2-22-2024

U.S. Health Care Leaders' Perceptions of a $15 Living Wage and Its Influence on Organizational Outcomes

Mary Trenice Richardson
Walden University

Walden University

College of Management and Human Potential

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Mary Trenice Richardson

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Review Committee
Dr. Christina Anastasia, Committee Chairperson, Management Faculty
Dr. Steven Tippins, Committee Member, Management Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

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by

Mary Trenice Richardson

MHRM, Keller Graduate School of Management, 2010

BS, North Carolina Central University, 1997

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

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February 2024

Abstract

In the United States, paying employees a living wage has been a salient topic for organizations, social advocacy groups, and politicians in recent years. Advocates have introduced a $15 per hour wage as an appropriate living wage. There is existing research on living wages; however, research is limited on perceptions of living wages among leadership in the health care industry. The purpose of this qualitative case study was to explore leaders' perceptions of a $15 living wage and its influence on organizational outcomes in the health care industry. The efficiency wage theory provided the theoretical framework for the investigation. A case study design was used. To answer the research question, interviews were conducted with a purposive sample of leaders at a health care organization. Data collected during virtual interviews were transcribed and analyzed using NVivo software. A thematic analysis was conducted, and results of the study showed that the participating leaders had an overall positive perception of implementing a $15 living wage but varied in their perceptions regarding the influence on organizational outcomes. Improved retention, increased salary budget, no impact on absenteeism, and decreased vacancy rates are some of the key themes that emerged. The recommendation is for future researchers to continue to explore the impact of implementing a $15 living wage in other industries. The findings may effect positive social change by providing human resource professionals, organizational leaders, politicians, and social advocacy groups with insight needed to guide future living wage legislation with the goal of eliminating poverty and the concept of the working poor.

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Dedication

My doctoral study is dedicated to Jesus Christ as without him and his love, grace, and mercy none of this would be possible. I would also like to dedicate this study to my loving and supportive family. First to my parents, George and Mary Hatfield, as a little girl I told my Daddy that I wanted to be the smartest person in the world and since that day he has encouraged and supported me through my educational journey. He always encouraged me to set goals, accomplish them, and to continue striving for ways to grow, develop, and learn. My mother has always provided a gentle nurturing love that gave and continues to give me the strength to persevere and overcome any obstacle. To my brothers, George Jr., Keith, Darrell, and Kevin for their encouragement and support. I watched my brother Keith fight and beat stomach cancer this year. His strength and perseverance during that journey let me know that I could accomplish anything. To my sisters, Trellis, Charlene, and Christine, words cannot describe what your support has meant me. Our sister texts or group calls have gotten me through a many hard days and your encouragement during this journey has been incredible and I will forever be grateful. To my nieces, nephews, stepchildren, great nieces, and granddaughter, I pray that this serves as an example that you can accomplish anything.

Last but definitely not least, to my loving husband Maurice, thank you so much for your support through this long journey. Your love, passion, and humor have been consistently encouraging. When I was ready to throw in the towel, your response was "absolutely not" I continued the journey and haven't looked back since that day. I love you and am so grateful for you and the love we share.

Acknowledgments

I want to acknowledge all of my family, friends, and colleagues that supported me during this doctoral study. It seems like every time I was stuck, I'd get a call, text, or email asking how's your dissertation going? I do not think any of you know how motivating and encouraging it felt to know that you all cared about my journey and were routing for me to be successful.

I also want to recognize my committee chair, Dr. Christina Anastasia, better known as Dr. A. My journey at Walden was not my first attempt at this goal. At the last university I got caught in the rigmarole between my chair, committee, and university reviewer. Each version of my proposal that one of them said was good to go, the others tore apart, and it resulted in me reaching max completion time and being unable to complete the journey there. There was one point in my Walden experience that I felt that things were going the same way, but Dr. A jumped in immediately reached out to the Dean advocating on my behalf and has provided unwavering support throughout this entire journey. Thank you, thank you, thank you! Additionally, I would like to thank Dr. Tippins, you joined my journey later on in the process and I have appreciated your support and guidance through it all.

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Chapter 1: Introduction to the Study

Article 23, Section 3 of the Universal Declaration of Human Rights states that "everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection" (United Nations, n.d.). The favorable remuneration described in the Universal Declaration of Human Rights has been noted to be directly tied to paying employees a living wage (Searle & McWha-Hermann, 2020). Although most can agree on the concept of a living wage designed to work towards the goal of eliminating the working poor (Adams, 2017; Werner & Lim, 2016), there has been debate in scholarship and practice related to what amount is an effective living wage (Reburn et al., 2018; Simonovits et al., 2019) and the effects paying a living wage has on employees and organizations (Brennan, 2019).

In the United States, advocates and politicians have introduced $15 per hour as an appropriate living wage (Chen, 2016; Dill & Hodges, 2019; Luce, 2017). Paying employees, a $15 living wage has been a hot topic for social advocacy groups and politicians in the country for over a decade (Wicks-Lim, 2016). Although a $15 living wage has not yet been adopted as federal legislation, leaders of many states, counties, cities, and organizations have moved forward with adopting strategic compensation guidelines that require paying a $15 living wage to employees (Brown, 2018; Paul Leigh et al., 2019; Reich et al., 2019; Romich et al., 2020). This includes organizations in the health care industry (Gooch, 2019) that are noted to be the largest and fastest growing in the United States (Hartz & Wright, 2019; Paul Leigh, 2019)

The $15 living wage is in some instances over 100% above the current minimum wage that organizations are currently paying their employees (Pollin & Wicks-Lim, 2016), and this additional cost will significantly increase organizations' salary budgets. With this increased cost, it is important that health care leaders have an understanding of how implementing a $15 wage living influences organizational outcomes. In reviewing the literature, I found little understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. In conducting this research, I sought to address that gap. The study's findings may influence discussions related to paying a living wage and maintaining an adequate level of health care staff for future needs and growth.

In Chapter 1, I will explain the background, problem, and purpose of this study. I will also explain the theoretical framework for the study. This chapter also includes the research question; definitions of key terms; and discussion of the assumptions, scope and delimitations, limitations, and significance of the study.

Background of the Study

The health care industry employed over 18 million workers in the United States (Prescott, 2015). With a projected growth of 3.8 million employees by 2024 (Prescott, 2015), the health care industry is noted to be the largest and one of the fastest-growing industries in the country (Hartz & Wright, 2019; Paul Leigh, 2019). In projecting this growth, forecasters have noted that several of the health care roles described as bright outlook careers are noted to pay less than the $15 living wage (Cooke, 2019; Hartz & Wright, 2019; Kinder, 2020). The focus on paying living wages to low-paid health care

employees also heightened during the COVID-19 pandemic as many of the health care positions that were deemed as essential were paid wages below the $15 living wage (Hecker, 2020; Kinder, 2020). The low wages, the predicted continued growth, and the struggle for qualified talent due to the pandemic may have been related to the "great resignation" (Vozza, 2021). The "great resignation refers to the period after the pandemic where many employees were leaving or thinking of leaving their jobs (Vozza, 2021). Because of this situation, health care leaders have worked frantically to ensure that strategic human resources practices are in place to recruit and retain top health care talent to meet the future needs of the industry (Kinder, 2020). If the health care industry does not meet the need for future growth, this could in turn affect U.S. citizens' and residents' future access to quality health care (Prescott, 2015). For these reasons, leaders of many health care organizations are adjusting their strategic compensation plans to include paying a living wage, but they are doing so without insight regarding how implementing the $15 living wage affects organizational outcomes in health care organizations.

The literature on paying a living wage in health care organizations illustrates that many health care workers are paid low wages (Hartz & Wright, 2019; Himmelstein & Venkataramani, 2019; Johnson, 2016). Health care employees are noted to directly contribute to the health and welfare of vulnerable populations while at the same time represent some of the lowest-paid employees in the United States (Hartz & Wright, 2019). Researchers have found that these low wages lead to employees' poor health due to lack of health insurance (Himmelstein & Venkataramani, 2019) and dependence on government welfare programs (Johnson, 2016). It is difficult for health care leaders to

ignore the issue of low wages (Mette & Loehrer, 2020; Paul Leigh, 2019). Many leaders are seeking to determine whether adjusting their compensation philosophy to pay a living wage is an appropriate business decision. Paying a $15 living wage is presented as a viable solution to address these issues, but there is no research, according to my review of the literature, which provides insight into the perceptions of leaders at a health care organization after a $15 living wage has been instituted. Having this insight may be useful for health care organizations whose leaders are considering the move to a living wage. This insight may also be useful if or when a $15 living wage is legally mandated.

There is a gap in the body of knowledge and understanding regarding leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. According to Kim and Jang (2019), although the existing research has focused on providing a general understanding of increased wages and the effect on overall employment, limited attention has been given to how specific industries that are highly sensitive to increased wages are influenced by the increases. Leadership perceptions have been explored in other industries such as hotel (Balasingam et al., 2020), restaurant (Repetti & Roe, 2018), retail/trade, and manufacturing (Romich et al., 2020). The existing research highlights recommendations for future research related to employee-related organizational outcomes such as productivity, engagement, and satisfaction (Repetti & Roe, 2018) and organizational outcomes like financial performance (Che Ahmat et al., 2019a). A study of the perceptions of leaders at a health care organization regarding their implementation of a $15 living wage and its influence on organizational outcomes may address this gap.

Problem Statement

In 2020 over half of the fastest growing occupations cited by the U.S. Bureau of Labor Statistics (2020) are occupations in the health care industry, and many of these roles pay below the $15 living wage proposal that social advocacy groups across the United States, such as the Fight for a Fair Economy Coalition, Working America, and the Occupy Movements, are suggesting that organizations pay to promote improved quality of life and work life for employees (Brown, 2018; Hirsch, 2018; Paul Leigh, 2019; Luce, 2017). The COVID-19 pandemic accentuated the importance of health care support, service, and direct care jobs, which are predicted to grow (Kinder, 2020). In 2020, the average compensation for employees in these roles was $13.48 (Kinder, 2020). The social problem was that many employees who are essential to health care operations are paid below the recommended living wage and as a result, many of these employees cannot afford basic necessities for their families (Adams, 2017). Approximately 20% of the employees in these roles in 2020 lived in poverty while over 40% relied on some form of public assistance (Kinder, 2020; Scales, 2020). The general problem is that although some leaders of health care organizations view paying a living wage as the right thing to do, they find paying a $15 living wage is extremely costly and sometimes unsustainable for their organizations (Brennan, 2019; Werner & Lim, 2016), specifically in health care where cost is a significant challenge (Barow, 2019). The specific problem is that even with these noted concerns, leaders of health care systems are implementing compensation philosophies that meet the social call to pay a living wage without an

understanding of how making the strategic compensation decision to implement a living wage influences organizational outcomes (Paul Leigh, 2019; Reich et al., 2019).

Purpose of the Study

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. I gathered data by interviewing leaders at a health care organization whose leadership had implemented a $15 living wage. This project is unique as it addresses the under researched area of leadership perspectives on the influence of a living wage implementation at a health care organization. This perspective has not been addressed in the previous research on this topic (Repetti & Roe, 2018; Rotea et al., 2018).

Research Question

How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry?

Theoretical Foundation

The principles of the efficiency wage theory provided the theoretical framework for this study. A premise of the efficiency wage theory is that organizations pay employees wages higher than the market rate with the goal of increasing employee productivity (Akerlof, 1982; Yellen, 1984). Efficiency wages and employee productivity are the two key components of the efficiency wage theory, and these elements are often tied directly to organizational outcomes (Morris Morant & Jacobs, 2018).

There are a variety of assumptions that underpin the efficiency wage theory (Akerlof, 1982; Yellen, 1984). Key assumptions are that paying efficiency wages decreases employee shirking, minimizes turnover, attracts quality candidates, increases productivity, and improves overall employee health (Weltmann, 2019). These assumptions have led to various models of the efficiency wage theory, such as the gift-exchange model, the fair wage effort model, the adverse selection model, the turnover model, and the shirking model. Researchers developed these models to explore how paying an efficiency wage motivates employees at work; the models highlight the potential benefits of paying efficiency wages and their effects on organizational outcomes (Tomohara & Ohno, 2013).

The research question—How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry? —deals directly with the facets of the efficiency wage theory. The $15 living wage which is higher than the market rate for entry-level positions in health care represents the efficiency wage, and the assumptions that paying an efficiency wage may decrease shirking, decrease turnover, improve candidate quality and employee health are elements that affect organizational outcomes. Understanding the ways in which efficiency wages influence organizational outcomes was the focus of my research question and was used to guide the thematic analysis of the data. An exploration of the theoretical foundation and current literature will be covered in more detail in Chapter 2.

Nature of the Study

To address the research question in this qualitative study, I used a case study design that involved interviews with leaders at a health care organization whose leadership had implemented a $15 living wage. The data collected using semistructured interviews were used to guide this qualitative analysis to meet the goal of improving the understanding of health care leaders' perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry.

I drew from the work of Marshall and Rossman (2011), who described qualitative research as a broad emerging and evolving approach that involves studying social phenomena as they occur in a natural setting, focusing on context and drawing on multiple methods. Qualitative research allows the researcher to provide an in-depth understanding of ideas, concepts, and concerns related to people and organizations (Van den Berg & Struwig, 2017). A researcher who uses case study methodology gathers multiple sources of data to examine a bounded system over time to gain insight into a program, individual, activity, or event (Tasci et al., 2019). Case studies are built on the researcher's desire to obtain an in-depth understanding of the case in real-world situations (Yin, 2018). The focus of a case study is to gather and analyze data to gain a better understanding of the topic (Hayes et al., 2015). The goal of case study research in business and management is to produce new knowledge concerning a case that is related to events and processes taking place in organizational settings (Mills et al., 2010). The purpose of this study was to gain a better understanding of a compensation practice that

was initiated within an organization, and a case study design was the most appropriate method to achieve that purpose.

I conducted semistructured interviews to collect data. For the semistructured interviews, I recruited a purposeful sample of 10 leaders at a health care organization who had experienced a $15 living wage adjustment. I conducted individual, semistructured interviews with the selected sample. Semistructured interviews were selected because they give the researcher flexibility as the interview is conducted; the researcher is able to compare the participants' responses and at the same time, gain insight to each participant's unique experiences (Mills et al., 2010). I developed the interview protocols to address the problem and purpose of the study. The protocol involved drafting interview questions that aligned with the problem and purpose and creating a pre and post interview script that included informed consent and prompts to ensure that the interviews flowed appropriately and remained on topic (Jacob & Furgerson, 2012). The interviews were recorded. NVivo was used to transcribe, organize, and analyze the data to search for patterns and emergent themes.

