experience, (c) viewing experience and behavior as a critical part of the whole person, (d) focusing on the wholeness of the experience in total rather than individual parts, (e) creating questions that demonstrates the passion and interest of the researcher, (f) reviewing the meaning of experience rather than a measured response, and (g) gathering first-person accounts provides true perceptive reasoning.

Phenomenological analysis creates an in-depth review of personal perspective and insight (Eberle, 2012). Employee engagement is a personal choice influenced by an environmental context, interpersonal relationships, and experience. Experience holds the hidden keys to the reasons why behaviors occur. A phenomenological heuristic approach focuses on understanding how personal experience influence behavior (Moustakas, 1994). The personal experience of an employee provides insight into understanding the influence of meeting employee expectations on engagement.

I selected a phenomenological design for this study following an evaluation and review of five design approaches. The five qualitative designs were case study, grounded theory, narrative, ethnography, and phenomenology. Although grounded theory is systematic, it may not lead to new discoveries or new information about the research topic (Jones & Alony, 2011; Licqurish & Seibold, 2011). Case study design focuses on a group in a real life setting that studies related events over time (Yin, 2009). Case study design was not compatible with my doctoral study because group dynamics can influence an individual not to express personal experiences and views because of peer pressure (Yin, 2009). The purpose of a narrative research design is to structure experiences as narratives. A narrative design would not be preferred for my study because a narrative design can have a broad reach, and would not offer the narrow focus on how lived experiences may influence leadership strategies (Bernard, 2013). The purpose of ethnography is to study people and cultures by observation. An ethnographic approach would be excessive and beyond the narrow scope of my doctoral study (Sangasubana, 2011).

Population and Sampling

The population for the study consisted of 23 health care leaders who influence employees. The group mix also included front office supervisors, nursing leaders, managers, lead technologists, directors, and physicians. I selected a snowballing technique for the selection of participants. Snowballing is a chain referral system that works by using current social networks (Jawale, 2012). Participants referred other possible participants through social interaction and interpersonal relationships.

Bernard (2013) suggested that the appropriate sample size is 15 to 20 for a qualitative phenomenological study. Saturation occurs when newly acquired data does not lead to new information and themes (Walker, 2012). I reviewed the data to determine if saturation occurred within the first 20 participants. The data did not clearly indicate that saturation occurred; therefore, I interviewed three more participants until no new information or themes occurred (Walker, 2012).

Sample size justification in interviewing studies occurs by interviewing participants until saturation occurs (Walker, 2012). Saturation occurs when interview responses provide no new data, coding, or themes, and the study is easily replicated (O'Reilly & Parker, 2012). There are several principles in evaluating saturation: (a) initial sample size, (b) interviews needed, (c) reliability analysis conducted by multiple coders, and (d) ease of evaluation (O'Reilly & Parker, 2012). I interviewed 23 leaders. The leaders consisted of physicians, nurses, technologists, and clerical workers until saturation occurred with no new data, coding or themes emerging from interview responses.

Diversity in the sample pool provided a rich texture of experience from different levels within the organization. The sampling size of 23 health care leaders provided a diverse makeup of leaders, which creates a reliable data collection pool. The tenure requirements of participants for this study effectively narrowed the pool of participants to people employed for at least one year and who work more than 10 hours per week. To be eligible, participants must provide supervision to employees who have direct patient

contact. Patient interactions provide a connection to the emotional connection between employee engagement and patient satisfaction.

I selected a quiet place for the interview sessions creating a safe environment for the discussions. The environment had adjustable lighting, comfortable seating, and a table for personal items. All windows had shades ensuring a confidential environment. The ambiance of the setting enhanced the chance for a safe environment for honest dialogue. I held the interviews away from the job site in a neutral location to increase the comfort of the participants.

Ethical Research

Researchers have an obligation for ethical conduct while doing human research (Seppet, Paasuke, Conte, Capri, & Franceschi, 2011). Ethical challenges persist in qualitative research in health care when researchers bring personal emotions in the research process (Haahr, Norlyk, & Hall, 2013). Participants decided to join the study on a volunteer basis and could have withdrawn from the study at any time by providing verbal or written notice. I provided the mandatory informed consent form for participation in the study. The consent form outlined the purpose of the study, the procedures of the study, and the communication channel with me throughout the study. I discussed the role of the participant by reviewing the informed consent form with each participant, ensuring confidentiality and an understanding that participants could withdraw from the study at any time without penalty. A sample of the informed consent form is in Appendix A.

I held all data, communications, audio files, and transcripts in strict confidence. A participant's naming structure used position type rather than names to ensure confidentiality. I stored all data on a password-protected external hard drive and after 5 years will destroy all information related to the study. All interview results will remain confidential.

Data Collection

In this section, I describe the data collection templates, the collection techniques, and the organization techniques that I used in the study, and refer to the alignment of specific interview questions with themes from the literature review. Participants reviewed transcribed manuscripts of the interview sessions. As the researcher, I took notes of their comments and reactions while not changing the transcripts. I also describe the processes for assessment of reliability and validity.

Instruments

I was the data collection instrument. An in-depth list of open-ended, semistructured interview questions created an appropriate instrument for gathering perspectives from participants (Bernard, 2013). I used a recording device in conjunction with the paper instrument. My personal journal allowed me to take notes while listening to employees. I took into consideration the goal of the study by designing the primary collection instrument to solicit answers to my research questions. My analysis of the interview answers may provide insight on general themes listed in the literature review.

I asked each participant the same set of questions ensuring consistency. I held interview sessions in the same location and over a constant time duration. Participants

provided demographic data and answers to the open-ended questions. I asked permission to record the interviews before each session. As the participants answered the questions, I kept a personal journal to take relevant notes. Participants returned for a follow-up interview to review transcribed interview notes and provided additional information on the original set of questions. All information gathered from the interviews is stored on an external hard drive and will remain in a safe and secure location in my home for 5 years. After the 5 year time duration, I will destroy all data associated with the study.

Well-thought-out interviews provide a valuable tool kit for researchers (Lampropoulou & Myers, 2013). Interviews provide valuable insight into the experience of a person. Face-to-face interviews provided me with the ability to interact with the participants, observe nonverbal communication, and express my gratitude for their participation.

Data Collection Technique

In this qualitative phenomenological study, I relied on health care leaders' answers to open-ended semistructured interview questions and my interpretive analysis. I completed a member check by conducting a transcript overview and reviewing the findings with each participant. I used member checking which provided an opportunity to validate findings by sharing interview analysis and interpretations with participants (Miles, Huberman, & Saldana, 2014). Along with recording each interview and the transcription of the responses for analysis, I also kept track of data and emerging understandings through reflective journals. I focused on themes of psychological ownership, leadership, expectations, and employee engagement. These themes related to

the main research question of this study. The semistructured format allowed participants to provide answers and creates opportunities for follow-up questions and answers.

Data Organization Techniques

Data organization is an important aspect of a data management system. I used reference numbers instead of names for participants, which ensured confidentiality of each participant. I created a separate file for each reference number. Participant files contain the informed consent form, interview voice files, transcribed journal notes, and transcribed interview sessions. I used NVivo 10 software in conjunction with Microsoft Office products on a Macintosh operating system for data management. All items will exist on an external, password- protected hard drive stored up to 5 years after the completion of my doctoral study. After 5 years, I will destroy the items. I used a coding system to identify positive words and themes associated with the subject matter. Review of themes created an opportunity to understand the experiences of employees as it relates to employee engagement. I analyzed the data and provided insight for understanding themes and for learning more about employee engagement.

Data Analysis Technique

Qualitative data analysis is a complex process that requires clear critical thinking (Bergin, 2011). Well-constructed interview questions aid in the thought process, and provides for substantive data collection leading to robust data analysis. I completed a member check by reviewing the interview transcripts and data interpretations with the participants. Interview questions complemented the overarching question: What strategies do health care leaders need to engage their employees to provide better patient

care? Data analysis led to themes related to meeting employee expectations and employee engagement.

I used a heuristic method of review and the modified Van Kaam method of data analysis in this study. Researchers use heuristics ultimately to focus research on introspective views from the participants (Nikookar, 2013). Experience and individual perception create a personal perspective. The modified Van Kaam method of data analysis provided a systematic process of data analysis (Moustakas, 1994). The data analysis consisted of: (a) creating list of experiences, (b) testing of each experience, (c) clustering like experiences into a theme, (d) reviewing the compatibility of the themes, and (e) constructing a description of the essence of the themes. In the following questions, *PQ* preceding the number indicates the question relates to personal demographic information:

Interview Questions

PQ1. What is your name?

PQ2. What is your job title?

PQ3. What is your age?

PQ4. How long have you been in the health care field?

PQ5. What is your educational background?

PQ6. How many jobs in health care have you had in your career?

PQ7. What do you do in your job?

PQ8. What does health care reform mean to you?