The data included the recorded responses to interview questions regarding how participating leaders perceived paying a $15 living wage and its influence on organizational outcomes in a health care organization. The goal of achieving data saturation from the interviews was met with the 10 leaders who participated in the interviews. Data saturation occurs at the point in which there is no new themes or information resulting from the interviews (Boddy, 2016), and in qualitative research data saturation determines the ultimate sample size (Goodman et al., 2020). The data collected

during the interviews provided triangulation and supported a comprehensive understanding of leaders' perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry.

Definitions

The following terms and definitions will be used throughout the study:

Compensation philosophy: An overarching statement aligned with the mission, vision, and values that guide an organization's compensation resources and practices (Weinberger, 2010).

Compression: A situation in which employees with more experience make the same as or less than employees with less experience; compression also occurs when employees in leadership roles make the same as or less than their direct reports (Steward, 2020).

Efficiency wages: Wages that are set higher than the market-determined rates for a position with the goal of increasing employee efficiency (Morris Morant & Jacobs, 2018).

Living wage: The minimum income necessary for an individual to meet the minimum standard of living in the individual's community or region based on the typical expenses (Glasmeier & MIT, 2020; Reburn et al., 2018).

Market rate: The rate that aligns with the market average rate for a specific job (Martocchio, 2013).

Minimum wage: The lowest hourly amount an organization can pay an employee for work (Mattingly & Mattingly, 2019). At the time of this study, the minimum wage in the United States was $7.25 (U.S. Department of Labor, 2020).

Shirking: A term that refers to an employee underworking or not meeting productivity standards or guidelines (Antosz et al., 2020).

Assumptions

Assumptions are things that are believed to be or accepted as true. In qualitative research, the key philosophical assumption is that reality is constructed by individuals' interactions in their own social worlds and that meaning is set based on these experiences and mediated through the researcher's perceptions (Santosh, 2021). Based on these definitions, for this study I assumed that the responses from the health care leaders who participated in the study would be true and honest. I also assumed that the participants' responses would be useful in providing details that would further understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. Another assumption I made was related to my sample size, as I assumed that I would be able to recruit the adequate number of participants needed to reach data saturation. The use of a qualitative case study design allowed me to explore through semistructured interview questions the perceptions of leaders who had experienced a $15 living wage adjustment. I was also able to gain an understanding of how participating leaders perceived influence of the $15 living wage adjustment on organizational outcomes in the health care industry.

Scope and Delimitations

The scope of this study was delimited by a number of factors. Delimitations in research refer to decisions made by a researcher before beginning a study that affect the study's scope (McGregor, 2018). I used a qualitative case study design to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. The leadership of the target health care organization had implemented a $15 living wage. I selected the health care organization as the research site for this reason. Semistructured interviews were conducted with a purposive sample of leaders at the health care organization. A purposive sample was selected to ensure that the participants were all leaders at a health care organization whose employees were directly affected by the $15 living wage adjustment. The size and scope of this study may limit its transferability, but the goal is that the findings may provide useful information for the leaders of other organizations (health care and other industries) who are considering implementing a $15 living wage.

Limitations

Unlike the delimitations explained in the Scope and Delimitations section, limitations are factors that are beyond the control of a researcher and that represent potential weaknesses of a study (McGregor, 2018). A potential challenge of this study was researcher bias. I am a human resource professional and at the time of the study, I had been working in the profession for over 15 years. To eliminate the potential for bias, I strove to be objective to ensure that the research was not marked by personal prejudice or values (see Kakabadse et al., 2002). To ensure an objective approach, I only

considered leaders whom I do not work with directly as participants for the study. I also selected participants from various areas throughout the system to ensure that the sample represented the entire organization. I believe that utilizing these practices reduced the potential for researcher bias.

Another limitation to this study was timing. Leaders at the target organization implemented a $15 living wage in 2018. The COVID-19 pandemic introduced major challenges in the health care industry, which may have made it difficult for the participants to determine whether any fluctuations in organizational outcomes since 2018 were related to the pandemic or the living wage. To reduce this limitation, I ensured that the interview protocol and questions included prompts to remind the leaders to only provide details regarding their perception of how the $15 living wage influenced organizational outcomes.

Significance of the Study

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. This study is significant in that it could make an original contribution to theory and practice by increasing understanding of leadership perceptions of implementing a $15 living wage and its influence on organizational outcomes. Previous researchers have not examined health care leaders' perspectives after implementing a living wage at their organization (Repetti & Roe, 2018; Rotea et al., 2018). With the existing research noting the potential negative impacts of the loss of work hours, increased health care costs, and loss of fringe benefits (Himmelstein & Venkataramani, 2019), this insight is important to

ensure that health care leaders and their human resource partners have the knowledge needed to determine whether implementing a living wage is appropriate for their organization.

Significance to Theory and Practice

To meet the social call to pay a living wage, leaders of several health care organizations have either implemented or have plans to implement a living wage (Boulton, 2018; Gooch, 2019). This choice is being made at a time when this decision is difficult for many health care organizations as the increasing cost of health care staff is listed as one of the top concerns for hospital executives (Barow, 2019) and compensation represents one of the largest organizational costs (Che Ahmat et al., 2019a). The findings of this study may influence human resource professionals and leaders regarding their decision to implement a living wage.

Significance to Social Change

At the time of this study, the $15 living wage was a heavily debated social initiative (Adams, 2017; Brennan, 2019; Brown, 2018; Lesica, 2018). This study may increase awareness regarding the impact implementing a living wage has on organizational outcomes. Advocates for paying a living wage have focused on the potential positive impact that implementing a living wage may have on employees (Paul Leigh, 2019) whereas the research from an organizational perspective have often presented negative impacts (Brennan, 2019; Himmelstein & Venkataramani, 2019). Organizational leaders and policy makers who are considering whether to implement a living wage need greater understanding of whether implementing a living wage affects

organizational outcomes, as perceived by business leaders. My research may provide that insight and contribute to positive social change.

Summary and Transition

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. In conducting this study, my goal was to address the lack of research on the study topic. To address this gap in the literature, I utilized a case study approach to explore the perceptions of leaders who had implemented a $15 living wage at a health care organization. In this chapter, I presented the background of the study; problem and purpose statements; research question; theoretical foundation; nature of the study; definitions; and assumptions, scope and delimitations, limitations, and significance of the study. In Chapter 2, I will review the current literature on living wages, including historical information, arguments for and against, and the relationship of living wages with organizational outcomes. I will also provide an in-depth explanation of the theoretical framework and its applicability to this study.

Chapter 2: Literature Review

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. In this chapter, I review historic and current research on living wage in the health care industry, the theoretical framework, compensation strategies, and organizational outcomes in health care. I gathered materials for this literature review from Academic Search Complete, Business Source Complete, CINAHL Plus, Education Source, Emerald Insight, ERIC, Hospitality & Tourism Complete, Political Science Complete, PsycARTICLES, PsycINFO, Science Citation Index, Social Sciences Citation Index, ScienceDirect, and SocINDEX.

Literature Search Strategy

The search words I used included *$15, $15 living wage*, *compensation*, *efficiency wage theory*, *entry-level healthcare workers*, *Fair Labor Standards Act*, *healthcare*, *human resource management*, *issues in healthcare*, *living wage*, *low wage healthcare employees*, *minimum wage*, *organizational outcomes in healthcare*, and *working poor*. The process of gathering the literature included the use of peer-reviewed journal articles, books, and trade resources. The literature review consists of 137 sources, of which 102 (74%) are peer-reviewed articles and 63 peer-reviewed articles (63%) have a publication date less than 5 years from my anticipated graduation date of 2023. This study contains a total of 200 sources, of which 106 (53%) have publication dates within the last 5 years, substantiating that 53% of the total sources have a publication date 5 years or less from my expected graduation date.

Theoretical Foundation

In reviewing the available literature on living wage and organizational outcomes, I concluded that the efficiency wage theory (Morris Morant & Jacobs, 2018) would provide the best theoretical foundation for this study. According to the premises of the efficiency wage theory, organizational leaders are willing to pay wages higher than the market-clearing ranges with the goal of increasing employee productivity and effort (Akerlof, 1982; Yellen, 1984). The efficiency wage theory promotes a compensation philosophy that is based on compensating employees with wages above the market equilibrium to impact how the organizations' employees are motivated at work (Simpson, 2018). The term *efficiency wage* was initially introduced by Marshall (1920) to describe organizations paying the most efficient employees more and the less efficient employees less. This concept resulted in the organization having no preference between the low- and high-efficiency employees as it was deemed that each employee was paid their worth and performed at the appropriate level supported by their pay (Marshall, 1920). Over time, a more modern definition of the term has developed that defines efficiency wage as wages that are set higher than the market-determined rates for a position with the goal of increasing employee efficiency (Morris Morant & Jacobs, 2018).

The basic components of the efficiency wage theory, efficiency wages and employee productivity, are two key elements that can be directly tied to organizational outcomes. In some of the earlier literature on the efficiency wage theory, Katz (1986) posited that employee productivity depends positively on employee wages. According to Morris Morant and Jacobs (2018), there are two schools of thought on efficiency wages.

The first discussed by Webb and Webb (1902) indicates that efficiency wages improve productivity, increase aggregate trade, and raise the standard of living without cost to the organization or disadvantage to the community. The second school of thought has been presented by various scholars in the seminal literature and suggests that involuntary unemployment is also a result of paying an efficiency wage (Akerlof & Yellen, 1986; Salop, 1979; Yellen, 1984). These two schools of thought illustrate the complexity of the efficiency wage theory as it predicts outcomes that can be viewed as both positive and negative to organizations and the community. The variety of assumptions of the efficiency wage theory supported this theory as an appropriate theoretical foundation for this study of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry.

Models Stemming From the Efficiency Wage Theory

According to Weltmann (2019), there are five reasons for the existence of the efficiency wage theory: (a) avoid shirking as employees work harder to remain employed, (b) minimize turnover as employees are happy with their pay and recognize that their organization pays more than the market rate, (c) improve adverse selection as organizations that pay the higher wages attract top candidates, (d) encourage gift exchange as the higher wages are noted to increase employee morale which in-turn increases productivity, and (e) support nutritional theories that indicate that the higher pay gives employees the ability to eat better which in-turn improves the overall health of the employee positively affecting employee productivity and decreasing health care cost. As the analysis of the efficiency wage theory has evolved over the years, these five

frames of thought have led to the introduction of several models built upon efficiency wage theory. Some of the frequently noted models are the gift-exchange model, the fair wage effort model, the adverse selection model, the turnover model, and the shirking model.

Akerlof (1982) developed the gift-exchange model, which emphasizes that organizations are rewarded by employee reciprocity. Reciprocity indicates that employees will see the higher wages as a gift and in turn return that gift to the organization with higher effort and productivity (Kong et al., 2020). Under the gift exchange model, both the organization and the employee benefit from the exchange. Akerlof and Yellen's (1990) fair wage effort model is based on the social exchange theory in sociology and the equity theory in psychology (Akerlof & Yellen's, 1990 as cited by Sugiyama & Saito, 2016). In this model, employee effort and productivity depend on how employees perceive the fairness of their wages (Palley, 1994). The fair wage effort model assumes that employees have knowledge of the fair wage for their position (Sugiyama & Saito, 2016). With that knowledge, if employees perceive their wages as fair the fair wage model predicts that productivity will increase and if the wage is not perceived as fair, productivity will decrease (Arocena et al., 2011). The adverse selection model predicts that organizations that pay higher wages attract top candidates (Malcomson, 1981; Weiss, 1980). In this model, organizational leaders use higher wages as a way to sort out low-quality employees from high-quality employees when quality is difficult to observe (Altonji, 1986). According to Weiss (1980), in the presence of adverse selection the quality of an organizations' employees is directly related to the

wages paid. Organizations recognize the benefits of offering efficiency wages and stay away from providing lower wages because offering the higher wage is noted to increase productivity and reduce cost (Burki, 1995). The turnover model of the efficiency wage theory is built upon the premises of organizations paying efficiency wages to decrease involuntary turnover and the associated cost to the organization such as advertising and training (Stiglitz, 1974). In this model, the number of employees who quit the organization is very low due to the efficiency wages that the employees are paid (Altonji, 1986). As in the other models, employees see their higher wages as a positive, which affects their commitment to the organization.

These models are built around determining what motivates employees at work. Work motivation is frequently noted to affect organizational performance (Tomohara & Ohno, 2013). The efficiency wage theory and the potential organizational outcomes predicted in these models—increased productivity, lower vacancy rates, reduced shirking, and decreased turnover —illustrate the variety of ways in which the efficiency wage theory can explain how paying efficiency wages affects organizational outcomes. Of the frequently used models of efficiency wages, I opted to use the shirking model because I thought it would allow me to achieve a greater level of understanding regarding leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry.

The Shirking Model of Efficiency Wages

Shapiro and Stiglitz (1984) introduced the shirking model of efficiency wages, which emphasizes the payment of efficiency wages to discourage shirking at work (Chua

et al., 2014; Giménez et al., 2018). Shirking at work refers to an employee underworking or not meeting productivity standards or guidelines (Antosz et al., 2020). The shirking model has three assumptions: (a) organizations require increased effort from employees to meet or exceed production standards, (b) an employee's effort is perfectly observable, and (c) organizations terminate employees who provide less than the required effort (Alexopoulos, 2003). In the shirking model, employees are motivated to work hard to avoid dismissal (Tomohara & Ohno, 2013).

Raff and Summers (1987), in one of the most cited articles on efficiency wages (Taylor, 2003), utilized the efficiency wage theory and referred to employee shirking in their examination of Henry Ford's decision to introduce the $5 per day wage in 1914. Henry Ford's decision to pay the $5 per day doubled the wages for the majority of the employees at the Ford Motor Company and was implemented as a remedy to improve turnover rates, employee morale, and productivity (Raff & Summers, 1987). Employee shirking was a major part of this decision as this decision could have had a negative impact on organizational financial performance if the employees were paid the higher rate and employee production stayed the same or decreased (Raff & Summers, 1987).