In the following questions, *C* preceding the number indicates the question refers to conceptual information, and *F* designates follow-up questions related to the research inquiry.

C1. How do you define employee engagement?

C2. How does employee engagement affect the day-to-day operations of your department?

C3. What expectations do you have as an employee?

C4. How does your attitude affect you meeting employee expectations?

C5. How does your personal ownership of the workplace influence your performance as a leader?

C6. How does trust influence your employees' engagement within the organization?

C7. How does leadership influence engagement in your workplace?

C8. How is your motivation affected by your leader meeting your expectations?

Targeted follow-up questions relating to the conceptual questions were as follows:

C1F1. What examples do you have of employee engagement?

C1F2. What are the components of employee engagement that influence your employees?

C2F1. What are your key operational tasks?

C2F2. What are the specific drivers of employee engagement that influence the job tasks of your employees?

C3F1. What expectations do you have that are reasonable?

C3F2. What expectations do you have that are not reasonable?

C4F1. How can the attitudes of employees be improved?

C4F2. How can you improve your attitude to improve engagement?

C5F1. How do you improve your personal ownership of your work environment?

C6F1. How do you improve trust between you and your employees?

C6F2. How might a decrease in job security affect your engagement?

C7F1. How can your leadership skills improve the likelihood of meeting the expectations of your employees?

C8F1. How does communication affect your relationship with your supervisor?

C8F2. How does a strong interpersonal relationship with your employees affect your desire to meet organizational goals?

Following the completion of the personal interviews, I transcribed the responses of the participants and then coded emerging themes by using the qualitative data analysis software NVivo10. To analyze data, I: (a) organized data and transcribed interviews for clarity, (b) reviewed transcripts, ascertaining general mood, depth, and overall creditability of responses, (c) began data analysis by using a coding process that focuses on organizing themes, (d) used the themes as a foundation for theoretical development (e) demonstrated how themes support the qualitative nature of this study, (f) interpreted data, and (g) developed next steps for research.

Software assisted in the coding of themes, collected ideas, and it allowed comparisons between words and phrases used in the interview sessions. I used NVivo 10

because it is a qualitative based analytic software package. This software provided a single point of entry for data collection. The system is a repository of interview recordings, journal notes, and questionnaire results.

Data coding is an important part of data analysis in qualitative research (Nikookar, 2013). My focus was on comparing and contrasting verbal responses to all of the interview questions in order to analyze responses. The goal of researchers is to find common themes based on experiences of participants (Jennings & Van Horn, 2012). Theme development is the focus of data analysis in qualitative research.

The conceptual framework for this study was Vroom's expectancy theory, which suggested that employees work harder when leaders meet basic employee expectations in the workplace (Lunenburg, 2011). Employee motivation increases when leaders meet personal expectations (Lunenburg, 2011). The interview questions enabled participants to generate responses related to the primary themes of (a) psychological ownership, (b) leadership influence, and (c) expectation management. Questions C2, C3, C6, and C7 focused on leadership and expectations, while questions C1, C4, C5, and C8 pointed to psychological ownership.

Answers to the open-ended, semistructured questions provided greater understanding of how meeting employee expectations influences employee motivation. The final stage of this study includes presentation, interpretation, and explanation of the study findings. Data analysis focuses on answering the main question of this study. Interview questions focus on different themes in an attempt to understand the personal experience of health care employees.

Reliability and Validity

The value of research depends on research design and data collection, analysis, and interpretation (Yu, Jannasch-Pennell, & DiGangi, 2011). Ensuring the reliability and validity of data provides objectivity and creditability (Anderson, 2010). I provided opportunities for participants to review transcribed responses in an effort ensuring accuracy captured through thoughts and themes. I kept detailed notes on how the participants modified their response.

Reliability

Reliability is the replication of themes and results by other people in different settings (Yu et al., 2011). Reliability for this study first focused on a snowball sampling method that would lead to a diverse sample group. The use of NVivo 10 software provided another aspect of reliability by using computer aided coding throughout the entire study, thus removing biases. Reliability rests in the consistent themes of data collection. Reliability results from (a) detailed notes, (b) complete documentation of the interviews, (c) accurate transcripts, and (d) accurate coding system for themes (Yu et al., 2011).

Due to many different types of methodologies, achieving reliability may be difficult in qualitative research because of the complexity of data analysis (Anderson, 2010). I enhanced reliability by including audits, data collection descriptions, theme creation, and the development of conclusions. Structured documentation of the research process adds both consistency and reliability by standardizing data collection, analysis, and storage procedures (Cook, 2012; Patton, 2002).

Validity

The goal of this study was to identify reliable and valid processes and information that mitigates the chance of bias and incorrect interpretations (Bernard, 2013). The objective was to have both internal and external validity while making sure saturation occurs when no new data or themes occur (Lakshmi & Mohideen, 2013). Internal validity refers to how accurately the study findings answer the research question (Anderson, 2010). The four methods of validity are triangulation, contradictory evidence, respondent validation, and constant comparison.

Respondent validation provided an opportunity for participants to complete a transcript review. Participants reviewed transcripts for corrections, authentication, and meaning clarification (Mero-Jaffe, 2011). I completed a member check by reviewing the study findings with the participants. This member check provided an opportunity to validate findings by sharing results with the participants (Miles et al., 2014). I achieved respondent validation by having a closing interview with each participant. I provided a transcript of the first interview and reviewed the results from the study. The participant had time to review answers and formally sign the transcript validating the authenticity of the answers. I kept detailed notes on the comments and concerns of the participants. Contradictory evidence refers to personal biases (Anderson, 2010). I mitigated bias by recognizing personal agendas, views, personal beliefs, and experiences.

External validity is the transferability of accurate representation of study results (Thomson & Thomas, 2012); however, transferability is left up to the reader to decide (Marshall & Rossman, 2011). I established validity by ensuring that I conducted the

interviews in a consistent and controlled setting (Moustakas, 1994). I conducted interviews by presenting each question in the same order therefore increasing validity by assuring consistent communication. I allowed adequate time for the participants to answer each question thoroughly. Each interview lasted 1 hour and occurred in the same setting. The timing of the interviews coincided with participant availability.

Transition and Summary

In Section 2, I covered the research method and design. I outlined the reasoning behind the selection of a qualitative phenomenological design to explore the phenomenon of meeting employee expectations. I included a description of the role of the researcher, the participants, and the snowball sampling technique. I also presented the selected data collection method of semistructured interview questions, and emphasized the ethical aspects, the reliability, and validity of the study. Section 3 includes the findings of the study and potential implications for social change. In Section 3, I will provide recommendations for action and further study, as well as a summary of the study.

Section 3: Application to Professional Practice and Implications for Change

In this section I describe themes that emerged from personal interviews with health care leaders targeting leadership strategies that affect employee engagement. Section 3 includes an overview of the study and specific findings. I also provide an opportunity to gain an understanding of how the findings might apply to professional practice, the implications for social change, and recommendations for leadership actions. Lastly, Section 3 concludes with recommendations for further study while providing a final summary.

Overview of Study

The purpose of this qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care. A qualitative research design offered the best method to understand the social impact of meeting employee expectations on an organizational level. The participants in this research study answered the main research question: What strategies should health care leaders implement to engage employees and enhance patient care? The objective of this study was to explore the lived experiences of health care leaders influencing employee engagement.

The 23 study participants consisted of a diverse group of directors, managers, and supervisors associated with the delivery of health care services. The selection of participants provided valuable insight into strategies that influence employee engagement. Leaders in health care also represent the point of view of an employee, as these leaders were all employees of their respective health care organizations. All

participants had reliable experience and knowledge of strategies that affect employee engagement, which contributed to the validity of the data (Lakshmi & Mohideen, 2013).

All participants in this study expressed the need for employee engagement in the optimization of both personal and professional objectives. Responses from participants indicated that employee engagement begins with individual desire and intention to make a psychological bond with the organization. This bond of psychological ownership is essential to create employee engagement.

Of the participants, 91% recognized that meeting employee expectations is a factor in influencing employee engagement. Expectation realization produces a positive effect on interpersonal relationships and secures the employee-organizational bond. Improved relationships foster improved teamwork, positive social interactions, and emotionally safe work domains.

Leadership played a vital role in influencing employee engagement. Trust developed when leaders met the expectations of employees. In the study, 81% of the participants suggested that trust influences the employee-leader relationship. Employees that lack trust in the leadership of an organization will not engage emotionally. Leadership provides the necessary motivation to meet employee expectations and reinforce commitment to an organization.