In a later study, Alexopoulos (2003) also referred to the shirking model of efficiency wages to explore the relationship between growth and unemployment. Alexopoulos determined that shirking did decrease as a result of paying an efficiency wage, resulting in termination of shirkers as well as decreasing employment as the productivity was maintained by the employees who did not shirk, thus eliminating the need to replace the shirkers. Although they are positive for an organization, efficiency

wages have a negative effect on the economy as they reduce the long-run economic growth rate (Alexopoulos, 2003). Tomohara and Ohno (2013) also utilized the shirking model to explore how employees responded to both monetary and non-monetary awards. In their examination of various work incentive models, Tomohara and Ohno found the shirking model to be ineffective as it only resulted in increased productivity when there were rules in place that resulted in the termination of employees that shirked. If the employees who shirked were allowed to remain employed and paid the efficiency wages, this would result in an increased cost for the organization negatively affecting the bottom line. To decrease the potential for the increased cost, Tomohara and Ohno suggested that monitoring be used to effectively manage and remove shirkers.

The Efficiency Wage Theory in Living Wage Literature

The efficiency wage theory has been presented in the existing literature as a method of exploring the effects of a living wage or increased minimum wages. Aligning with the definitions provided earlier, the literature utilizing the efficiency wage theory produced a variety of outcomes. Álvarez and Fuentes (2018) utilized the efficiency wage theory to analyze the effects of minimum wage increases and the cost of terminating employees on firm-level total factor productivity. In this study, it was found that large increases in the minimum wage had a negative impact on the firms' total factor productivity and that this negative effect was stronger in sectors with higher exposure to minimum wage (Álvarez & Fuentes, 2018). In a study examining the effects of increased minimum wages and retirement Borgschulte and Cho (2020) utilized the efficiency wage theory to explore whether or not the theory which predicts increased productivity forces

older workers into retirement because of their inability to keep up with the increased productivity standards. Borgschulte and Cho found that increased minimum wages did not force older workers into retirement and higher minimum wages had positive effects on the supply of older works. The efficiency wage theory was also presented by Reich et al. (2019) in the exploration of the effects of implementing a $15 minimum wage by 2024 in the United States and Mississippi. Reich et al. predicted that the move to the $15 minimum wage would result in substantial benefits for low-wage workers while only increasing wage cost for organizations by 0.6%.

In addition to the studies that have focused on the efficiency wage theory, there are several articles that utilize the efficiency wage theory in combination with other theories. The efficiency wage theory was utilized along with the basic competitive model and the monopsony model by Ferraro et al. (2018) in their assessment of the effects of increases in the Estonian minimum wage in 2013-2016 on the probability of workers at different wage levels retaining employment. The justification for using this combination of models was based on the conflicting predictions that are presented by each component (Ferraro et al., 2018). When minimum wages are increased the competitive model predicts declines in employment, the monopsony model predicts increases in employment if the increase prevents the organizations from exploiting market power, and the efficiency wage model predicts reduced shirking and increased productivity (Ferraro et al., 2018). In their study Ferraro et al. (2018) found that minimum wage adjustments had little to no effect on employee retention. Fahimullah et al. (2019) utilized the efficiency wage theory and the monopsony model to estimate the economic impact of the $15 living

wage policy and how the District of Columbia's earned income tax credit (EITC) interacts with the higher minimum wage. Fahimullah et al. predicted that a higher minimum wage would significantly increase the wage of the city's low-income employees with few job losses as well as reduce the EITC which would be offset by the increase in wages.

The existing research on minimum and living wage increases utilizing the efficiency wage theory illustrates the variety of outcomes in the existing studies based on this theory. Even with the existing research Yao et al. (2017) indicated that the research on the living wage based on the premises of the efficiency wage theory was underdeveloped. A gap in the literature is also noted in the body of knowledge and understanding regarding leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. According to Kim and Jang (2019) while the existing research has focused on providing a general understanding of increased wages and the effect on overall employment, limited attention has been given to how specific industries that are highly sensitive to increased wages are influenced by the increases. In this study health care organizations are listed as organizations that are sensitive to wage increases (Kim & Jang, 2019). Leadership perceptions have been explored in other industries such as hotel (Balasingam et al., 2020), restaurant (Repetti & Roe, 2018), retail/trade, and manufacturing (Romich et al., 2020), but there are no existing studies that explore leaders' perceptions in the health care industry. Utilizing the efficiency wage theory to fully explore the understanding of

leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry will assist in filling these gaps.

Literature Review

The Concept of a Living Wage

Strategic human resource management is the practice of utilizing the systems aimed at enhancing and motivating employees to support the strategic goals of an organization (Al-Ayed, 2019). The decision to pay a living wage is a key decision in an organizations' compensation philosophy, and the compensation philosophy is a component of an organizations' strategic human resource plan. Utilized for the first time in the 1800s, scholars and activist used the term living wage to mandate that organizations pay employees enough to support themselves and their families (Luce, 2012). The concept of a living wage was introduced in the United States in the 1930s by Franklin D. Roosevelt (Adams, 2017) and was implemented with the goal of eliminating poverty and the concept of the working poor by offering a wage that provides both quality of life and work-life not only economic sustenance (Carr et al., 2016; Harris et al., 2018; Yao et al., 2017).

The term *living wage* has been represented by several definitions in the literature, all built around eliminating poverty and improving quality of work and life. According to Calleja (2019) quality of life consists of 11 dimensions, housing and quality employment, employment and quality working life, savings – wealth and assets, social relationships, leisure and spare time activities, physiological well-being, religion and spiritual life, information and knowledge, government performance, and political participation. Carr et

al. (2018) indicated that a living wage theoretically enables individuals to escape poverty through qualitative improvements in quality of life and work beyond a set income. According to Devinatz (2013), a living wage is based on the notion that individuals working full-time jobs should not live in poverty and is an estimation of the official poverty threshold for a family of four. Gardella (2020) posited that the idea of a living wage is that the living wage would provide an individual with an income that allowed the individual to sufficiently support a spouse and children. In another similar definition Hirsch (2018) indicated that the concept of living wage links an individual's hourly pay rate with the standard of living obtained by that individual and their household. Wells (2016) takes another approach to the definition and indicates that employees should have the means and leisure time to meaningfully participate in the civic life of their community. The overall concept of a living wage links an employee's pay rate to the standard of living attained by the employee or the employee's household (Hirsch, 2018).

While all of the definitions are fairly similar the specific amount that is deemed to be the living wage can potentially vary and there are also definitions that address the amount of the living wage. According to Devinatz (2013), a living wage is based on the notion that individuals working full time jobs should not live in poverty and is an estimation of the official poverty threshold for a family of four. Glasmeier and MIT (2020) and Reburn et al. (2018) take that definition and step further and refer to a living wage as the minimum income necessary for an individual to meet the minimum standard of living in the individuals' community or region based on the typical expenses. Of these two definitions the definition presented by Glasmeier and MIT and Reburn et al. appears

to provide the most precise calculation, as in addition to the poverty threshold the calculation also includes typical household expenses such as housing, food, medical bills, childcare, transportation, and taxes.

The initial implementation of a living wage was introduced through the federally mandated minimum wage, but over time a significant gap has developed in the federal minimum wage and a wage that is considered to be a living wage (Reburn et al., 2018). With this gap and the push from social and political organizations to pay a living wage human resource professionals and organizational leaders are finding themselves at a crossroads where a strategic decision has to be made in regard to compensation; continue to pay the minimum wage mandated by the federal government or pay a living wage (Brennan, 2019). According to Ford and Deptula (2019), organizational leaders are currently faced with a strategic opportunity to address the living wage issue or risk being forced to implement a living wage due to new legislation or pressures from the external market.

Minimum Wage Versus Living Wage

Over time the terms minimum wage and living wage have started to merge blurring the lines between minimum and living wage campaigns (Luce, 2015). These blurred lines support the importance of having a solid understanding of the differences. The minimum wage is the lowest hourly amount an organization can pay an employee for work (Mattingly & Mattingly, 2019). The federal minimum wage in the United States was implemented in 1938 as a part of the Fair Labor Standards Act (FLSA) at a rate of $0.25 per hour (Adams, 2017). Along with minimum wages the FLSA also established

guidelines surrounding overtime pay, record keeping, and youth employment standards for private sector, federal, state, and local government employees (U.S. Department of Labor Statistics, n.d.). The minimum wage was implemented with the goal of stabilizing the economy by securing stable wages and work environments that were destroyed during the Great Depression (Kim & Jang, 2019). To date, the FLSA is noted to be the most far-reaching and far-sighted program implemented for the benefit of employees ever adopted in the world (Reich, 2015).

In regard to the progression of the federal minimum wage, the minimum wage has increased 22 times since the implementation of the FLSA (Perez, 2015). The FLSA initially increased the minimum wage whenever inflation caused the real value to fall below the poverty line for a family of three, but these increases took a turn in the 1980s (Klassen, 2020). In the 1980s it was noted that the minor increases over the years, resulted in a minimum wage that was slightly above the poverty line for a single person with no children (Klassen, 2020; Reich, 2015). After a 10-year battle in Congress on whether or not to increase the minimum wage, the Fair Minimum Wage Standards Act of 2007 was implemented to address the issue of the significant increase in the cost of living and the eroding value of the federal minimum wage (Democratic Policy Committee, 2007). The Fair Minimum Wage Standards Act amended the FLSA and gradually increased the federally minimum wage from $5.15 per hour to $5.85 in 2007, to $6.55 in 2008, and to $7.25 in 2009 (Fair Minimum Wage Act of 2007, 2007). The increase in 2009 was the last adjustment to the federal minimum wage.

The lack of minimum wage adjustments does not represent a lack of interest in adjusting the minimum wage to more closely align with a living wage. Like the 10-year battle that occurred before the implementation of the Fair Minimum Wage Standards Act of 2007, there are many battles currently occurring in the United States working towards paying American workers a living wage. There have been several bills introduced to bring the federal minimum wage closer to the living wage, including one during the Obama administration that would have incrementally increased the minimum wage to $12.00 by 2020 with automatic increases annually thereafter (Perez, 2015). The plan proposed by President Obama initially received interest during his campaign for President, but the interest in the proposal dwindled as a result of the economic downturn that occurred during the Great Recession of 2007 to 2009 (Devinatz, 2013; Luce, 2017). With many organizations still struggling from the downturn of the economy, the legislature found it difficult to implement mandates to increase wages at a time when organizations were already struggling financially (Luce, 2011). Living wage conversations in the government decreased during the Trump administration but gained steamed during the Trump/Biden election and are still heavily debated to date.

Similar resistance was noted before the FLSA was implemented based upon the principle of liberty in contract as the government did not want to interfere in the business decisions of organizations (Klassen, 2020). The principle of liberty in contract is still at play today as there is still a healthy debate on whether it is the organizations' duty to pay a living wage. Arguments exist that indicate that living wages should come from the government in terms of decreased income taxes, increased earned income credits, or other

forms of welfare payments (Brennan, 2019), while others believe organizations have a moral and ethical duty to pay living wages (Adams, 2017; Butner, 2019).

While the debate on whether or not to increase the minimum wage to more closely align with a living wage has been stagnated based on the competing views in the social, political, and economic arenas many state governments have made the decision to move forward with paying wages that more closely represent a living wage (Luce, 2015). The federal minimum wage is the minimum threshold that an organization is legally required to pay employees, but many states have utilized their state legislative power to implement state mandated minimum wages (Luce, 2017). There are currently five states with no state minimum wage laws, Alabama, Louisiana, Mississippi, South Carolina, and Tennessee (U.S. Department of Labor, 2020). Sixteen states, Georgia, Iowa, Idaho, Indianan, Kansas, Kentucky, North Carolina, North Dakota, New Hampshire, Oklahoma, Pennsylvania, Texas, Utah, Virginia, Wisconsin, and Wyoming that currently align their minimum wage with the federal minimum wage (U.S. Department of Labor, 2020). The remaining 29 states and the District of Columbia have implemented a minimum wage higher than the legal minimum wage and at an amount that more closely aligns with the calculated living wage for the geographical area. Those states are Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Massachusetts, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, Nevada, New York, Ohio, Oregon, Rhode Island, South Dakota, Vermont, Washington, and West Virginia (U.S. Department of Labor, 2020). The District of Columbia currently has the highest minimum wage at $15.00 per hour, Washington has

the next highest at $13.50 per hour, and Massachusetts is third at $12.75 per hour (U.S. Department of Labor, 2020).

The Living Wage Movement in the United States

The modern United States living wage movement launched in 1994 in Baltimore, Maryland (Devinatz, 2013; Hannan et al., 2016; Harris et al., 2018; Luce 2017). A group of pastors called the Baltimoreans United in Leadership Development running a food pantry noticed that many individuals that utilized the services of the pantry were employed but poor (Devinatz, 2013). This issue greatly concerned the pastors, and they joined the American Federation of State, County, and Municipal Employees (AFSCME) and the Baltimoreans United in Leadership Development (BUILD) (Hannan et al., 2016). Together these groups formed a local living wage campaign that they used to pressure the mayor to develop a plan to address the issue of the working poor (Hannan et al., 2016). This pressure resulted in an ordinance that set a living wage of $7.25 for any organization holding a service contract in the city of Baltimore (Luce, 2017). This wage was introduced 15 years before the federal minimum wage increased to $7.25. While this ordinance only affected a small number of workers the success of the living wage movement in Baltimore energized other living wage activists across the United States (Devinatz, 2013; Luce, 2002; Luce 2017). The living wage movement in Baltimore set the blueprint for future living wage campaigns as it forced the official recognition that the federal minimum wage was no longer effective for alleviating poverty (Devinatz, 2013; Evans, 2017). Similar to the living wage campaigns in Baltimore the other living wage campaigns across the United States were also led by activists and they utilized tools such

as protests, media, public education, and rallies to lobby elected officials to mandate living wages (Luce, 2017). The living wage movement in the United States is considered to be broad and dynamic as the movement was coherently organized and included support from coalitions such as anti-racism, unions, immigrants' rights, women's rights, and various economic justice groups (Evans, 2017). The living wage movement raised awareness and initiated discussions and education about the negative effects of wage inequality in the United States (Devinatz, 2013). Even with the diversity of the coalitions leading the living wage movements, the results of the majority of living wage movements had several common features: adoption at the city or county level, setting a living wage rate that was considered sufficient to provide a minimum standard of living, included provisions that organizations pay higher wages if health insurance is not provided, and the ordinances only extended to a certain subset of employees i.e. employees in public jobs (Sosnaud, 2016).