The findings of this qualitative, phenomenological study underscore the need for leadership strategies on the improvement of employee engagement, which creates positive organizational outcomes. Specific responses from participants supported the results of the theme analysis, with specific conclusions: (a) participants expressed

consistent understanding of employee engagement, (b) employee engagement is critical for creating positive organizational results, (c) psychological ownership creates the personal initiative needed for employee engagement, (d) meeting employee expectations is necessary in developing employee engagement, (e) communication between employees and leaders creates opportunities to influence interpersonal relationships, (f) leadership meeting employee expectations creates an environment of trust, and (g) trust influences the employee-leader relationship. The findings suggest there are four leadership strategies that affect employee engagement: (a) improving psychological commitment, (b) expectation realization, (c) trust actualization, and (e) decreasing the emotional distance between senior leadership and employees. Organizations need to create strategies that influence expectation realization, improve communication pathways, and increase the trust in employee-leader relationships. Employee motivation increases when leaders meet employee expectations. Leadership improves opportunities for the development of trust by keeping honest and open communication with employees.

Presentation of the Findings

The primary research question addressed in this study was: What strategies should health care leaders implement to engage employees in order to enhance patient care? I developed the interview questions in order to gain an understanding of strategies that influence employee engagement. In the following questions, *PQ* preceding the number indicates the question relates to personal demographic information:

Interview Questions

PQ1. What is your name?

PQ2. What is your job title?

PQ3. What is your age?

PQ4. How long have you been in the health care field?

PQ5. What is your educational background?

PQ6. How many jobs in health care have you had in your career?

PQ7. What do you do in your job?

PQ8. What does health care reform mean to you?

In the following questions, *C* preceding the number indicates the question refers to conceptual information, and *F* designates follow-up questions related to the research inquiry.

C1. How do you define employee engagement?

C2. How does employee engagement affect the day-to-day operations of your department?

C3. What expectations do you have as an employee?

C4. How does your attitude affect you meeting employee expectations?

C5. How does your personal ownership of the workplace influence your performance as a leader?

C6. How does trust influence your employees' engagement within the organization?

C7. How does leadership influence engagement in your workplace?

C8. How is your motivation affected by your leader meeting your expectations?

Targeted follow-up questions relating to the conceptual questions were as follows:

C1F1. What examples do you have of employee engagement?

C1F2. What are the components of employee engagement that influence your employees?

C2F1. What are your key operational tasks?

C2F2. What are the specific drivers of employee engagement that influence the job tasks of your employees?

C3F1. What expectations do you have that are reasonable?

C3F2. What expectations do you have that are not reasonable?

C4F1. How can the attitudes of employees be improved?

C4F2. How can you improve your attitude to improve engagement?

C5F1. How do you improve your personal ownership of your work environment?

C6F1. How do you improve trust between you and your employees?

C6F2. How might a decrease in job security affect your engagement?

C7F1. How can your leadership skills improve the likelihood of meeting the expectations of your employees?

C8F1. How does communication affect your relationship with your supervisor?

C8F2. How does a strong interpersonal relationship with your employees affect your desire to meet organizational goals?

Concept interview question 1: How do you define employee engagement? The purpose of Question 1 was to understand and uncover the perspective of each participant on the basic definition of employee engagement. Questions C1F1 and C1F2 provided

opportunities to clarify C1. Employee engagement is the emotional connection between an employee and an organization that creates personal motivation to meet organizational goals (Fu, 2014). The answers and comments of the participants demonstrated a slight variety of definitions of employee engagement. Participant 4 commented that employee engagement was the act of an employee caring about the mission and vision of the organization. Engaged employees demonstrate the will to make the organization better.

Participants 1, 12, and 16 acknowledged that employee engagement is essential for organizational success; however, engagement is a personal commitment by employees not only to the organization but also to each other. Engaged employees work to meet organizational goals while working independently to be good team members. The personal relationship with other employees is equally as important as meeting job performance goals for engaged employees.

Participants 15 and 20 described disengagement in an attempt to define engagement. Employee disengagement is a social disconnect between the employee and the organizational environment. Disengaged employees strive to do the basic minimum to maintain employment. In some cases, actively disengaged employees work against organizational goals and team members in an effort to reduce overall productive outcomes.

Concept interview question 2: How does employee engagement affect the day-to-day operations of your department? Questions C2F1 and C2F2 provided opportunities to clarify C2. The purpose of this question was to explore the impact of employee engagement on operational performance. Employee engagement influences

organizational productivity, operational performance, and customer satisfaction (AbuKhalifeh & Som, 2013).

Of the participants, 73% acknowledged that employee engagement has a positive influence on operational performance. Disengagement creates opportunities for dissension, decreased service quality, and customer dissatisfaction. The following quote demonstrates the importance of employee engagement.

> I think employee engagement affects it every day, every minute of the day. Some days you know you're going to have a good day and some days you know by walking in you're going to have a rough day. And I think that has to do with the environment. (Participant 8)

Employee engagement provides the motivation needed to meet organizational objectives. Participant 10 concluded that employee engagement is instrumental in meeting goals and one person can negatively affect the entire team. Active disengagement creates obstacles that reduce the likelihood of successful outcomes, which increases sustainability issues for organizations.

Concept interview question 3: What expectations do you have as an employee? Questions C3F1 and C3F2 provided opportunities to clarify C3. The intent of this question was to explore the connection between meeting personal expectations and employee engagement. Motivation occurs when leaders meet the expectations of employees (Bembenutty, 2012).

According to expectancy theory, a relationship between meeting employee expectations and personal motivation exists (Bembenutty, 2012). A general agreement

between the participants demonstrated that expectation realization is a key to fostering an environment of employee engagement. Participants 4, 7, 11, 12, and 19 provided common examples of expectations. These examples are: (a) trust, (b) transparency, (c) fair compensation, (d) fairness, and (e) open communication. However, expectations are particular to the individual and can vary.

Lunenburg (2011) expanded on expectancy theory by suggesting that meeting employee expectations could increase employee morale. Unequal and unfair treatment of employees can create disengagement. Leaders who hold people accountable create an environment of meeting expectations. Participant 20 described how fair and equal treatment influence expectations.

> Employees expect fair and equal treatment. When employees see others not being held accountable, it creates real disengagement. I believe that you have to have clear expectations as a leader and hold everyone to the same standard. When this occurs people engage even if they are held accountable because fairness is transparent. Meeting employee expectations with recognition or discipline must be consistent throughout the organization. (Participant 20)

Concept interview question 4: How does your attitude affect you meeting employee expectations? Questions C4F1 and C4F2 provided opportunities to clarify C4. The purpose of this question was to explore the influence of leadership on meeting the expectations of employees. Leadership had a role to play in meeting employee expectations while building strong interpersonal relationships (Krishnan, 2012). Many of

the participants acknowledged that their attitude has a direct influence on the attitude of their fellow employees. Participant 4 explored the influence of the attitude of leaders.

> I think it's huge. I think that if you have a positive attitude, a realistic attitude, a down-to-earth attitude, you are going to be able to really influence how they are in a day. Like if I come in here in my day and be all mad at the world, feel like my needs aren't being met, you know it's all about me, I'm negative and I'm looking at everything. (Participant 4)

Negative attitudes from leaders can create an environment that fosters disengagement and negativity (Mutebi, Kakwezi, & Ntayi, 2012). Participants 15 and 21 suggested that the actions of their supervisor affect their attitude. Their supervisor demonstrates a positive attitude, which inspired their efforts to motivate other employees.

Concept interview question 5: How does your personal ownership of the workplace influence your performance as a leader? Questions C5F1 and C5F2 provided opportunities to clarify C5. The reason for this question was to gain an understanding of the role that psychological ownership plays in increasing employee engagement. Psychological ownership is the ability of an employee to take a personal ownership stake in the organization (Kaur, Sambasivan, & Kumar, 2013). Participants 3, 10, 13, and 18 commented that leadership could not make employees take ownership of their workplace. Psychological ownership and commitment is a personal choice of the employee.

Participant 13 commented that leaders needed to take personal ownership of the workplace. The emotional connection between leadership and the organization influences personal commitment. The following quote expands on this thought.

> Psychological ownership significantly influences it because I own what I do and how I do it. There are days when it's more difficult to own that because you know that you can't change what's happening or you can't change people's behavior but I think it's very important to own what's ours, good and bad. (Participant 13)

Participants agreed that psychological ownership is the initial step in the process of employee engagement. The decision to engage creates the ability to build emotional connections with the organization. Psychological ownership develops the environment to build organizational relationships, which increases the ability to create positive employee engagement (Nafei, 2014). To add to this concept another participant replied,

> You cannot make a person commit to an organization. The employee must first make the conscious decision to make an emotional connection to the organization. The leader cannot force that decision. Once the employee psychologically commits, then the leader can influence employee engagement. (Participant 7)

Concept interview question 6: How does trust influence your employees' engagement within the organization? Questions C6F1 and C6F2 provided opportunities to clarify C6. The point of this question was to explore the connection between trust and employee engagement. Trust is an important driver that influences the employee-leader relationship (Tuan, 2012). Participants suggested that trust is the product

of the consistency of meeting expectations. The level of trust in the organization directly affects employee engagement and attitude.