The living wage campaigns in the United States were fairly successful, between the years of 1994 and 2010, with over 140 cities and counties passing living wage ordinances (Evans, 2017) that set the minimum wage to the federal poverty line for a family of four with annualized indexed increases (Devinatz, 2013; Luce, 2017). While these campaigns were beneficial to the living wage movement, there were still several concerns regarding the success of the movement across the nation. One of the major concerns was that the movements did not affect the federal minimum wage and therefore only affected a small portion of workers in the United States (Devinatz, 2013; Luce, 2017). Another concern was setting the living wage based on the poverty level, advocates

believe that the formula for calculating the living wage should have been based on more complex formulas that included expenses such as housing and transportation (Luce, 2017). Even with these concerns, the living wage campaigns persisted as the groups viewed the success as a complementary step to increasing the federal minimum wage and assisted to build employee power for fighting for living wages (Luce, 2017). The living wage campaigns in the United States remained strong for over a decade but struggled to maintain momentum when the nation was hit by the economic crisis of 2008 (Luce, 2017).

The Campaign for a $15 Living Wage

As the economy recovered from the economic crisis the living wage movements began to reemerge in the United States. In 2011 the Occupy Wall Street Movement emerged as a catalyst for renewing living wage campaigns with a focus on the issues of economic inequality and political democracy around the world (Luce, 2015). Wage inequality has been a long-term issue in the United States. According to Devinatz (2013) between 1973 and 2007, the average income for top earners in the United State grew by $30 million while the average income for the lowest earners only grew by $286. More recent research by Ford and Deptula (2019) continues to illuminate the issue and provided statistics that described a 233% increase in the income of the top wage earners in the United States with the incomes of the low wage earners increasing by only 32% between 1979 and 2015. It is also noted that in the United States the ratio of the average salary of an employee to CEO has grown from 20:1 in 1965 to 311:1 in 2017 (Ford & Deptula, 2019). These statistics are an example of diminished social fairness in the

United States and illustrate the need to reduce the wage gap between the poor and the rich (Peters & Volwahsen, 2017). These issues fueled the Occupy Wall Street Movement and led to protests that erupted all over the nation focusing on ending poverty wages (Wells, 2016). The momentum from the Occupy Wall Street Movement spurred the Fight for $15 Campaign which launched with a day of protests in 2012 with over 100 fast-food workers in New York City walking off of their jobs to strike for higher wages and better working conditions (Brown, 2018; Chen, 2016; Luce, 2015). The protest in New York resulted in a state law that implemented a $15 minimum wage by the end of 2019 (Luce, 2017). The success of these protests gained momentum moving from New York to other states across the United States and to low-paid workers in other industries such as health care, retail, and academia (Chen, 2016; Wells, 2016). The Fight for $15 Campaign has now expanded to more than 300 cities in the United States and 60 countries around the world on six different continents (Fight For $15, n.d.).

The $15 living wage is an increase of greater than 100% than the current federal minimum wage, $7.25 (Wicks-Lim, 2016). This large increase prompts many to ask why $15. There are several justifications behind the choice to make $15 the amount of the living wage. According to Luce (2015), the $15 rate was determined during a meeting of fast-food workers to decide on the groups' demands (Luce, 2015). Luce (2015) quoted Kendall Fells a member of the group stating that the group felt that New York City's current $10 living wage was too low but also felt that $20 would be too big of an ask so they decided to go with $15. Around this same time frame, the union at the Seattle Airport was working to negotiate higher wages (Luce, 2017). The organizers in the union

selected $15 as that rate was slightly higher than the $13 and $14 per hour living wage ordinances that were already in place for airport workers on the west coast (Rolf, 2016). Based on this scenario the $15 living wage was set with no math or economic formulas to support it (Luce, 2015). The lack of a formula to set the $15 rate serves as fuel for many opponents of the $15 living wage (Wicks-Lim, 2016). However, this method is similar to what was used in the implementation of the FLSA as the minimum wage was executed without prescribing an algorithm to determine the wage (Calandrillo & Halperin, 2017).

Even without a mathematical formula or prescribed algorithm, the $15 wage has gained momentum and is being promoted as the appropriate living wage rate for the United States. To date, $15 minimum wage mandates have been implemented in seven states; California, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, and New York, as well as in the District of Columbia (Ballard et al., 2019), with legislation in progress attempting to follow suit in many other states (Ford & Deptula, 2019). Absent of legislation many cities, towns, and organizations are moving forward with implementing $15 living wage policies. According to Romich et al. (2020) since 2012 over 30 cities and counties in the United States have implemented minimum wages higher than the federal minimum wage, with wages at the $15 rate being implemented in large urban centers such as Chicago, Los Angeles, New York City, San Francisco, and Seattle. Brown (2018) discussed the expansion of the implementation of a living wage outside of the large urban centers and examined cities in the southern United States, such as Durham and Greensboro in North Carolina and Richmond in Virginia, where $15 living wages were

implemented for some positions. The wide variety in where the $15 living wage is implemented illustrates its popularity across the United States.

In regard to organizations, one of the most popular organizations that has implemented a $15 living wage is Amazon (Ford & Deptula, 2019). Amazon in the past was perceived to be an organization with poor work quality and poor pay and the $15 living wage was implemented as an attempt to change these perceptions (Gibb & Ishaq, 2020). Other organizations that have implemented $15 living wages are Target, JPMorgan Chase, Facebook, Costco, Charter Communications, Disney, Wells Fargo, Google, and Santander Bank (Olya, 2020). These organizations that are making the commitment to pay the $15 living wage without being mandated are illustrating what Osterman (2018) referred to as high road strategic human resources practices. Organizations that deploy high road practices follow the law and have strategic compensations strategies in place to ensure adequate wages for the employees (Osterman, 2018). The gold standard for organizations that utilize high road practices is to provide adequate compensation to their employees that is typically above the going market rate for the role (Osterman, 2018), and the organizations with compensation philosophies that support a $15 living wage are noted to meet that standard. Being an organization that has implemented a compensation philosophy to pay a living wage means that the organization recognizes the value of all of its employees including the lowest paid and acknowledges that the cost of living requires more than paying the federally mandated minimum wage (Haar, 2019).

Some of the most recent federal legislation to raise the federal minimum wage to $15 is H.R. 582 – Raise the Wage Act. This act increases the minimum wage in phases to implement a $15 federal minimum wage by 2024 (Reich et al., 2019). The law was passed in the House of Representatives but stalled in the Senate due to a lack of support from Republicans (Campbell, 2019a). If passed this policy would have increased the earnings of 41.5 million employees with an average annual pay increase of 17.3% (Reich et al., 2019). The rise and fall of H.R. 582 illustrate the ongoing debate against and for the $15 living wage that is still occurring in the United States. The $15 living wage was also a hot topic in the most recent Presidential election. The majority of all the democratic candidates, including Joe Biden, who won the election supported increasing the minimum wage to $15 while the majority of republican candidates were against the increase (Campbell, 2019b). These differences predict that the debate for and against the $15 living wage will continue for years to come. With the election of Joe Biden and Kamala Harris, both advocates of the $15 living wage (Barber II & Theoharis, 2020), to the White House it will be interesting to see how the debate progresses during their time in office.

In an attempt to provide a $15 living wage to all citizens of the United States, President Joe Biden included the increase to the $15 living wage in his initial drafts of the COVID-19 financial relief bill (Wiseman, 2021). This attempt at living wage legislation was met with the same conflicting views as it has been met with in the past. With the country still struggling from the COVID-19 pandemic, the opponents are using the justifications that have been presented in the past such as job cuts, but they are now also

using the pandemic to discourage the increase to $15 (Collins, 2021). One of the biggest arguments is that organizations such as movie theaters, hotels, and restaurants that were hit the hardest by the pandemic would be negatively affected by the increase to $15 as the cost right now would just be too much to handle on top of the financial losses these organization experienced due to the pandemic (Wiseman, 2021). The proponents on the other hand argue that now is the perfect time to provide these increases. The low-wage frontline earners were some of the most negatively impacted by the pandemic and providing the $15 could give these individuals the boost needed to recover after the pandemic (White, 2021). Ultimately it was determined by the Senate that the $15 federal minimum wage increase could not be included in the bill as it violated the budgetary rules that limited what could be included (Cochrane, 2021). A major element of the Biden Harris campaign was advocating the increase to $15 (Barber II & Theoharis, 2020) the removal of the plan from this bill may be a bump in the road but it is inevitable that this will come up again in the future.

While the $15 living wage increase was removed from the COVID-19 financial relief bill, President Biden has introduced another approach to getting the nation to $15 by passing an executive order to increase the minimum wage to $15 for federal employees and contractors (Clark, 2021). These increases will occur incrementally by moving to $10.95 in March 2021 and progressing to the $15 threshold by 2024 (Clark, 2021). These executive orders are met with the same pro and con arguments that have been presented in the past – raising almost 1 million people out of poverty while at the same time increasing unemployment and the cost of goods and services (Clark, 2021).

Arguments Against and For Implementing Living Wages

The literature on living wage presents both the pros and cons of implementing a living wage. The arguments listed as pros and cons often contradict one another. The opponents of paying a living wage argue that paying living wages does little to benefit workers, while the supporters of living wages argue that low-wage workers deserve a better quality of life and that paying a living wage would accomplish that goal (Adams, 2017). Critics posit that paying living wages disrupt the market for labor while the supporters indicate that paying living wages reduces inequality and promotes social inclusiveness (Sodsriwiboon & Srour, 2019) which would in-turn improve the overall economy (Malloy, 2020). One of the major cons listed by the opponents of a living wage is the increased cost of wages for the organization and the potential negative outcomes that could theoretically result from those increased costs (Fahimullah et al., 2019). According to Allegretto and Reich (2018), the increase in the cost of wages is transferred to the customers through increased pricing. Bodnár et al. (2018) support this point and presented increased product pricing as a popular channel organizations can use to adjust to the cost of an increased minimum wage. The increase in pricing has been noted to lead to decreased business as some consumers are not able to afford the increased prices (Reich et al., 2019), and a loss of customers is negative for organizations. A reduction in employment is also noted as a possible negative outcome of paying a living wage. A reduction in employment refers to the need to eliminate staff to offset the increased cost of wages (Majchrowska & Strawinski, 2018). In addition to an overall reduction in employment Calandrillo and Halperin (2017) listed stifled job growth resulting from

lower turnover rates as a potentially negative effect of implementing a living wage. In a study that explored increasing the minimum wage to closer to a living wage in manufacturing plants, Álvarez and Fuentes (2018) noted that paying a living wage reduced total factor productivity. Total factor productivity refers to the "ratio of output to a combination of inputs used given the technology available and the policy constraints to use that combination" (Álvarez & Fuentes, 2018, p. 193). Productivity is a key concern for all organizations as productivity is directly related to profit.

Wage compression is also another negative impact presented by opponents of paying a living wage. Wage compression occurs when employees with more experience earns the same as or less than employees with less experience and can also be illustrated when employees in leadership roles make the same as or less than their direct reports (Steward, 2020). Compression is often the consequence of a living wage adjustment as employees who make more than the implemented living wage do not receive increases that are comparable to the employees that are moved to the living wage thus compressing the wages (Ifft & Karszes, 2016). Howell (2019) found that the implementation of an increased minimum wage to more closely align with a living wage resulted in wage compression for employees at the bottom and middle parts of the urban wage distribution. According to Wong (2018) wage compression resulted from a minimum wage increase and led to a decrease in income equality. Wage compression is noted to have negative effects on an organization such as increased turnover, employee disengagement and potential lawsuits for pay inequity (Steward, 2020). To reduce wage compression Pollin and Wicks-Lim (2016) suggested that organizations increase compensation for all

employees to ensure that the employees retain their position in the wage distribution hierarchy pre and post living wage implementation. This allows the organization to maintain the internal wage ladders that existed before the living wage adjustment (Romich et al., 2020). While this method is optimal as it decreases the compression issue, this strategy extends the cost of the living wage beyond the employees below the living wage and results in additional costs for organizations (Leonardi et al., 2019; Pfeifer, 2016). The potential organizational-related cons of implementing a living wage are important elements of organizational success that organizations considering implementing a living wage should take into account during the strategic compensation strategy decision-making process.

While the majority of the potential cons are noted at the organizational level there are cons noted in the literature at the employee level. Paying a living wage of $15 could potentially affect employees' eligibility for government welfare programs and subsidies. Fahimullah et al. (2019) listed a decrease in the earned income credit tax credit as an employee-related con of paying a living wage. The earned income tax credit is recognized as one of the most effective policies in the United States for reducing poverty as it supplements the wages of low-wage workers through tax credits (Shanks-Booth & Mettler, 2019). The earned income tax credit is based on wages thus increasing wages reduces the amount of the credit. Paying a living wage is also noted to decrease welfare programs such as housing benefits and free school meals (Werner & Lim, 2016). Most social welfare programs are income based, and an increase in income decreases and in some instances eliminates the welfare benefits offered to individuals. The losses in these

benefits and programs due to paying a living wage have the potential to equal out or eliminate the positive financial impact for some individuals (Calandrillo & Halperin, 2017).

The proponents of paying employees a living wage on the other hand present positive outcomes of paying a living wage and like the opponents the pros are listed at both the employee and organizational level. In regard to the employees, paying a living wage is noted to improve the quality of life of the employees (Balasingam et al., 2020). This quality of life is noted in things such as work-life balance and job satisfaction (Haar et al., 2018). In a study exploring the perceptions of implementing an increased minimum wage, Che Ahmat et al. (2019a) found that employee perceptions of minimum wage policy significantly influenced their satisfaction with compensation and work motivation, and that the employee's satisfaction with compensation significantly influenced work motivation, job satisfaction, and perceived quality of life. Low wages have been noted to affect employee's physical and mental health (Marcil et al., 2020). According to Silver and Boiano (2019) low-paid health care employees had a high prevalence of multiple adverse health metrics and a low prevalence of positive health behaviors compared to employees in other industries. To counter the negative health-related outcomes of low-wage health care employees, increased wages have been noted to improve overall and mental health (Paul Leigh et al., 2019). The positive effects of paying a living wage are also noted to extend beyond the employee to their families (Hirsch, 2018). In the examination of the effects of higher minimum wages on family life and children's well-being, Hill and Romich (2018) found that increased wages would boost income thus

reducing poverty introducing benefits related to child development that promote intergenerational mobility.