The realization of employee expectations is the key to building trust. Participant 15 commented that trust is a vital component of the leader-employee relationship. Trust provides a consistent positive connection between psychological ownership and employee motivation. Lack of trust creates negative reactions and disengagement (Tuan, 2012). "If your employees don't have any trust in you, that could be absolutely disastrous because then the things you say or try to implement, there's no validity. Trust is the glue that keeps everything together" (Participant 11).

Trust is essential to build interpersonal relationships (Tuan, 2012). Participant 17 suggested that lost trust is very difficult to regain. Leaders that lose trust fail to properly motivate and lead employees (Tuan, 2012). Employees lose organizational commitment when leaders fail to meet expectations. The following comment supports the importance of trust.

> I don't care what you do, if you lose trust, you lose everything. Once employees mistrust the leader, then commitment, you've lost the emotional commitment. Leaders must improve communication and meet employee expectations. People build trust once their expectations come true. Trust, once lost, is very difficult to regain. (Participant 18)

Concept interview question 7: How does leadership influence engagement in your workplace? Question C7F1 provided opportunities to clarify C6. The purpose of this question was to understand the influence of leadership on employee engagement.

Transformational leadership provides a positive influence on interpersonal relationships, trust, and communication (Ghafoor et al., 2011). The responses from the participants suggested that leadership has a direct influence on employee engagement. Commitment from leaders to meet employee expectations provides a structure to foster employee engagement.

Participant 13 explained that leaders influence employee engagement by over communicating openly, meeting employee expectations, and building trust. Open communication creates opportunities to increase trust and transparency. Trust increases as leaders meet expectations and build strong communication pathways. Participant 1 suggested that leadership had an obligation to lead by example. Organization requires leaders to set a positive example in an effort to build organizational commitment and positive employee engagement.

Concept interview question 8: How is your motivation affected by your leader meeting your expectations? Questions C8F1 and C8F2 provided opportunities to clarify C8. The goal of this question was to determine the relationship between expectations and motivation. Employee engagement occurs when organizations meet the expectations of employees (Lowe, 2012). Vroom suggested that motivation is the product of meeting employee expectations (Lunenburg, 2011).

Participant 11 stated that there was a significant importance to leadership meeting expectations focused on respect, perceived organizational value, and managerial support. Participant 15 suggested a major driver of motivation was an expressed feeling of value from leadership. Several other participants further explained that feeling valued is

extremely important to build and keep engagement.

Personal motivation begins with individual desire and is inspired by leaders (Ghafoor et al., 2011). Participant 9 explained that indigent leadership, mistrust, and negative attitudes could adversely impact motivation. In addition, the delivery of fair and impartial treatment influenced motivation, because fairness is an important aspect of employee expectation. The following participant discussed aspects of motivation.

> Motivation is completely affected by it, because I am very loyal to my leader and obviously this is confidential, you have to be able to trust your leadership team and sometimes if that trust is broken that's disengaging. I have to be honest, it does affect my engagement and motivation to a point where I become disengaged when I lose faith in my leader." (Participant 6)

Theme Development

For this study, I used descriptive coding, which is a coding technique for social environments and actions (Miles et al., 2014). The data retrieved from the interview transcripts connect to various categories, which then led to the development of the main themes of the study. The themes corresponded to the main research question, conceptual framework, information included in the literature review, and the lived experiences of leaders in health care. The primary research question for this study was: What strategies should health care leaders implement to engage employees in order to enhance patient care? Based on the data analysis from personal interviews, the following themes were found: (a) consistent definition of employee engagement, (b) psychological ownership, (c) drivers of employee engagement, (d) trust, (e) expectation realization, and (f)

leadership power distance. Table 3 lists the themes and key words/phrases derived from the 23 interviews. The *Participants'* column indicates the number of participants who mentioned the words/phrases and the *References* column specifies the number of times the participants mentioned the words/phrases.

Table 3

Themes and Key Words/Phrases from Personal Interviews

Themes	Key Words/Phrases	Participants	References
Theme 1: Consistent definition of employee engagement	Employees are positive	16	19
	Good worker	12	13
	Important	11	11
	Go the extra mile	10	12
	Meet objectives	7	7
	Positive to work with	3	4
Theme 2: Psychological ownership	Do the right thing	14	14
	Hard worker	9	11
	Pride in job	8	9
	It is my business	8	9
	Cannot teach it	6	6
	Not engaged without personal ownership	6	6
	First step		
	Good team members	5	8
	Impact	5	8
		5	5
Theme 3: Drivers of engagement	Open communication	20	23
	Transparency	17	19
	Feeling valued	17	17
	Respect	16	17
	Openness	12	12
	Recognition	10	10
	Trust is important	9	9
	Communication	7	9
	Fairness	4	7
Theme 4: Trust	Absolutely necessary	21	21
	Key to engagement	20	21
	Reason for disengagement	19	22
	Lack of trust is bad	19	21
	Hard to repair	17	17
	Honesty needed	13	13
	Harm relationships	11	11
	Lead by example	5	5
Theme 5: Expectation realization	Trust in leaders	21	21
	Meet my needs	20	22
	Very important	19	19
	Clear expectations	14	15
	Job security	14	15
	Communication needed	10	12
	Listen to me	6	6
Theme 6: Leadership power distance	Trust is necessary	20	21
	Fairness	18	19
	Transparency	17	17
	Clear communication	16	17
	Good attitude	15	16
	Show value	14	16
	Lead by example	9	12
	Honesty needed	9	12
	Distance from employees	9	10

Theme 1: Consistent definition of employee engagement. There was a slight difference in interpretations of the definition of employee engagement throughout the entire pool of participants, but it was consistent with the literature review. Nieberding (2014) suggested that employee engagement is the personal relationship of the employee with the work environment. Nasomboon further explained that employee engagement is the motivation of the employee to dedicate emotionally to an organization. The following quote supports this particular view of employee engagement.

> It's defined by that employee that comes in and gives 110%, is willing to do the work and cooperate and collaborate with his coworkers, and buys into the understanding of what the hospital and department want to accomplish. (Participant 9)

Participant 9 suggested that employee engagement is not just an internal process but also a process of collaboration with team members. This would suggest that employee engagement has influence over the dynamics of people working together. Disengagement can negatively influence other employees by creating barriers to relationship building (Hynes, 2012). Participant 6 explained that employee engagement influences the dynamics of teamwork.

> To me employee engagement is not only participating in patient care, it's participating with coworkers, helping whenever you can, making a tough situation better, being involved with upper management as they make decisions. (Participant 6)

Participant 6 believed that better outcomes occurred when employees and management worked together in making key decisions. Improving employee engagement may lead to better relationships with coworkers and managers. Positive relationships between employees and leaders may lead to higher employee engagement and better patient care (Lowe, 2012). "Employee engagement to me is accountability, responsibility, ownership. An employee that is accountable and responsible feels part of a team" (Participant 6).

This definition covers personal responsibility and collaboration with the work team. Employee engagement can influence overall team dynamics (Swarnalatha & Prasanna, 2013). Team members need to have a psychological commitment to the objectives of the team in order to support the team vision. "A disengaged employee is someone who doesn't want to be here. They don't work hard, are not a good team member, in fact, makes it very difficult to work here" (Participant 13).

Disengagement has a direct effect on service quality (Atta, 2012). Improved service quality influences customer satisfaction and loyalty (Metha, 2011). Decreasing employee disengagement will result in improvements in service quality. Meeting consumer expectations in service quality may lead to improvements in customer satisfaction.

Theme 2: Psychological ownership. Psychological ownership is the purposeful act of an employee taking emotional ownership in an organization (Pan, Qin, & Gao, 2014). Vroom suggested motivation occurs when leaders meet employee expectations (Lunenburg, 2011). Psychological ownership, motivation, and expectations interconnect

within employee engagement (Nafei, 2014). Of the participants, 72% commented on the importance of psychological ownership as the initial step in employee engagement. The following response is an illustration of the significance of this theme.

> If an employee does not want to be engaged you cannot make them. There is no way to make someone want to engage. It is a conscious decision by the person. Leaders can only do so much. Again, you cannot make a person emotionally connect. It is a personal choice. (Participant 17)

Participant 17 explained that engagement cannot occur without the personal choice of the employee. This would suggest that psychological ownership is a personal choice and the first step in employee engagement. The participants acknowledged the will of the individual is critical in facilitating employee engagement. Participant 14 acknowledged that a leader cannot force an employee to engage without that employee having the desire to do so. Another participant commented on the importance of the connection between a positive attitude and psychological ownership.

> I'm going to go back again to positivity. I don't know how else to put it. I enjoy working here. I think this is a great place to work. Being in business on my own for 25 years I understand that there are trials and tribulations that you can't control and as far as that is concerned there are people in positions higher than me that control that; that's not my forte. So my attitude here is to do what is best for not only my employees but also for the patients that are here as well. It comes down to patient care/employee care. I decide to have a very positive attitude when I come to work. (Participant 9)

Positive attitude is a subtheme to psychological ownership. Employees who connect emotionally to an organization proceed to develop positive attitudes. Attitude starts at the individual level and can influence job performance. “If I don’t have a good attitude then my employees are not going to respect me, they’re not going to listen to me. My attitude as a leader reflects on the people in my department” (Participant 14).

Employees with negative attitudes create issues of engagement and personal commitment. Improving the attitude of an employee is difficult and causes significant problems within the work unit. A negative attitude can spread to other employees, transforming positive employees to negative complainers. Participant 21 expressed how the attitude of a leader influences the attitude of employees.

> I think it’s critical. I think that your actions promote the values that you’re talking about. You can’t go into a unit meeting and talk about this strategy for 2015 and talk about what direction we’re going, but yet what they hear you saying and what they see you doing are two different things. So I think you really have to align your behavior with the goals and with the expectations of the organization. I mean, for teamwork. They expect a smile. If a manager comes in and doesn’t smile, if I say hello to one employee but there are four other ones that see me say hello to that employee, what does that imply? (Participant 21)

Employees who decide to emotionally connect to an organization create a sense of personal ownership. This connection strengthens the sense of personal involvement, accountability, and responsibility (Han et al., 2010). An employee who connects psychologically feels a sense of ownership and accountability. Sieger et al. (2013)

suggested psychological ownership creates a bond that facilitates trust and engagement and creates a collaborative team environment. Participant 9 suggested that psychological ownership is an important part of personal commitment.

> I have looked at psychological ownership in each one of my positions. As a director, I have looked at my department as my own little company. I have always felt that way… and in an effort to try to excel, I'm a highly competitive person, so we always want to make sure we're putting the best out there that we can. As a part of that, I guess I'm a business owner of a larger corporation, which is this hospital, so I want to make sure that my business is running as best as it can as well as the people within it being finely tuned. (Participant 9)

In the study, 67% of the participants suggested that employee engagement is not possible without personal investment and leadership support. Dollard and Bakker (2010) explained that leadership has a responsibility to create an environment to foster psychological ownership. Lack of this environment can hamper the fostering of personal commitment and psychological ownership (Dollard & Bakker, 2010). Participant 13 indicated that leadership has influence over the environment, which influences psychological ownership. The following quote supported this view,

> I've had several bosses over time. I can tell you the good ones made me want to work harder, but I had a few who made me disengaged because of their actions. I really felt out of place with them, no trust, bad leaders. (Participant 16)

Psychological ownership is the first step in the engagement process. Personal commitment is essential to creating employee engagement (Guerrero & Seguin, 2012).

Participant responses supported the importance of psychological ownership and the influence of leadership. Meeting employee expectations may influence the degree of psychological ownership and motivation. The attitude of leadership may ultimately influence the degree of psychological ownership. Participant 20 explored the importance of personal commitment as a driver of engagement.

> Personal commitment has a huge impact. If I'm not engaged and I am kind of grumbly or when I picture an employee who's not engaged, I'm picturing someone, you know, that kind of attitude and I can't get that, you know, I can't get that way. If I'm steering the ship and I want them to be engaged, I have to feel the same way. So it's important that I maintain a healthy relationship with the Foundation as a company and that, I feel that my needs are met and that I feel my questions are answered so that I can build relationships. (Participant 20)

External influences may have an impact on employee engagement (Guerrero & Seguin, 2012). The attitudes of leaders, teamwork environment, and personal issues influence the personal commitment of employees. Psychological ownership and personal commitment create the environment for increased employee engagement. Participant 19 explored how external factors can decrease engagement.

> External factors can have a great effect. I'm the type of person who feels like you know when you walk through these doors you leave everything else behind, you don't drag your personal issues into work. You cannot let things that happen at home affect what happens at work. (Participant 19)

Theme 3: Drivers of employee engagement. Drivers of engagement can be both

internal and external to an individual. External drivers of employee engagement represent actions and behaviors that influence the attitude and engagement of an employee that exist in the work environment (Gruyter, 2014). Internal drivers include personal goals, biases, and perceptions that influence employee engagement. External and internal drivers influence employee engagement, which may negatively impact service quality, patient satisfaction, and health care delivery (Lowe, 2012). The participants collectively remarked on several levels of drivers of engagement. These are: (a) communication, (b) transparency, (c) trust, and (d) feeling valued. In the study, 61% participants believed that these drivers created opportunities to influence employee engagement. However, external drivers cannot influence an employee with the absence of personal commitment because psychological ownership creates the foundation for engagement. Leaders who fail to meet external drivers of engagement can negatively influence personal commitment.

Communication. Communication is a vital component in the employee-leader relationship (Welch, 2011). Open communication allows people to express views and opinions without fear of retribution. Guay (2013) suggested that leaders have a fundamental responsibility to listen to employees. Guay remarked that sometimes listening is a bigger driver than using verbal communication. Participant 10 illustrated the importance of communication as an external driver of engagement.

> Communication has to be a key part; that has to be the number-one thing. With having several different realms of management here it needs to be a collaborative effort again. We need to know kind of like what the left hand needs to know the right hand is doing. (Participant 10)

Participant 14 further explored the importance of communication in the context of improving patient care.

> I would say the same as before. If you are able to communicate with them if they're there and they're actually communicating with you, it makes you more engaged to be able to want to try to work together and change things rather than them not being receptive to you or not being available when you need them to be. (Participant 14)

Transparency. Improved communication leads to transparency. Transparency is the act of providing open communication in an honest format, which delivers the truth while building creditability (Welch, 2011). Employee engagement increases as transparency increases (Welch, 2011). Increasing transparency improves the interpersonal relationship between employees and leaders. Participant 21 commented that it was very important to have transparency because honest and open communication reduces specialization, gossip, and assumptions. The following response from Participant 21 supports this claim.

> Having transparency and open communication with senior leadership is very important. I need to feel good about working here and I want the truth, good or bad. If a leader is dishonest, I lose interest in the organization. Too many times, I've seen leaders hide things only for the truth to come out later. I can handle praise and criticism. I expect to be told the truth in all circumstances. (Participant 21)

Trust. Trust is the foundation for building strong employee-leader relationships (Tuan, 2012). Trust is the byproduct of expectation realization. It is a feeling of understanding that there is an anticipated reaction to an action (Tuan, 2012). Trust builds strong relationships between leaders, employees, team members, and patients, with each link having a unique connection. Lack of trust may affect personal commitment by damaging the employee-leader relationship. Participants emphasized the importance of trust in the ability to engage with the organization. Participant 12 suggested that trust is necessary to foster relationships. Lack of trust is a driver of disengagement. The following comment demonstrates the significance of trust.

> It's huge. If people don't trust you they don't buy into what you're saying. It is one of the problems that even here not only in our department but also in our organization there's always been this trust is that five letter word. That is the bad word, and we have teased and kidded about that and we've tried to promote a value of trust to each other. I trust that they come to work to do the best job they do. I trust that they are going to do these things. I think we're getting through that. There was a lot of distrust because of the way things were handled in the past. I think we've overcome a lot of it but we still have some work to do. So it has a major impact. (Participant 9)

The following comments further supported the importance of trust.

> It is everything and I think you build trust by communication. I don't know that you can make every single person feel that trust, but with enough communication you can build some trust. I think it's not just trust, it's trust with our physicians,

> it's trust between administration, different departments, it's trust everywhere and communication I think is the bridge to help that. (Participant 3)

Feeling valued. Employees who feel valued are more satisfied and willing to work harder in meeting the mission of the organization (Sawang, 2012). The feeling of worth improves self-confidence while improving baseline attitudes (Sawang, 2012). Leaders have a duty to ensure that employees have a sense of well-being and feel that their efforts create value to an organization. Participants 11,17, 20, and 21 explained that the feeling of value was important because it provided a sense of a meaning in life. Value becomes important when leaders took the time to appreciate personal effort. In addition to value, a feeling of respect and fairness also influenced engagement. Fair and respectful treatment creates an environment that fosters employee engagement (Fearon et al., 2013). The following comment supported this finding.

> I want to feel valued. I want to feel that I make a difference for the organization and my patients. When I feel valued, I feel the leaders respect what I do and how I do it. This makes it all worthwhile in the end. (Participant 5)

Drivers of engagement play an important role influencing employee engagement (Timmerman, 2009). Fearon et al. (2013) suggested that employee engagement begins with a personal commitment but external drivers influence that commitment. Of the participants, 76% commented that external drivers exist and do influence their engagement.

> Well, I can tell you that I walked in the doors of this hospital at 18 years old and I've been here now for 25 years. I feel like I do have a stake in ownership in this

> facility. That is where it all starts. I think we've seen it grow together. You know, it's allowed me to raise a family, be successful. (Participant 16)

Personal commitment is the foundation for the development of employee engagement. External drivers of employee engagement can influence personal commitment, which affects employee engagement. Participant 14 explained that personal commitment is the foundation of employee engagement.