Many of the positive organizational outcomes presented by the proponents of a living wage relate to elements that are directly connected to the positive employee outcomes. This is illustrated in research conducted by Che Ahmat et al. (2019b) that sought to gain insight into the mediating roles of work motivation, work engagement, and job satisfaction in predicting outcomes such as turnover intention and work engagement after implementing a minimum wage adjustment to more closely align the minimum wage to the living wage. In this study, Che Ahmat et al. (2019b) found that these work factors had a significant impact on turnover intention and turnover intention is noted to be a key predictor of turnover behavior (De Simone et al., 2018). Turnover is an important organizational outcome that directly affects the organizations' bottom line. In the health care industry, it is noted that organizations lose up to 5.8% in revenue due to turnover (Belasen & Belasen, 2016).

Another negative presented by the opponents that is also listed as a positive by the proponents is decreased participation in government welfare programs and subsidies. The positive presented by the proponents for living wage as it relates to welfare believe that individuals who in the past felt they were incentivized to live off welfare rather than work full-time will be motivated by the increased living wage to work full-time as the wages at the living wage rate would equate to more than the benefits offered by welfare (Fahimullah et al., 2019). According to Calandrillo and Halperin (2017), this would result in a decreased cost for taxpayers as the cost for programs such as Medicaid and food

stamps would decrease. Reich and West (2015) estimated that increased wages would result in savings of over four billion dollars in spending on welfare programs such as food stamps. In regard to implementing a living wage both the pros and cons present compelling arguments. However, if organizations and politicians making the decision regarding living wages go back to those original thought processes that were utilized when a minimum wage was established, the moral obligation of eliminating the concept of the working poor, the decision to pay a living wage appears to be an easy one.

Advocacy for a Living Wage in the U.S. Health Care Industry

Health care is one of the largest industries in the United States with 18.6 million employees (Paul Leigh, 2019). The health care industry is predicted to continue to be the largest as over half of the 10 fastest-growing occupations in the United States are health care occupations; nurse practitioners, occupational therapy assistants, home health and personal care aids, physical therapy assistants, medical and health service managers, and physician assistants (U.S. Bureau of Labor Statistics, 2020). By 2024 the workforce in the health care industry is predicted to grow by 3.8 million employees, and this growth is noted to be the largest number of jobs added in any industry in the next decade (Prescott, 2015). This increase in health care jobs is presented as positive for the industry but the bright outlook for growth is dimmed by low wages for some health care employees (Cooke, 2019). According to Himmelstein et al. (2019), the health care industry employs the largest percentage of the citizens in the United States and many of these workers are paid so poorly that they live in poverty. Johnson (2016) reported that one in four employees in the health care industry lives in poverty. Hartz and Wright (2019) refer to

health care workers as in demand and undervalued due to the low pay of many of the key roles in health care operations. Hussein (2017) conducted research on a subset of low-paid workers in the health care industry and found that these workers were financially vulnerable, struggled to manage bills, and received some level of public assistance. These findings are extremely troubling for a fast-growing industry that presents these roles as "good jobs" for low and middle-skill workers (Dill & Hodges, 2019).

Due to the continued promotions of social advocacy and political groups in the United States to pay a $15 living wage and the overall importance of the availability of health care staff in the future many health care organizations are exploring the concept of paying a living wage to determine if this is an appropriate compensation practice for their organization. In an article exploring the pros and cons of implementing a $15 living wage in health care Paul Leigh (2019) discussed many of the positive and negative arguments that are presented by other industries. Some of the pros presented were improved health for workers and their families, lower occupational injuries, and workers compensation costs, and decreasing income inequality, and the cons presented were cost and affordability, increased unemployment and decreased hours, wage compression, and the cost of living in some regions not supporting a $15 living wage (Paul Leigh, 2019). For many health care leaders and human resource professionals in the industry, the pros outweigh the cons as not addressing the issue of low wages could result in the inability to meet the health care staffing needs of the future negatively impacting the resilience of health care organizations. Mallak (1998) defined organizational resilience in health care organizations as the ability to design and implement positive flexible behaviors that react

quickly to manage situations faced by the organization. Organizational resilience will be important to meeting the health care challenges of the future.

Strategic human resource practices such as compensation are noted to have a positive impact on organization resilience (Al-Ayed, 2019). Moses and Sharma (2020) specifically listed compensation as an integral component of a health care systems market logic to attract and retain employees. Based on these positive relationships many health care organizations are moving to implement living wages. The Becker Hospital Review reported 13 health care systems that plan to implement living wages (Gooch, 2019). Ochsner Health System based in New Orleans, LA, Atrium Health in Charlotte, NC, Novant Health and Wake Forest Baptist in Winston-Salem, NC, Geisinger Health in Danville, VA, and St. Francis Healthcare System based in Girardeau, MO are moving to rates below the $15 mark, while Jefferson Health based in Philadelphia, PA, Virtua Health System based in Marlton, NJ, Advocate Aurora Health based in Milwaukee, WI, the Cleveland Clinic in Cleveland, OH, Christiana Care Health System based in Wilmington, DE, Cooper University Health Care based out of Camden, NJ, and Allegheny Health Network based out of Pittsburgh, PA are moving to a living wage rate at or above $15 (Gooch, 2019). In a separate article, the chief human resource officer for Sentara and Optima Health, one of the largest employers in Virginia and based out of Hampton Roads, discussed taking a phased approach to moving to a $15 living wage (Toliver, 2020).

The number of health care organizations moving toward paying living wages illustrates the importance of living wage in the health care industry and the spotlight on

the importance has increased during the COVID-19 pandemic. Jones (2020) posited that "every crisis presents an opportunity for society to take stock of its values, principles, and the existing political order to move its members toward a true social compact that ensures that everyone has dignity and worth" (p. 5). The spotlight on paying a living wage during the pandemic aligns with the historic discussions on living wage as there are advocates and opponents to the practice. The opponents are fueled by cost. Many health care organizations had to limit revenue-generating services such as elective surgeries during the pandemic (Solis, 2020; Stradling, 2021; Thorud, 2021) which negatively affected the finances of health care organizations (Bollag, 2020) which makes increasing wage cost a more difficult decision during these times. The advocates on the other hand are fueled by the important work the low-wage employees deemed as essential have performed during the pandemic. According to Hecker (2020) all employees specifically those that have been deemed as essential during the pandemic should be paid a living wage. Income inequality has been highlighted during the pandemic as low-income workers have been noted to feel obligated to report to work even when not feeling well to continue to meet financial obligations which further intensifies the spread of the virus (Searle & McWha-Hermann, 2020). In health care specifically, low paid essential workers in support, direct care, and service roles such as housekeepers, pharmacy aides, and nursing assistants represent over 80% of essential health care workers and are often undervalued and underpaid as they are often left out of the outpouring of public appreciation for frontline heroes and are paid at or below the poverty level (Kinder, 2020).

Summary and Conclusions

Paying employees a fair living wage has been a key topic for organizations, politicians, and social advocacy groups for over a century (Werner & Lim, 2016). The review of the current literature reveals that there are pros such as improved productivity and increased employee engagement and cons such as increased cost and wage compression presented for organizations and employees regarding implementing a living wage. Even with all of this research, the research utilizing the conceptual framework of the efficiency way theory is noted to be underdeveloped (Yao et al., 2017) specifically related to leadership perceptions (Balasingam et al., 2020; Repetti & Roe, 2018; Romich et al., 2020), in organizations such as health care organizations that are sensitive paying efficiency wages (Kim & Jang, 2019). Over the years the United States has determined that $15 is the appropriate rate for the living wage (Luce, 2017), and legislation to implement a $15 living wage is currently flowing through our legislative bodies (Campbell, 2019a). With the frequent delay and conflict between politicians at the federal level on this topic, many states and organizations are making the high road decision to implement compensation philosophies that provide the $15 living wage before the government mandates organizations to do so.

While some organizations are currently making the decision before a mandate to compensate employees with a living wage greater than the current federal minimum wage, the data presented in the literature and the social climate in the United States makes it appear that implementing some level of a living wage will be inevitable in the future. Since organizational leaders are key to organizational success and ensuring that

changes are implemented successfully across organizations (Oreg & Berson, 2019), it is important to gain the perceptions of leaders that have experienced the implementation of a living wage adjustment. Leadership is always important, but the COVID-19 pandemic has resulted in a spotlight on the importance of the leadership of service employees (Bartsch et al., 2021) and this importance is highlighted in the health care industry. A research study that explores the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry will fill the gap in the literature by focusing on leadership perceptions and the health care industry, an industry that has been noted to be sensitive to living wage increases. The results may provide health care leaders, human resource professionals, politicians, and social advocacy groups insight regarding how implementing a living wage influences organizational outcomes. This insight will assist organizations in the planning process of implementing a compensation philosophy to pay a living wage, with the goal of ensuring that there are strategies in place to neutralize or reduce the potential negative effects.

In Chapter 3, I will describe the method I used to gather data on the perceptions of leaders that have experienced a $15 living wage implementation and its influence on organizational outcomes in the health care industry. This data may prove beneficial to leaders and human resource professionals to improve organizational outcomes after either taking the high road or being mandated to pay a living wage. This could be achieved by providing resources that can be used to allow the organization to continue to obtain and exceed organizational goals while at the same time paying efficiency wages to employees in the low wage earning roles. This may lead to reducing the social issue of the working

poor as well as putting an infrastructure in place that will allow organizations to remain successful after the implementation of a living wage.

Chapter 3: Research Method

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. In this chapter, I will explain why I selected the qualitative case study design for this study and provide details about the participants and their rights, the survey instrument, the interview process, and the data analysis techniques. As I noted in Chapter 2, there is a gap in the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. Case studies are used to develop an up-close, in-depth understanding of a case in its real-world setting (Yin, 2012). Conducting a case study at a health care organization whose leadership had implemented a $15 living wage was a way to address this gap.

Research Design and Rationale

I used the qualitative case study method to explore the following research question: How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry?

Central Concept/Phenomenon

The central phenomenon that I studied was the perceptions of leaders at a health care organization who had implemented a $15 living wage. I sought to examine their thoughts regarding how their implementation of a $15 living wage had influenced organizational outcomes at a health care organization. This insight is important as the existing research on the $15 living wage gives anecdotal information on what may

happen if a $15 living wage is implemented (Hartz & Wright, 2019; Himmelstein & Venkataramani, 2019; Himmelstein et al., 2019). I sought to clarify what might occur.

Research Tradition and Rationale

The research design that was used for this study was a qualitative case study. Qualitative research is defined as the "iterative process in which improved understanding to the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied" (Aspers & Corte, 2019, p. 139). I selected the qualitative approach for this study because qualitative research takes place in the real-world setting, involves the use of multiple natural and humanistic methods, focuses on context, and is emergent and interpretive (Marshall & Rossman, 2011). Qualitative research is based on the subjective, naturalistic, and humanistic paradigm (Goodman et al., 2020), which focuses on the holistic exploration of complex realities constructed by individuals in the context of their everyday worlds (Erlingsson & Brysiewicz, 2013). One of the key identifiers of qualitative research is that the research is investigated from the participants' point of view (Williams, 2007). My exploration of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry touched on these components. The research occurred in a health care organization and featured multiple natural and humanistic methods, with virtual interviews performed to gather data. In relation to the emergent and interpretive nature of the research, the context was a health care organization whose leadership had implemented a $15 living wage. The findings emerged as the data were analyzed.

Research design is a critical component of a research study that specifies the purpose and explains the strategy that will be utilized to answer the research question (Abutabenjeh & Jaradat, 2018). When exploring the various research designs to use for this study—qualitative, quantitative, and mixed methods—I concluded that qualitative was the most appropriate approach for a variety of reasons. The primary reason for my choice of research design was based on the paradigms that each method is based upon. Quantitative research is based on the objective, positivistic, and reductionist paradigm, which focuses on the search for the truth through pure scientific experimentation and hypothesis testing where the variables and contexts are tightly controlled and the researcher is objective and detached (Goodman et al., 2020). A quantitative design was not an appropriate choice for my study due to the subjective nature of the study and the desire to gain insight into the perceptions of leaders. Rather than testing a hypothesis and using specific variables, I used a subjective approach to gain insight into the perceptions of leaders in a health care organization regarding the implementation of a $15 living wage and its influence on organizational outcomes. Mixed-methods research is a combination of both quantitative and qualitative approaches. Creswell and Plano Clark (2009) provided some examples when a mixed-methods approach would be appropriate; these include when one of the other approaches would not provide an adequate understanding of the concept and when unfamiliar concepts might emerge. Based on my understanding of the existing literature, I concluded that neither of these reasons applied. This conclusion further reinforced my decision to conduct a qualitative study.

There are several qualitative research strategies, including case study, ethnography, grounded theory, phenomenology, and narrative research. Case studies are conducted with the goal of producing understanding to further learn something new about real-world behavior (Yin, 2012). Ethnography is the study of social interaction and cultural groups (Reeves et al., 2013) and is conducted with the goal of obtaining holistic insight into the participants' actions and worldviews in their natural habitats (Hughes, 1992). Grounded theory involves multiple stages of data collection and the refinement and interrelationships of categories of information that is pulled together to develop an abstract theory that is grounded in the views of the participants (Creswell, 2009). Phenomenology is the study of lived experiences and how those lived experiences are understood to develop a worldview (Marshall & Rossman, 2011). An individual's worldview is the "basic set of beliefs that guide action" (Guba, 1990, p. 17). Narrative researchers study the lives of individuals to obtain information about their lives (Creswell, 2009). In my analysis each of these strategies, case study stood out as the most appropriate because it is instrumental in researching complex phenomena and building and testing theories (Tasci et al., 2020). According to Yin (2012), the role of theory in case study research represents a key difference between case study and other qualitative methods, thus supporting the use of case study for this research. I sought to test the premises of the efficiency wage theory to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. None of the other research designs, I determined, would have enable me to satisfy the purpose of this study.