> Actually I feel like I have ownership in any job that I've ever had. I take great pride in my work. I always put my full effort forward, I'm always willing to do whatever's asked of me. I am always willing to go above and beyond. I have always had great pride in my work and I always try to work at the top of the scale. (Participant 14)

Theme 4: Trust. Trust is a significant driver of the employee-leader relationship (Kottke & Pelletier, 2013). All of the participants felt that trust was an important aspect of the employee-leader relationship. Trust is the product of expectation realization. Leaders who consistently meet the expectations of employees build a foundation of trust that influences the engagement of their employees (Agarwal, 2013). Improvements in trust may lead to increased employee satisfaction and improved employee retention. Trust was an important topic for 92% of the participants. "If your employees don't have any trust in you that could be absolutely disastrous because then the things you say or try to implement there is no validity" (Participant 2).

Trust is an attribute that takes time to acquire (Tuan, 2012). Trust in the employee-leader relationship improves the likelihood for positive employee engagement.

Participant 23 suggested that there are current members of the medical staff who have a high level of distrust in the senior leadership team. This mistrust affects the engagement of the medical staff. Participant 23 explained this distrust with the following response.

> There are pockets within the medical staff that distrust the senior leadership. This creates all sorts of issues. The physicians will not engage into the strategic objectives of the hospital. This has to affect the operation and efficiency of the hospital. (Participant 23)

The significance of trust between leaders and followers influences the integrity of the employee-leader relationship (Tuan, 2012). Without trust, this relationship succumbs to distrust, conflict, and disconnection. Failure in the development of trust decreases the possibility of personal commitment and expectation realization in the workplace. Meeting expectations increases motivation (Lunenburg, 2011), which is the basis of the conceptual framework for this study. When leaders meet expectations, motivation increases because employees start to trust the intentions of their leaders (Kottke & Pelletier, 2013).

Theme 5: Expectation realization. I chose expectancy theory as the conceptual framework for this doctoral study. This theory made evident the notion that employee motivation increased when employers met the expectations of the employees (Lunenburg, 2011). Communication within the employee-leader relationship may lead to expectation discovery. This discovery is a bidirectional process between employees and leaders. Employees have a desire to understand the expectations of the employer in addition to having their personal expectations met (Mone et al., 2011). In this study, 84% of the

participants felt that bidirectional expectations affected engagement. The following comments illustrated this concept.

> I expect the organization to treat me fairly, value my services, be honest, and give me the tools to do my job. Actually, what is equally important is I understand my boss's expectations of me. I don't see how you can be engaged if I don't know what the hospital wants me to do. Expectations are important from both sides of the equation. (Participant 11)

Employee expectations are a set of personal desires and needs (Lunenburg, 2011). These needs may differ between employees. Meeting these expectations is an objective of leadership. Common expectations are fairness, equal pay, honest communication, and having the tools to do the job. Participant 21 described how meeting expectation affects performance.

> I guess reporting to a vice president here, I expect the organization to develop me as a leader for the organization. I expect clear communication from my vice president on what is expected of me just like my employees would expect the same. I want to know what's expected of me. It is important to feel valued while understanding that my contribution is making a difference. (Participant 21)

Participant 7 explained that trust suffers when the organization fails to meet expectations. Distrust is the result of not meeting employee expectations (Tuan, 2012). Participant 7 further emphasized what happens to engagement when management fails to listen.

> Well, the enthusiasm of the techs is down, because you know management does

> not really care and you know not that you are here for passing is buck. Part of it is like you say the overall employer, the whole hospital, they say you're doing a real great job but they give you a…your cost of living raise is way below the average and you're not even catching up with the cost of living. If you express your opinion to management and you know it's just going in one ear and out the other, then you tend to not engage in them at all. (Participant 7)

Motivation is an important aspect of employee engagement. Personal commitment builds a base for motivation, while expectation realization provides the necessary fuel for motivational endurance (Eisele et al., 2013). Bembenutty (2012) explored the connection between motivation and expectations. Expectations have a direct effect on personal motivation (Bembenutty, 2012). The participants identified several drivers of expectations but focused on job security as a key expectation. Employees expect that their jobs have a certain amount of security (Nasomboon, 2014). This viewpoint underscored the importance of job security.

> I think job security is very important. I expect management to make good decisions for the organization. I know for me, I get totally distracted when I hear layoffs are coming. I immediately start to distrust the leaders of the organization. I start to look for other employment opportunities. (Participant 1)

Expectation management is a key function of leadership teams. Organizations must deliver clear expectations to employees while understanding the expectations of the work force (Mone et al., 2011). Expectation realization is a fundamental aspect of

employee engagement and the development of trust. Expectation realization fosters employee engagement by meeting the desires of the employees.

The ability of leaders to gain an understanding of employee expectations is important to maintain and improve employee engagement. Meeting expectations develops opportunities to improve trust between employees and leaders while improving the likelihood of increasing employee engagement. Expectation realization generates opportunities to motivate employees by connecting leadership empathy with personal needs of the employees. Participant 16 explained that honesty is important while organizational direction is necessary.

> I expect for them to be consistent and honest with me. I expect the organization to have a direction. If I'm floating then I have a problem. If I know where I want to go then I usually feel pretty good. It doesn't always have to be perfectly sound or absolutely to the letter, but you have to pick your direction. And that's what I expect from my organization. (Participant 16)

The responsibility of expectation realization rests with both employees and leaders. Employees must understand and communicate personal expectations. Leaders need to be proactive in the ability to listen and learn about the expectations of the employees. This interaction develops the necessary foundation for the employee-leader relationship. Leaders have the opportunity to influence personal commitment and expectation realization.

Theme 6: Leadership power distance. Leadership has an active role in improving employee engagement. Leaders have the ability to improve communication,

respect, and trust (Tims et al., 2011). Simola et al. (2012) suggested leadership influences service quality, profitability, and productivity by influencing employee engagement. Of the participants, 87% felt that leadership plays a significant role in influencing employee engagement. Leaders influence engagement by supporting a positive attitude, reducing the power distance, and influencing drivers of employee engagement. Participant 3 remarked that leaders have a fundamental accountability to have a positive attitude. The attitude of the leader sets the tone for the employees. The following participant reply links to the response of Participant 3.

> I think it has a probably 100% effect. If I have a bad attitude, if I am constantly complaining, if I am nasty or negative, they notice that easily. You have to portray a positive attitude, we have some stumbling blocks, we've got some problems, we've got some challenges to get over, but you know we've got a smart group of people and we need to get over this together. So I think it has a huge effect on it. (Participant 9)

Leadership influence depends on the ability of the leader to emotionally connect with employees. The strength of this connection depends on the emotional distance between leaders and employees, otherwise known as the power distance (Loi, Lamar, & Chan, 2012). The power distance is the emotional distance between senior leadership and frontline employees (Loi et al., 2012). This distance can affect employee engagement because length of distance can hinder interpersonal relationships, decrease communication, and create gaps within expectation realization (Loi et al., 2012). The health care industry has lengthy vertical organizational structures with long power

distances (Winkler, Busch, Clasen, & Vowinkel, 2014). Several participants commented on the lack of senior leadership connection to the employee because of the vertical nature of the organizational structure. This senior leadership disconnection creates opportunities to increase disengagement while decreasing the motivation of employees. The following remarks support the importance of the power distance.

> I feel the management of the organization fails to really understand what happens on a day-to-day basis. They are too far from where things happen. I'm not sure many of them know who I am and surely don't know my employees. I often wonder if they really care what happens in my department. (Participant 18)

The power distance may prevent feedback from traveling back up through the organization (Loi et al., 2012). An obstruction of communication can lead to unacceptable operational outcomes, decreases in service quality, and customer dissatisfaction. Participant 19 expressed appreciation for the support of senior leadership but expressed concern in the perception of the separation between leadership and employees. The following remarks support the context of this subject.

> I believe that my vice president does care about what happens in my area, but her bosses seem to be completely disconnected from what happens here. Decisions get made with really no clear connection to what really needs to happen. I often wonder how things can get so mixed up and we make bad decisions. (Participant 21)

The power distance between employees and senior leadership creates disconnection between expectation realization and leadership influence and

understanding. Increasing the power distance decreases the opportunity for leaders to build interpersonal relationships with employees. Building interpersonal relationships creates an environment where leaders gain an understanding of the expectations of employees. This knowledge gives leaders an opportunity to meet expectations, which has a positive influence on employee engagement by increasing communication, active listening, and empathy.

Improved communication leads to transparency between leaders and employees (Tims et al., 2011). Transparency builds leadership creditability, which improves trust (Tims et al., 2011). Participants in this study commented on the importance of transparency. Many felt that transparency was necessary in the evolution of trust and the employee-leader relationship. Participants were more interested in the truth than in hearing about positive data. The following remarks illustrate the importance of transparency.

> I don't care what the message is I just want to know the truth. I think there are things that management cannot tell us, but I would at least like to know what's going on. Maybe we can all come together in tough situations and find solutions. I get angry when our management team doesn't tell us what really is going on. (Participant 11)

Communication and transparency provide leaders with a chance to improve the flow of information. Improvements in communication channels make decision making easier. Another participant supported this premise.

> Communication is huge for engagement. I think constant communication is also

> important. You are kind of assessing and reassessing as you go along within a process or whatever change or whatever you want to do or have a vision for your organization or for your department, and then to be able to get that feedback and that two-way communication where you know explaining why this is important or why it is working or not working is important. (Participant 4)

Leaders have the ability to encourage communication as a driver of employee engagement (Tims et al., 2011). Opening communication pathways creates dialogue between employees and leaders. Employee-leader dialogue generates information transfers and supports emotional connectivity and personal bonding. Leaders have the responsibility to build relationships that influence personal commitment, expectation realization, and employee engagement.

Enhanced leadership skills develop interpersonal relationships (Krishnan, 2012). These interpersonal relationships build the foundation for trust by understanding the importance of expectation realization. Ultimately, leaders cannot force an employee to engage, but ineffective leaders can definitely discourage personal commitment and effectively make employees disengage from the organization.

Conclusions From Themes

The conclusions of the theme analysis create an opportunity to build a model to influence employee engagement. Specific responses from participants supported the results of the theme analysis, with specific conclusions: (a) participants expressed consistent understanding of employee engagement, (b) psychological ownership creates personal initiative for employee engagement, (c) meeting employee expectations is

necessary in developing employee engagement, (d) communication between employees and leaders influence interpersonal relationships, (e) leaders who meet employee expectations created an environment of trust, and (f) leadership power distance influences the employee-leader relationship.

The purpose of this qualitative, phenomenological study was to explore the lived experiences of health care leaders in their desire to design strategies to engage employees in order to provide better patient care. Based on the theme analysis, I suggest there are four leadership strategies that influence employee engagement: (a) improving psychological commitment, (b) expectation realization, (c) trust actualization, and (d) reduction in the power distance of leadership. Leadership strategies focused on these strategies provide the best opportunity to influence employee engagement.

Psychological commitment. Psychological ownership and commitment begin with the desire of an individual to emotionally connect with an organization (Zhang, Nie, & Yan, 2014). Psychological commitment is the foundation for employee engagement. Improved personal commitment increases productivity, innovation, and customer satisfaction. Without psychological ownership, employee engagement cannot occur.

Expectation realization. Vroom described expectancy theory as a link between employee expectations and motivation (Bembenutty, 2012). Employees commit to a set of personal expectations. Leadership can influence expectations with improved communication, active listening, and improving the employee-leader relationship. Meeting expectations creates an environment to foster employee engagement and improve business outcomes.

Trust actualization. Trust is an individual's reliance on actions of another person to meet personal expectations (Tuan, 2012). Trust is the product of consistently meeting expectations. The establishment of trust improves teamwork, interpersonal relationships, and the ability to meet the goals of the organization. Distrust creates opportunities for damaged relationships, decreased employee engagement, and loss of institutional commitment.

Reduction in the power distance of leadership. Health care organizations have a vertically integrated health leadership structure, which creates a high power distance (Winkler et al., 2014). Increased power distance between employees and senior leaders can hinder expectation realization and trust, resulting in a decrease in employee engagement. Leadership has the responsibility and authority to reduce this distance, which creates an opportunity to gain an understanding of the employee expectations. Reducing emotional distance provides a better chance at improving employee engagement, patient satisfaction, and increasing sustainability in a changing workplace environment.

Application to Professional Practice

The culture of consumerism is starting to change the customer-supplier relationship in health care because of health care reform (Baird & Gonzalez, 2011). Educated consumers now focus on quality, cost, and perception of health care services. The new age in health care is the convergence of health care and hospitality. New demands from health care customers create challenges for health care organizations in service quality, improved patient satisfaction, and meeting new customer expectations

(Lowe, 2012). Service quality in health care historically has focused on meeting quality outcomes from medical services (Baird & Gonzalez, 2011). New demands on service quality focus on hospitality items such as (a) cleanliness, (b) food taste, (c) quietness of environment, (d) empathy of staff, (e) caregiver communication, (f) dignity, and (g) respect (Kompaso & Sridevi, 2010).

Changes in health care consumer requirements create a demand for changes in the employee-patient relationship. Based on the six main themes of this study, the four leadership strategies are: (a) improving psychological commitment, (b) expectation realization, (c) trust actualization, and (d) reduction in the power distance of leadership. These findings provide the best chance to influence employee engagement in order to meet the new requirements of health care consumers. Improving employee engagement in health care provides an opportunity to strengthen the connection between employees and patients. This study has application to professional practice by focusing on practical solutions that will influence the main findings of the study: (a) improving the hiring process, (b) developing leadership, (c) building trust, and (d) reducing the power distance of leadership.

Improving the hiring process. Psychological ownership begins with self-actualization and the desire of an individual to emotionally connect with an organization (Rothmann & Welsh 2013). From the research findings, 72% of participants believed that personal commitment was important in developing positive attitudes and employee engagement. Leaders in organizations must identify those candidates who fit the culture of the organization. Leaders need to initiate mentoring to improve employee engagement

and performance while removing disengaged employees from the organization. Increasing the number of engaged employees provides an opportunity to improve profitability, productivity, and sustainability (Nasomboon, 2014).

Developing leadership. Vroom described expectancy theory, which suggested that leaders influence employee motivation by meeting employee expectations (Bembenutty, 2012). Leaders have a responsibility to develop interpersonal relationships with followers. Of the participants, 84% suggested that understanding and meeting expectations lead to improved employee engagement and the development of trust. Leaders should take time to gain an understanding of the expectations of their employees. Once leaders understand the expectations they can develop system-wide strategies to improve expectation realization. Consistently meeting expectations will lead to improved motivation and employee engagement.

Building trust. Trust influences the employee-leader relationship (Goh & Low, 2014). From the research findings, 92% of participants mentioned that the development of trust influenced the strength of the employee-leader relationship. Leaders in health care must gain an understanding of trust issues within the organization. Improvement in trust develops the ability to strengthen interpersonal relationships while improving employee engagement.

Reducing the power distance of leadership. Health care has a vertical power distance. Eighty-four percent of leader participants believed the emotional distance from leaders to employees influenced employee engagement and trust. Implementation of a more horizontal hierarchy provides an opportunity to reduce the distance between senior

leaders and employees (Zwingmann et al., 2014). This can be accomplished by reducing the number of management layers (Winkler et al., 2014). This reduction may improve communication, understanding of employee expectations, and may increase the likelihood of trust actualization by placing leaders emotionally closer to employees (Loi et al., 2012).

Implications for Social Change

The findings of (a) improving psychological commitment, (b) expectation realization, (c) trust actualization, and (d) reduction in the power distance of leadership indicate a connection between personal commitment, leadership, and trust, which influence employee engagement. Seventy-two percent of the participants mentioned that personal commitment is the first step in influencing employee engagement. While 67% of the participants believed that employee engagement was not possible without leadership support. Improved employee engagement has an influence on patient care and satisfaction (Lowe, 2012). All the participants believed that employee engagement had a positive influence on the organization. Employee engagement increases service quality, which leads to better medical outcomes (Ramez, 2012). Improved patient satisfaction provides an opportunity for patients to concentrate on healing (Ramez, 2012). Improved personal health may increase the ability of people to interact socially. A healthier society creates a stronger social network and community.

I made a business case for reducing the management layers in health care administration to decease the power distance between senior leaders and frontline employees. Of the participants, 83% suggested a reduction in the power distance of

leadership increases the likelihood of improving the employee-leadership relationship and increased employee engagement. High employee engagement increases productivity, profitability, and service quality of health care organizations (Lowe, 2012). Improving operational results influences organizational sustainability. Improving the sustainability of health care organizations provides a stable framework for social interaction and improves the health of the community as the population ages.

The Baby Boomer generation is the largest population segment in the history of the United States moving to the retirement phase in a social setting (Chiesl, 2012). This segmentation may change the fundamental culture of consumerism in health care by demanding that hospitality merge with health care creating a new social platform for caring for the emotional and physical needs of patients (Wu & Robson, 2013). Sections 1 and 2 and the results in Section 3 were focused on the social, corporate, ethical, medical, and business need for better strategies to encourage the likelihood of increasing personal commitment, meeting employee expectations, and developing trust in an effort to improve employee engagement. From the research findings, 72% of the participants suggested that personal commitment was necessary for developing employee engagement. While 84% of the participants believed that employee engagement was important in developing employee engagement. Improving personal commitment, expectation realization, trust actualization, and reducing the leadership power distance may increase employee engagement. Eighty-seven percent of the leader participants agreed that reducing the power distance would influence employee engagement. Increasing employee engagement influences consumer satisfaction, which may improve

the overall health of the patient. Improved personal health may create social change in health care.