An additional rationale for using the case study approach was that case studies are conducted with the goal of producing understanding that reveals something new about real-world behavior (Yin, 2012). Case studies may involve participant interviews, examination of documents, and/or participant observation (Bryman & Stephens, 1996). The case in the case study method represents the main unit of analysis and is usually bounded by an entity that could be represented as an organization, event, or other social phenomenon (Yin, 2012). Researchers who conduct case studies in the field of business and management explore issues related to the industrial and economic foundations of the world (Mills et al., 2010). In case study research, the researcher collects a variety of data to explore individuals, programs, processes, activities, or events (Creswell, 2009; Stake, 1995). The case that was explored in depth in this study was a health care organization whose leadership had implemented a $15 living wage.

Role of the Researcher

The role of the researcher in qualitative research is to serve as the observer, recorder, and analyst of the data (Chesebro & Borisoff, 2007). The researcher serves as the primary instrument of the study by examining documents, interviewing participants, or observing behavior (Creswell, 2009). In my role as researcher, I interviewed leaders at a health care organization whose department/division was directly affected by the $15 living wage adjustment. With the term directly affected, I am referring to leaders whose employees received a pay adjustment as a result of the $15 living wage implementation. I am not employed by a department/division that was directly affected by the $15 living wage; but I am employed by the organization as a human resources professional. As a

human resource professional, I directly provide guidance on human resource matters but do not directly support any of the departments/divisions included in my study.

Personal Biases

Biases can happen at any phase of the research process and occur when the researcher conducts the research by selecting or encouraging one outcome or answers over others (Pannucci & Wilkins, 2010). Bias has the ability to distort the results of a study, which makes it extremely important to recognize and understand research bias (Galdas, 2017). Biases are easier to handle when clearly stated as this makes the readers of the final study aware of the biases and allows them to assess how those elements affected the study (Marshall & Rossman, 2011). According to Smith and Noble (2014) "minimizing bias is a key consideration when designing and undertaking research" (p. 101). To mitigate bias for my study, I:

- Separated my own views and experiences with the organization and the $15 living wage implementation.
- Ensured that I do not work directly with or support the leaders participating in the study.
- Kept records of all of the data collected and reviewed and analyzed data with an open mind.

While it is understood that a research study cannot be 100% free from bias, I employed these tactics to reduce bias to ensure that the participants are able to reveal their true feelings about the topic without distortions (Sarniak, 2015).

Methodology

Research is the "orderly investigative process with the purpose of creating new knowledge" (Swanson & Holton, 2005, p. 4). Of the three research methodologies, quantitative, qualitative, and mixed methods, the qualitative method is the research method that was used to conduct my study. Qualitative research has several characteristics "takes place in the natural setting, relies on the researcher as the instrument for data collection, is inductive, is based on participants' meanings, is emergent, often involves the use of a theoretical lens, is interpretive, and is holistic" (Creswell, 2009, p. 201). My study meets these characteristics and the specific steps, participant selection, instrumentation, recruitment, participation, data collection, and data analysis will be described in this section.

Participant Selection Logic

The population in qualitative research consists of the individuals, groups, or organizations the researcher seeks to understand and to whom or which the results of the study may generalized (Casteel & Bridier, 2021). The target population for this study will comprise of the approximately 375 leaders at a health care organization that has implemented a $15 living wage adjustment. ABC Healthcare System is a not-for-profit health care system employing over 30,000 employees, consisting of 14 hospitals, 18 hospital campuses, with over 100 physician practices across the state in both urban and rural areas. In order to provide their perceptions, the participating leaders will have served in a leadership position at a health care organizations pre and post a $15 living wage adjustment.

The nature of most research does not allow the ability to study every relevant event, individual, or circumstance in an in-depth manner therefore researchers must select samples to conduct their studies (Marshall & Rossman, 2011). To select the sample the researcher must select the research site, setting, population, and the phenomena to be studied. In my research exploring the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry, the research site and setting is the health care organization that implemented the $15 living wage. The target population was the approximately 375 leaders at the health care organization with employees who were directly affected by the $15 living wage adjustment. The phenomena that were studied were the perspectives of leaders that have experienced the implementation of a $15 living wage.

For this qualitative case study, I used a purposive sample to recruit and interview leaders from the health care organization that have employees that were directly affected by the $15 living wage adjustment. Purposive samples are frequently utilized in qualitative research (Patten, 2012). A purposive sample is a sample in which "individuals are handpicked to be participants because they have certain characteristics that are believed to make them especially good sources of information" (Orcher, 2005, p. 48). According to Creswell (2009) the idea behind qualitative research is to purposively select participants that will assist the researcher in better understanding the research problem and question, and the purposive sample selected fulfills that idea. The decision on the size of the sample in qualitative research "is contextual and partially dependent upon the scientific paradigm under which investigation is taking place" (Boddy, 2016, p. 426).

This sample size selection process in qualitative research is not as prescriptive as it is in quantitative research where formulas such as power analysis can be used to determine the appropriate size (Yin, 2012). My goal was to have a sample size of 10 to 15 health care leaders that were willing to participate in the study. Based on the size of the population, approximately 375, I am hopeful that I will be able to get at least 10 to 15 of those leaders to participate in my study.

Using my goal of the sample size, the plan is to use data saturation to determine when the appropriate sample size has been met (Goodman et al., 2020). Data saturation refers to the point in which new participants are no longer providing new insights into the topic (Orcher, 2005), and sufficient data to account for every aspect of the phenomena are obtained (Morse et al., 2002). Small sample sizes in case studies are typical (Yin, 2018), therefore the selected goal of 10 to 15 should be appropriate for the study.

To gain access to the leaders at the health care organization that have employees that were directly affected by the living wage adjustment I worked with the health care organizations research department to obtain a letter of agreement. This letter of agreement (see Appendix A) provided me access to the names and contact information of the leaders.

Instrumentation

Instrumentation refers to the tools or means by which the researcher uses to measure items of interest in the data collection process (Salkind, 2010). In qualitative case study research, the researcher serves as the instrument (Stake, 1995; Yin, 2014), and as the instrument works to gather data from a variety of reliable and valid sources to

answer the research question (Yin, 2018). For my study, the sources of data came from semistructured interviews with the leaders of the health care organization. Data collected during interviews are listed by Stake (1995) and Yin (1994) as sources of evidence in case study research (Tellis, 1997). I conducted interviews via Zoom and recorded them to ensure that I kept an accurate account of the full conversations. The recordings were also downloaded into NVivo data analysis software. My interviews with the leaders provided insight into the perceptions of the leaders regarding the impact of the $15 living wage adjustment and its influence on organizational outcomes in the health care industry.

An interview protocol is an instrument of inquiry that asks questions specifically related to the study and also serves as an instrument for conversation around the topic (Castillo-Montoya, 2016; Patten, 2012). The interview protocols used for my study followed Castillo-Montoya's (2016) four-phased approach to interview protocol refinement. The four phases—(a) ensuring that the interview questions align with the research questions, (b) constructing an inquiry-based conversation, (c) receiving feedback on interview protocols, and (d) piloting the interview protocol—provide a road map for the researcher in developing an instrument that is appropriate for the participants and aligns with the purpose of the research study (Castillo-Montoya, 2016, p. 812). In the first phase, I drafted an interview script and semistructured interview questions. Semistructured interview questions were selected because they are noted to support a mix of questions, prompts, and topics to inform the study while at the same time providing the opportunity to follow hunches and intuitive direction (Durdella, 2019). Semistructured interviews are the most widely used in qualitative studies (Patten, 2012) and are listed by

Yin (2018) as an effective format to conduct interviews for qualitative case study research. In semistructured interviews, the researcher can veer from the predetermined questions to reword the questions for the participants and ask follow up questions such as "can you tell me more about that?" (Patten, 2012). To ensure that the interview questions aligned with my research question, I created a matrix to map each interview question with my research question. This matrix assisted with illustrating gaps that exist in what I planned to ask and the research question I was trying to answer (Castillo-Montoya, 2016).

Pilot Study

In the second phase of the interview protocol refinement, I conducted a small pilot study with two of leaders in the health care organization to ensure that my questions were appropriate and that the responses to the questions aligned with my problem, purpose, and research question. The plan was to utilize the results of the pilot study, to revise and refine my interview questions to ensure that the questions promoted a conversation on the topic rather than just an answer to the research question. To successfully complete this phase, it was important that I recognized the difference between the research question and interview questions. According to Maxwell (2013) "your research questions formulate what you want to understand; your interview questions are what you want you ask people to gain understanding" (p. 101). I followed the guidance by Castillo-Montoya (2016) and used my knowledge of the context and norms of my participants to draft questions that were understandable and relatable to promote an inquiry-based conversation. To guide the interview and conversation I utilized introductory, transition, key, and closing

questions to “preserve the conversational and inquiry goals of the research” (Castillo-Montoya, 2016, p. 822).

I completed the final two phases of the interview protocol refinement outside of my research participants. I worked with my dissertation chair to review my interview questions and protocols. Once we came to an agreement on the questions, I utilized two leaders at the health care organization to pilot my interview protocol by conducting practice interviews. Based on the feedback, the plan was to revise the interview questions and protocols and resubmit to my dissertation chair and committee for review. Once we all agreed, the interview questions and protocols were finalized to use for my study.

Procedures for Recruitment, Participation, and Data Collection

I used semistructured interviews as the data collection protocol. For the semistructured interviews, I utilized the leader list provided by the human resource department to send emails to these participants. An email was sent to the potential participants explaining the study and requesting their participation. I sent two follow up emails, the first follow up email was sent 1 week after the initial invitation to continue to solicit interest for participating in my study. The second follow-up email was sent 5 weeks later after direction from my mentor to obtain additional participants.

Once I confirmed the participant’s interest, I scheduled 1-hr meetings to meet with the leaders via Zoom to conduct the interviews. While the meetings were scheduled for an hour to ensure that the time is blocked on the leaders’ calendar, the actual interviews took approximately 20 to 40 min to complete. The participants were given informed consent that included details on who will be conducting the research, my

contact information, the purpose of the study, the potential benefits and risks of the study, the steps that will be taken to maintain the participants' confidentiality and protect them from harm, and the participants right to withdraw from the study at any time without penalty (Orcher, 2005). Each participant was emailed the informed consent and verbally consented to the study during the Zoom meeting.

As the researcher, I served as the primary data collection instrument. I collected the data using an interview protocol. All interviews were conducted via Zoom and audio-recorded using Zoom as well as an EVISTR digital voice recorder. During the interviews, I also typed notes via Microsoft Word on my computer during each interview to support the audio recordings. Note taking is encouraged during the interview process to ensure that the data is collected in the event of an issue with the audio-recording equipment (Creswell, 2009). I set aside 2 weeks to conduct the interviews, but this process extended to 6 weeks to accommodate leader's scheduling conflicts and reach the number of interviews that supported data saturation. I scheduled interviews during business hours Monday–Friday, 8 a.m.–5 p.m. At the end of each interview, I thanked the participants for their participation, reminded them of elements of the informed consent, and gave them the opportunity to ask any questions or provide me with any information that may not have come out as a part of the interview. I also offered to provide them with a copy of the results once the study is completed.

Data Analysis Plan

Data analysis is conducted to make sense out of text and image data. To analyze the data for this study, I followed Braun and Clarke's (2006) six-step protocol for data analysis. This involved doing the following:

1. Familiarize myself with the data.
2. Generate initial codes.
3. Search for themes.
4. Review themes.
5. Define and name themes.
6. Produce a report utilizing NVivo that will illustrate the interpretation of the meaning of the data.

To analyze the recordings, I uploaded them into NVivo software to transcribe the data. Once transcribed I forwarded the data to the participants to ensure that I accurately captured their responses to the interview questions. Once the data was confirmed by the participants, I organized and prepared the data for analysis by storing the transcriptions as Microsoft Word documents. I also took the data and input into a Microsoft Excel spreadsheet to assist with recognizing codes and added and additional format for upload into NVivo. I utilized the NVivo software to code the data with key categories, themes, and connections that emerged from the data. During the data analysis process, I immersed myself in the data utilizing a spiral process that will go back and forth between the text from the transcriptions, my knowledge, and the theories to build new understandings (Erlingsson & Brysiewicz, 2013). Once all of these details were obtained, I combined

codes into categories and themes that I utilized to generate the descriptions used to write the results portion of the study.

Issues of Trustworthiness

Credibility

Credibility refers to the trustworthiness and confidence in the data (Tracy, 2010). According to Erlingsson and Brysiewicz (2013) prolonged engagement, triangulation, peer scrutiny, and member checking are guidelines that should be followed to promote credibility in the data. To follow the guideline of prolonged engagement I built relationships with the participants by telling them about myself and the study and asking introductory questions that allowed them to tell me about themselves opening the door for two-way communication. Through these questions, I met my goal of gaining familiarity with the participants which relaxed the atmosphere and opened the door for deep meaningful interviews. For the guideline of triangulation, I utilized a variety of sources of information; the data conducted from the interviews as well as my notes and observations. To meet the guideline of peer scrutiny I continuously discussed all of the aspects of my research with my chair and committee. For the last guideline of member checking, I ensured that I asked all participants to review their interview transcripts to ensure that I have captured their words in the way in which they meant to say them. Following these guidelines assisted in solidifying the credibility of my study.

Transferability

Transferability refers to the ability of the research to be applicable to other subjects and settings (Goodman et al., 2020). The concept of transferability has mixed

reviews in regard to qualitative studies as some feel that it is not relevant to qualitative research as qualitative research focuses on the uniqueness of experiences which in many instances limits transference (Barusch et al., 2011). Even with these mixed reviews, transferability is a term mentioned to support the trustworthiness of qualitative data and is listed specifically by Erlingsson and Brysiewicz (2013) as a guideline to promote trustworthiness in qualitative research. Transferability in qualitative research can be supported by providing thick description of the phenomenon that is under investigation (Erlingsson & Brysiewicz, 2013). "Thick description refers to the researcher's task of both describing and interpreting observed social action (or behavior) within its particular context" (Ponterotto, 2006, p. 543). With thick descriptions, rather than telling the readers what to think the researcher is able to show the readers enough detail so that they are able to make their own conclusions about the data (Tracy, 2010). To accomplish this in my study, I provided information about the participants and roles and described and interpreted the data in a manner in which the readers were able to relate, illustrating that the study could be applicable to other contexts.