Recommendations for Action

Employee engagement supports the mission of health care organizations by increasing patient satisfaction, service quality, and patient loyalty (Lowe, 2012). All the participants suggested that employee engagement had a positive influence on meeting organizational goals and consumer expectations. Health care organizations would benefit from improving personal commitment, expectation realization, trust actualization, and reducing the leadership power distance as strategic objectives. Sixty-seven percent of the participants mentioned the need for leadership focus and support to improve employee engagement.

Strategic objectives provide health care organizations an opportunity to develop action plans for improvement and implementation. I would recommend several steps in a process to access, diagnose, and improve employee engagement. The steps are:

- complete an employee engagement survey,
- complete an expectation audit for employees and the organization,
- create an action team composed of senior leaders and front-line employees to develop a strategy to decrease the power distance,
- develop action plans focused on improving trust within the organization
- develop hiring strategies to improve the selection process
- remove employees who are disengaged from the organization, and

- hold senior leadership accountable to improve employee engagement, trust, and expectation realization.

The board of directors has the responsibility for the direction of health care organizations (Guerrero & Seguin, 2012). Leadership strategies for employee engagement begin with the engagement of the board of directors. Directors should provide motivation for the senior leadership team to increase the engagement of the workforce. Improvements in employee engagement should be the ultimate goal of the organization in an effort to increase patient satisfaction and influence the patient care delivery system.

I will disseminate the results of this study by presenting my findings at national professional meetings. These meetings provide an opportunity to present insights into this study while creating interactive sessions by meeting with participants. I could provide consulting services to health care organizations in regards to training leaders and employees on aspects of this study.

Recommendations for Further Study

Following the leadership strategies of improving personal commitment, expectation realization, trust actualization, and reducing the power distance, future researchers should investigate the connection between employee engagement and corporate compliance. As I conducted the research study, I found many of the participants connected employee engagement to personal choice rather than organizational need. Corporate compliance is the process of ensuring that organizations operate within lawful guidelines (Habisch, 2012). Employee engagement may influence

compliance. Federal, state and local agencies require a proactive approach to corporate compliance (Habisch, 2012). This compliance is focused on (a) sexual harassment, (b) patient confidentiality, (c) JACHO accreditation, (d) fraud and abuse, and (e) general corporate compliance (Habisch, 2012). Corporate compliance tasks are very important to the success of health care organizations (Kane et al., 2012). Employee engagement may have a material effect on meeting corporate compliance requirements and reducing financial risk.

A major limitation of this study was the absence of secondary stakeholders in health care in the participant pool. For example, medical supply vendors, commercial payers, and equipment vendors have significant relationships with health care organizations (Aslin, 2011). From the research findings, 72% of participants suggested that personal commitment was important in meeting organizational goals. Further study may be necessary to understand the correlations between secondary stakeholder personal commitment and employee engagement in health care. Engagement with secondary stakeholders may influence health care employees by negatively affecting supply product delivery, quality, and functionality.

Researchers may benefit from gaining an understanding of the impact of employee engagement on the decrease of medical malpractice lawsuits. All the participants agreed that employee engagement is important to the goals of an organization. Reducing medical malpractice lawsuits may increase the profitability of health care organizations (Kane et al., 2012). Further study may lead to understanding

how employee engagement may influence patient satisfaction and reduce medical malpractice risk.

Reflections

The research process was challenging and emotionally draining. The diversity of the participants provided both an ease and difficulty in the interview process. The different mix of positions provided a unique perspective from various points of view from leadership roles within the organizational structures of health care organizations. However, this same diversity made some of the interviews difficult because of some participants' lack of strategic understanding of current health care issues and strategies. A major unseen benefit of the leadership pool was that the participants were both leaders and employees of their perspective organizations. This combination allowed participants to answer questions from both leadership and employee viewpoints.

I had little trouble finding adequate participants through an effective snowballing sampling technique. I interviewed 23 participants until no new information was gathered and saturation occurred (Walker, 2012). I maintained a good relationship with all the participants throughout both interview sessions. The data gathered from the interview sessions validated the choice of qualitative phenomenological study as the optimum research methodology and design in answering the main research question in this study. I felt overwhelmed by the dedication of the participants to serve patients. Regardless of position and title, many participants had a goal of helping patients.

My personal view of leadership changed throughout this study. I attempted to remove all biases, but some of my views on leadership caused me to judge the

participants based on the answers to their interview questions. At the beginning of the interviews, I perceived those participants who gave brief or obscure answers as inferior to my experience and expectations. Leadership is neither standardized nor stagnant and people experience things differently. Just because I did not experience the same lived experiences does not mean their perspectives were wrong. Finally, this entire study was a life-changing journey because the data collection and analysis provided insight into the aspects of employee-leader relationships in health care. This knowledge will provide an opportunity to make a difference for employees, leaders, and ultimately improved patient care.

Summary and Study Conclusions

The focus of this study was to explore the lived experiences of health care leaders in an effort to understand leadership strategies that could affect employee engagement. Responses from personal interviews provided insight into the aspects of psychological ownership, leadership, and employee engagement. An analysis of the responses produced six major themes. These themes produced a set of specific findings that consolidated the results into four leadership strategies for influencing employee engagement: (a) improving psychosocial commitment, (b) expectation realization, (c) trust actualization, and (d) reduction in the power distance of leadership.

The main takeaway from this doctoral study is that employee engagement starts with the individual and leads to expectation realization while influenced by leadership performance. The study also revealed the importance of trust in the employee-leader relationship. Trust is the foundation for improved interpersonal relationships. The

participants in this study provided a diverse mix of health care leaders who were also employees of health care organizations. Participants used their lived experiences as health care leaders as a resource to provide valuable information for this doctoral study.

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Appendix A: Informed Consent

CONSENT FORM

You are invited to take part in a research study to gain an understanding on how meeting employee expectations influence employee engagement in health care. The researcher is inviting health care workers with direct patient care duties who work more then 10 hours per week and have been employed for at least 1 year to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named John Vizzuso who is a doctoral student at Walden University. You may already know the researcher as the CEO of Radiology Associates of Canton but this study is separate from that role.

Background Information:
The purpose of this study is to gain an understanding on how meeting employee expectations influence employee engagement in health care.

Procedures:
If you agree to be in this study, you will be asked to:

- Participate in 1 initial interview lasting no more then 25 minutes. Data will be collected from the interview session.
- Participate in 1 follow-up interview lasting no more then 15 minutes. Data from the first interview session will be reviewed.

Here are some sample questions:

- How do you define employee engagement?
- How does employee engagement affect the day-to-day operations of your department?
- What expectations do you have as an employee?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Aultman Hospital will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not pose risk to your safety or wellbeing.

This study does have potential benefits in understanding motivational drivers of personal goal setting and improvements in understanding employee engagement.

Payment:
There is no payment or reimbursements for participation in this study.

Privacy:
Any information you provide will be kept confidential The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by storage on an external hard drive kept in a locked cabinet. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via [redacted] or e-mail at jvizzuso@leadershipedge,us. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is 11-03-14-0315765 and it expires on November 2, 2015.

The researcher will give you a copy of this form to keep. (for face-to-face research)

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, "I consent, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix B: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer: Kelly L Filiz

During the course of my activity in collecting data for this research: Leadership Strategies to Influence Employee Engagement in Health Care. I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

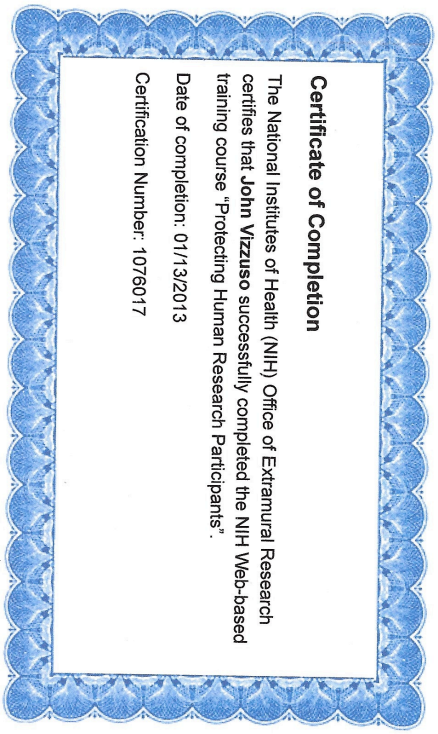
By signing this Confidentiality Agreement I acknowledge and agree that:

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

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

Signature:  **Date:** 10/6/14

Appendix C: Certificate of Completion of National Institutes of Health Training



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **John Vizzuso** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/13/2013

Certification Number: 1076017