Dependability

Dependability in qualitative research refers to illustrating that the findings are consistent and can be repeated (Erlingsson & Brysiewicz, 2013). I supported the dependability of my research by reporting in detail the processes I used to conduct the research. This was done in a way that another researcher could repeat my study based on the details provided. Triangulation is another strategy I used to support the dependability of my research. Triangulation is the technique of utilizing multiple sources to obtain data

on the research topic (Patten, 2012). “The purpose of triangulation is to deepen understanding by collecting a variety of data on the same topic or problem with the aim of combining multiple views or perspectives and producing a stronger account rather than simply achieving consensus or corroboration” (Barusch et al., 2011, p. 13). To obtain triangulation of the data I will interview leaders from a variety of service lines throughout the health care system and utilize the data collected in the recording as well as the notes taken during each interview. Utilizing these various methods demonstrates the use of multiple sources thus promoting triangulation. Another step I took to ensure dependability was working with my chair and committee to review and dissect my study to ensure that I have provided clear and logical documentation. These steps assisted in promoting my research as a dependable qualitative case study.

Confirmability

Confirmability refers to the ways in which the researcher can parallel the concept of objectivity (Marshall & Rossman, 2011). Confirmability is “the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest” (Erlingsson & Brysiewicz, 2013, p. 98). To support the confirmability of my study I utilized audit trails that provide in detail all steps used to conduct the research and explained the thought process around the decisions made throughout. Having an audit trail illustrates accountability and transparency on my part, and to do so I kept detailed records throughout the research process. Another strategy I used to promote confirmability is being forthright about my biases and beliefs going into the study and explaining the ways in which I planned to prevent them from affecting the study.

Ethical Procedures

Ethical principles were established to ensure that researchers keep research participants from psychological and physical harm (Orcher, 2005). The Belmont Report provides three basic ethical principles in protecting human subjects in research: respect for persons, beneficence, and justice (U.S. Department of Health and Human Services, 2018). To ensure that my research was conducted using the highest ethical standards I adhered to all of the Walden University and the health care system's Institutional Review Board (IRB) requirements for conducting research.

Before initiating the study, I obtained approval from both IRB boards which included the approval of method and interview questions. To begin the study each participant was given the details on the study that included the topic and nature of the study, my role as the researcher, their role as the participant, and their rights to ask questions at any time during the process. Before the interviews were conducted, I ensured that each participant verbally consented to the informed consent form. The informed consent document included an overview of the study, the procedures that will be followed including details regarding confidentiality, description of any benefits and risk involved, the estimated time commitment, the voluntary nature of their participation, and the ability for the participant to remove themselves from the study at any time. I began each interview after I verbally confirmed the participant's informed consent. During the interview process, I protected the anonymity of the participants by utilizing pseudonyms for each participant. Any information obtained during the interview that may identify the participants or the location was removed and replaced with descriptive language. I

transcribed each interview utilizing NVivo software. When the interviews were complete, I had each participant review their transcription to ensure that their responses were accurately accounted for. After all of the data was verified and accounted for, I stored all of the collected data in a password protected encrypted secure file folder in the cloud and on a USB device for backup. I will follow Walden's guidelines of storing data and will store these files for at least 5 years after the study is completed and will destroy all data when the time frame has been reached.

Another ethical consideration for the researcher is bias. The researcher has worked as a human resource professional for over 20 years and takes a strategic employee-centered approach to her work and strongly believes in the concept of strategic human resource management. With this belief, the researcher strongly feels that a strategic compensation plan built on competitive compensation for their employees is key in recruiting and retaining top engaged talent that work towards achieving the organizations goals. Even with this belief the researcher is not 100% sure how effective a $15 living wage is due to its downstream effects to other elements within the organization and the community. During this research, I considered and examined my own attitudes to ensure that these factors did not influence the interpretation of the research and findings (Kakabadse et al., 2002). The researcher ensured that she approached the research objectively to ensure the research was approached with the highest standards to produce a study that is not marked by personal prejudice or values (Kakabadse et al., 2002).

Summary

This chapter provided the details on the research design and rationale, methodology including participant selection procedures, data collection, data analysis plan, and the plan to maintain the highest ethical standards for this study. The details described in this chapter align with the purpose of my study to explore the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. Utilizing an interview protocol with open-ended questions will promote the ability to gain this understanding with the goal of filling the gap in the literature.

Chapter 4: Results

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. One research question underpinned the study: How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry? In designing the research question, I sought to address the lack of research on leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. To fill this gap, I conducted a qualitative case study.

Chapter 4 includes the details of the pilot study and a description of the research setting and demographic characteristics of the participants. In this chapter, I also describe the processes that I used to operationalize the data collection and analysis procedures that I described in Chapter 3. The study results are organized by theme. The chapter concludes with a summary of key points.

Pilot Study

I conducted a pilot study with two leaders of the health care organization. I used the same approach planned for my original study. I sent out invitations via email and scheduled 1-hr Zoom calls with each participant. During the calls, I explained the purpose of the study and what I hoped to accomplish during the pilot. The goal of the pilot was to have each leader listen to my questions to ensure that they understood each question and to gather their feedback on whether the questions aligned with the topic and purpose of the study. The leaders met the selection criteria of the full study as both

leaders had employees who were directly affected by the $15 living wage and were employed by the health care organization pre- and post-$15 living wage implementation.

During the pilot, I received feedback regarding whether a $15 living wage was the appropriate amount and on the utility of adding more descriptive words to the interview questions. Inquiry into what is an appropriate living wage was not one of the purposes of the pilot study. The semistructured interview format allowed the addition of descriptive words as needed, so I decided not to edit my interview protocol and questions and proceed to send out the official invitations to participate in the study. This plan was discussed with my chair, and she was supportive of moving forward with the study with no changes to the interview questions.

Research Setting

All participants for the study met the criteria described in Chapter 3: leaders of a health care organization (a) who had employees who were directly affected by the $15 living wage adjustment and (b) who were employed by the health care organization both pre- and post-living wage implementation. Due to Walden University's guidelines to support researcher and participant safety during the COVID-19 pandemic, all interviews were conducted virtually. I was the only one in the room during the virtual interviews, and each participant indicated that they had the appropriate privacy needed to participate in the interview. Use of the video option of the Zoom meeting platform gave the ability to capture nonverbal cues from the participants such as facial expression and body language.

The implementation of the $15 living wage at the target organization occurred in 2019, one year before the declaration of the COVID-19 pandemic. With the challenges health care leaders faced during the pandemic, I felt it was important that I remind the participants to provide responses that related only to the living wage issue and not to the pandemic response. This was specifically stated in my interview protocol. To my knowledge, there were no other personal or organizational conditions that influenced participants.

Demographics

Participation in the study was limited to leaders employed by a health care organization who had employees who were directly affected by the $15 living wage adjustment and were employed by the health care organization both pre- and post-living wage implementation. The study included 10 participants from various leader levels (supervisor, manager, assistant director, and director) and job classifications (clinical, professional, and paraprofessional) within the health care organization and with experience ranging from 5 to 26 years of service (see Table 1). The leaders represented various service lines across the health care organization. The service lines will not be specifically mentioned to support anonymity, but the participants were from a combination of frontline patient facing areas and support and ancillary services across the health care system.

Table 1

Demographic Information for Participants

Participant	Leadership level	Years of service

Participant 1	Manager	9
Participant 2	Manager	8
Participant 3	Manager	20
Participant 4	Director	11
Participant 5	Director	26
Participant 6	Manager	24
Participant 7	Supervisor	10
Participant 8	Manager	5
Participant 9	Assistant director	24
Participant 10	Director	20

Data Collection

Data collection for the study included the Zoom interviews with the 10 participants. I conducted each interview individually in a private setting; the interaction involved the participant and myself. The video option of the Zoom platform was used during the interview, but only the audio portions of the interviews were recorded using both the Zoom recording feature and an EVISTR digital voice recorder. I also typed notes in Microsoft Word during each interview. Before each interview, the three forms of recording were shared with each participant, and all participants orally gave their consent to participate in the study and to have the interview recorded.

During the interviews, I asked follow-up and probing questions to delve deeper into the participants' responses as well as provide clarity and understanding to the interview questions. While on video, I observed the participants' nonverbal cues such as facial expression and body language and gave each participant ample time to respond to each question. During four of the 10 interviews, there were disruptions on the

participants' end; the interviews were paused during the interruption and resumed when the setting was private again. The length of the interviews varied from 20 to 45 min. At the end of each interview, I thanked the participant for their involvement and let them know that I would be sending the transcriptions to them for their review. The recordings were saved in a password-protected folder.

The transcriptions for each interview were completed using NVivo software and saved as Microsoft Word documents. I listened to the audio of each transcription and compared the audio with the transcription to ensure that there was alignment. With the transcription being automated because of the use of NVivo, there were some discrepancies noticed between the recording and transcription. These discrepancies were due to the jargon used by me and the participants and the use of filler words such as "um" and "like." I made corrections to the transcripts to account for these discrepancies.

Each transcription was sent to the participants for review to ensure that their responses to the interview questions were accurately reflected. The 10 participants were given a week to respond and told that if they had not responded in a week, I would consider the transcribed data as accurately captured with no revisions needed. Nine of the participants responded that the transcripts accurately reflected their responses. One of the participants did not respond within the given time frame and after a week that transcript was noted as accurately captured.

Data Analysis

I analyzed the data for each participant to interpret the meaning, with the purpose of answering the research question: How do health care leaders who have implemented a

$15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry? As described in Chapter 3, I followed Braun and Clarke's (2006) six steps for data analysis. As the first step I familiarized myself with the data by listening to each recording and reviewing each transcript. To further familiarize myself with the data I took the transcripts and put them into a Microsoft Excel file. In the Excel file each participant was listed by row with each research question and the participants responses listed the in the columns. I used this format as an alternate format to see the responses to all questions listed together to assist in building the foundation for the coding process. I utilized NVivo software to conduct the second step of generating initial codes. Rather than use the automated coding feature of NVivo, I used the software to review each transcript individually and manually code the themes utilizing NVivo. This step resulted in the emergence of 36 initial codes. Examples of the codes included an overall positive perception of the $15 living wage adjustment, positive influence on retention, no influence on absenteeism, and positive influence on vacancy rates. The codes were then grouped into categories based on similar characteristics. The final step of the process was utilizing categories to develop themes.

Evidence of Trustworthiness

Credibility

Establishing credibility is noted as one of the key elements of a well written qualitative research study (Liao & Hitchcock, 2018). Credibility in qualitative studies is the equivalent to internal validity in quantitative studies (Korstjens & Moser, 2018), and refers to the truth of the data through the participants views and how the researcher

interprets and represents the data (Polit & Beck, 2012). Credibility in qualitative research is strengthened by the researcher describing experiences and verifying the research findings with the participants' (Cope, 2014). For this study I utilized prolonged engagement, triangulation, peer scrutiny, and member checking to support the credibility of the research. The interviews were scheduled for 1 hr, which allowed sufficient time for me to get to know the participants and become familiar with the setting as well as build trust between myself and the participants. Each interview began with small talk about the weather or day in general which helped to lighten the tone and make the participants comfortable before beginning the official interview questions. With these approaches I was able to employ the concept of prolonged engagement.

Triangulation supports the use of a variety of data sources (Korstjens & Moser, 2018). To meet the guideline of triangulation I used my visual observation of the leaders in the Zoom interviews, transcripts from the interviews, and the notes that were taken during each interview to enhance the qualitative research process. Using the various data collection methods enhanced the process of qualitative research. Having the various data sources ensured that all aspects of the data were covered as each source compensated for the weaknesses of the other source, thus improving the validity and reliability of the data (Sim & Sharp, 1998). For the guideline peer scrutiny my chair and committee have reviewed all aspects of my research and provided feedback as needed. For the final approach I used to ensure credibility, member checking, the transcripts were shared with each participant for review to ensure that I had actually captured and interpreted their responses to the interview questions.

Transferability

Transferability is the ability of the research to be applicable to other subjects in other settings through thick description (Goodman et al., 2020). To support transferability, I provided details on all aspects of the study, including the research process and the description of the participants. While my study included a purposive sample of leaders at a health care organization that were employed at health care organization pre and post $15 living wage adjustment and had employees that were affected by the living wage, the leaders represented various professional service lines within health care which presented variation in the sample. By using participants from various service lines, I was able to gain varying insight and compare the data among the participants.

Dependability

Dependability refers to the consistency of data over similar conditions (Cope, 2014; Polit & Beck, 2012). To promote the dependability of my study I ensured that there was consistency in my research procedures. I utilized previous research, articles from experts in qualitative research, and guidance and support from Walden to ensure that the procedures followed best practices and standards for qualitative research. The same procedures were taken with each participant of the study. I also documented each step, to ensure that other researchers have the blueprint to conduct similar studies in the future. Another concept used to promote dependability was triangulation. As described under the concept of credibility, to support triangulation various data sources were used to ensure that a variety of sources were considered and included in the data analysis process.

Confirmability

Confirmability relates to the neutrality of the research (Korstjens & Moser, 2018), and "getting as close to objective reality as qualitative research can get" (Stahl & King, 2020, p. 26). To achieve confirmability, I used audit trails that listed each step of the study as well as provide details on the thought processes that were used to develop the research plan. I also utilized self-reflection to ensure that I only used the participants responses to collect and analyze the data, rather than my personal beliefs or perspectives. Using this approach allowed me the ability to focus on the responses of the participants rather than my own experiences, beliefs, and biases.

Study Results

I approached the study with the goal of addressing a gap in scholarship and practice related to leaders' perceptions of the implementation of a $15 living wage and its influence on organizational outcomes in the health care industry. Through one-on-one interviews with 19 open-ended questions, data was collected that provided insight to answer the research question. The primary research question that was used to guide the study was, How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry? This section of the chapter addresses detailed information about the categories and themes that emerged from the data analysis. Table 2 provides an outline of the three major themes and 16 categories that were discovered.

Table 2

Major Themes and Categories

Major theme	Category	No. of responses
Positive perceptions	Overall positive perception of $15 living wage	10
	Improved retention	8
	Decreased vacancy rates	7
	No impact on staffing levels	7
	No Shift in Funding or increased costs	7
	Positive impact on employee productivity	6
	Improved employee engagement	5
	Total	50
Negative perceptions	Increased salary budget	8
	No impact on absenteeism	8
	No impact on employee engagement	4
	Total	20
Unclear perceptions	Not aware of how organization overcame challenges	3
	Too many other factors that affect org results to determine if the living wage had an effect	2
	Don't know how it influenced the budget	1
	Don't know how the living wage improved organizational outcomes	1
	Don't know if funds had to be moved around to cover the cost	1
	Don't know if the living wage affected vacancy rates	1
	Total	9

Thematic Analysis

The themes emerged from answers to interview questions that asked the participants to describe their overall perceptions of implementing a $15 living wage and its influence on organizational outcomes in the health care industry. The questions asked about specific organizational outcomes such as vacancy rates, retention rates, staffing levels, absenteeism, budget, employee engagement, and employee productivity. All 10 of the leaders interviewed, had a positive overall perception of implementing a $15 living

wage. The responses to the question regarding the overall perceptions of implementing a $15 living wage and its influence on organizational outcomes in the health care industry varied, as the perceptions ranged from positive, negative, or unclear. Eight of the 10 leaders interviewed perceived that implementing the $15 living wage did influence organizational outcomes in the health care industry. When asked at what point did the leaders noticed the influence on organizational outcomes the responses ranged from immediately after the announcement to within a month. Participant 8 stated, "I would say it was probably within a 2-week time frame. I had a couple of employees that were actively looking for other jobs. They weren't really as invested in their work because they were exploring other opportunities, but some of them experienced a significant increase. From the $15, some of them got bumped up to almost $20. A lot of them are more invested in their work even told me verbally that they were not looking for other jobs. And I would say within a 2-week time frame, it was a pretty quick turnaround of just overall productivity and morale." Several of the interview questions asked about specific organizational outcomes and because of that there are some categories that will be listed under all three themes, positive perceptions, negative perceptions, and unclear perceptions of implementing a $15 living wage and its influence on organizational outcomes in the health care industry. During the interviews, the leaders also shared information regarding their perception of the $15 living wage that were not specifically tied to organizational results. Those items are not included in Table 2 but will be explained and noted as other key categories.

The top 10 categories, overall positive perception of the $15 living wage, improved retention, increased salary budget, no impact on absenteeism, decreased vacancy rates, no impact on staffing levels, no shift in funding or increased costs, improved employee engagement, positive impact on employee productivity, and no impact on employee engagement will be explained in more details beneath the themes, positive perceptions and negative perceptions. The categories that fell within the unclear perceptions did not fall within the top categories, but they will also be explained in more detail.

Major Theme 1: Positive Perceptions

Category 1: Overall Positive Perception

The first theme was a positive perception of implementing a $15 living wage and its influence on organizational outcomes in the health care industry and is tied directly to the first category overall positive perception of implementing a $15 living wage. When asked the first interview question, "What are your perceptions on the health care system implementing a $15 living wage?," all 10 of the participants commended the health care organization for making the strategic compensation decision to pay a $15 living wage. One participant stated “I think it was a very good thing. My recollection is that we were maybe like one of the first and a lot of times I feel that we are trying to catch up versus leading the way. But I think that in this instance, other organizations were trying to respond to our action, and it led to others doing the same”. Another participant stated “I think that it was a great move and much needed for the folks that it applied to. It was helpful during that time as people were really struggling on many fronts for paying their

bills. Food just basic necessities. So, I think it was helpful to do so.". One participant agreed it was a positive thing but was disappointed that it took the organization so long to move to the $15 living wage.

When asked to describe an experience the leader had with an employee that received a pay increase a result of the $15 living wage adjustment five of the 10 leaders interviewed provided examples of employees being very appreciative of the adjustment. One of the leaders revealed that a teammate came into their office and personally thanked them. While another leader indicated that one of her employees that was actively looking for another job with higher pay stopped looking and is still with the organization today. One of the leaders wanted to be sure to point out how important it was to note that the $15 living wage affected a class of teammate that are often overlooked when it comes to adjustments in health care as many initiatives focus on the higher-level clinical roles like registered nurses, physicians, physical therapist etc. Participant 5 stated that the $15 living adjustment "bumped up to $15 and affected all of the people that are usually not licensed. So, it's not a nurse, it's not a doctor and it's not an anesthesiologist, you know, it's not those people that are in professions, it's the people that support the entire operating room department. It's the people that clean the rooms, it's the people that put the instruments together, and then of course, when you go to have your meal, it's the people that are working in the cafeteria and they're so integral to what gets done on a more serious level in health care". As it relates to organizational outcomes, the top categories linked to the positive perception theme were improved retention, decreased vacancy rates, no impact on staffing levels, no shift in funding allocations in the budget

or increased cost to customers, improved employee engagement, and improved employee productivity.

Category 2: Improved Retention

Improved retention was mentioned by eight of the 10 leaders and was referenced 18 times during the course of the interviews. When asked the interview question, "How do you feel implementing a $15 living wage influenced retention rates?," nine of the 10 participants noted a positive perception of improved retention rates. Participant 3 shared a specific experience of improved retention that occurred with an environmental services employee. Participant 3 stated, “I know personally of an environmental services worker who was planning on retiring in July of that year and because of hearing about the living wage, he decided to not retire. So, he and he's still here now, and it's now 2023.” On a similar note, Participant 4 stated “I think it definitely led towards people feeling valued and so like some increase in retention. Like some folks that I really was worried about, like possibly losing, I think stayed because of it.”

Category 3: Decreased Vacancy Rates

All 10 participants responded to the question; How do you feel implementing a wage influenced vacancy rates? Out of the 10 responses, decreased vacancy rates was mentioned by seven of the participants and referenced 11 time during the course of the interviews. One of the leaders perceived that the increase in candidate pool from two to three candidates per month to 15 to 20 candidate per month was a result of the $15 living wage adjustment. Retention was also mentioned in the responses regarding vacancy rates as the improved retention resulted in less vacancies thus decreasing the vacancy rate. One

of the participants stated “I think it's I think it definitely helped the vacancy rate. I know I'm not supposed to talk about the COVID piece, but I just I want to take note that that I think having that $15 an hour helped once COVID hit in terms of being able to retain people. So I think definitely that that affected the vacancy rate for the organization for their behalf.” On a similar note, another participant stated “We were able to actually garner more qualified candidates. And again, the retention rate improved, we were probably experiencing within a month's time frame three to four full time staff resigning. I think now we've only experienced one employee leaving in the past 6 months, and that was just due to disciplinary issues.”

Category 4: No Impact on Staffing Levels

Seven of the 10 leaders interviewed felt that the living wage had no impact on staffing levels. In the interviews staffing levels referred to the need to decrease or increase the number of employees to accommodate the implementation of the $15 living wage. Several of the leaders noted having approval from leadership to have a variance in the budget which allowed them to maintain their staffing levels and budget the appropriate salary dollars in the next fiscal year. Participant 6 stated “so we were fortunate that because of the increase we were not asked to reduce our amount of employees because of the $15 an hour wage” and Participant 8 stated “no, that did not get factored into the budget for that fiscal year.”

Category 5: No Shift in Funding or Increased Costs

When asked the interview question: *Did implementing a $15 living wage result in you removing funds away from other departmental initiatives or increase the cost of*

services? Seven of the 10 participants responded no. The no responses to this question are noted as a positive because this resulted in operations as usual for both the health care employees and no increase to the cost for services for their customers. One participant stated “No, it didn't. It was just the variance on the salaries and wages. That was it. Everything else, we continue to operate as usual.”

Category 6: Improved Employee Engagement

When asked the interview question: *How did implementing the $15 living wage influence employee engagement?* The responses were almost split down the middle six of the participants perceived that implementing the $15 living wage had a positive influence on employee engagement while the other four had either negative or unclear perceptions. Improved employee engagement was mentioned by six of the participants and referenced 12 times during the interviews. One participant stated, “They are more engaged. We actually had a survey. Our employees feel more comfortable coming to management with things. Now there's a lot more collaboration with management. They also feel like their voices are being heard. Um, so they've definitely been a lot more engaged in our initiatives. They've been more engaged in finding areas of opportunity for improvement and the department”.

Category 7: Positive Impact on Employee Productivity

Six of the 10 participants interviewed perceived that implementing the $15 living wage improved employee productivity in the health care industry. Participant 1 stated “I think it increased. I think you had more engaged employees and it seemed pretty immediately, honestly. I think it helped with the culture of happier employees. Yeah,

that's what it was, then they were more productive and more engaged and more gung-ho kind of, offering up suggestions of how we can do things better." Participant 3 stated "I believe it again just gave them a sense of pride to like, we're getting more money. I'm going to continue to try to do my best and show up and be a good team player. So I think it was positive. I think it helped internal team relations as well as external outside of our office relations as well." Similar sentiments were mentioned by Participant 8. Participant 8 stated "Employee productivity increased. There was not as much lag time in between their task. Even though, you know everybody use to come in and just talk a lot where now there's not as much idle time, they're more receptive to listen to my direct line supervisors. There's not as there's not as much time asking people to do things and then not doing them as there was in the past. Productivity has increased."

Major Theme 2: Negative Perceptions

The second theme that emerged from the thematic analysis was a negative perception of implementing a $15 living wage and its influence on organizational outcomes in the health care industry. Although all leaders had an overall positive perception of implementing a $15 living wage the perceptions surrounding the influence on organizational results varied. As it relates to organizational outcomes, the top categories linked to the negative perception theme were increased salary budget, no impact on absenteeism, no impact on employee engagement, no impact on vacancy rates, and no impact on employee productivity.

Category 1: Increased Salary Budget

Increased salary budget was mentioned by eight of the 10 leaders and was referenced 14 times during the course of the interviews. When asked the interview question, "How do you feel implementing a $15 living wage influenced your budget?," all 10 participants noted that the $15 living wage implementation directly increased the budget line item for staff salaries. Participant 9 stated, “Oh, it absolutely added to staffing expense. Yeah, because what we do is we went up $12 to $15 and then all the feathering at the time, I was not as involved with the budget as I am now. So I don't know what the actual number of dollars that are. The percent increase the staffing expense, but I know it had an impact on staffing expense.” While the increased salary budget is noted a negative perception, several of the participants shared things that the health care organization did to lighten the negative effects. Some things mentioned were the system budget office being supportive of the departments carrying a variance to cover the cost and shifting funding from non-business critical items such as new furniture or interior design to cover the cost of the increases.

Category 2: No Impact on Absenteeism

All 10 of the participants responded to the interview question: *How were your absenteeism rates affected by the $15 living wage adjustment?* Eight of the 10 participants perceived that the $15 living wage adjustment did not affect absenteeism rates. Participant 5 stated “my perception is it did not change, because once the euphoria wore off it was back to normal. You know, people's behavior is just what they normally were. So it had folks that would call out at certain times, right? They knew the rules of

the organization. So I don't think that the way that the $15 had a positive impact on all of the things of that nature, I think. I don't think that there was a change." Another participant stated "no, I wouldn't say that it affected the call out. We wish as a manager, we wish that it did, but it did not. It didn't directly do that."

Category 3: No Impact on Employee Engagement

Responses to the interview question, "*How did implementing the $15 living wage influence employee engagement?*", were almost split down the middle; four of the 10 participants had either negative or unclear perceptions whereas the other six participants perceived that implementing the $15 living wage had a positive influence on employee engagement. Participant 7 stated, "Other than a few thank you's from the five people that might have gotten it, I don't think it did. Some people were like, well thank you it's about time, but it didn't affect."

Major Theme 3: Unclear Perceptions

The third theme that emerged was an unclear perception of implementing a $15 living wage and its influence on organizational outcomes in the health care industry. When asked about items such as budget, overall influence on organization outcomes, shifting funding or increased costs, and increased vacancy rates some of the leaders answered that they did not know. One leader indicated that there were too many other factors to truly determine if implementing the $15 living wage influenced organizational outcomes. Participant 7 stated "patient satisfaction always goes up and down and up and down. You know that it was a beautiful sunny day will make a difference. You know it was no way for me to tease out that you got a 20% raise had an impact". In response to

the question about shifting funding or increased costs, participant 8 stated “they definitely might have had to increase the costs because it was a system decision to do that, but that's something again that they look at annually anyway. Just to be able to stay competitive supply costs and things of that nature. But I don't know.” When asked about the impact of the living wage on vacancy rates, Participant 7 stated “I don't think so, back then hiring to me seemed easier at the switch hiring now and like right last year was rough and now it's not easy to find out we're way past the wage adjustment. OK, now it's harder. I don't know if they made it better back then, but I know it's harder now.”

Other Key Categories

While not related to perceptions around influence on organizational results there were two popular categories regarding the overall perception of implementing a $15 living wage in a health care organization that I feel are important to share. The first was about selecting $15 as the amount and the other is in reference to the salary compression that occurred after the move to the $15 living wage.

$15 is Not Enough

One negative perception mentioned by seven participants and referenced 11 times during the interviews was that $15 was not the appropriate amount for the living wage. One participant clearly stated, “I personally don't feel that $15 is enough to provide for a family”, and another stated, “my perception is it still wasn't competitive for some industries”. A similar sentiment is noted in this response from another participant “for example, knowing that you can go to FedEx and make $18 an hour. But in health care, you're only doing $15. It makes you put things in perspective. How can someone that's

doing FedEx get $18 an hour and someone is doing direct patient care, giving life saving treatment, giving medications, and those types of things can be making far less and someone that's delivering packages. And as someone who's been in health care for a while, it's a hard sell sometimes, especially when you know how hard the clinical team works for that." Another participant specifically asked "why did we settle at 15? Why couldn't we have made it $17.50 or even $18?".

Compression

Compression was mentioned by four of the 10 leaders and was referenced eight times during the course of the interviews. One of the participants referred to compression as a negative after effect of the $15 living wage increase. The leader indicated that once the increases were effective some positions that had higher pay grades before the $15 living wage adjustment were now in close to the same pay grade as the employees in the lower-level roles. While the employees in the lower-level roles were feeling valued the employees in the positions that used to have higher pay grades felt undervalued. Participant 6 stated that "the compression on those lower-level positions, made it even harder to recruit them in some ways."

Summary

Chapter 4 described the details of the pilot study, the research setting, demographics, data collection and analysis process, evidence of trustworthiness, and the thematic analysis. The research question for this study was, How do health care leaders who have implemented a $15 living wage perceive the influence of paying a $15 living wage on organizational outcomes in the health care industry? The research question was

answered by asking 17 interview questions of the 10 participants in the study. After conducting the interviews, listening to the audio recordings, and reviewing and coding the transcripts, I developed insight into the health care leaders' perception of implementing a $15 living wage and its influence on organizational outcomes in the health care industry. Sixteen categories and three major themes emerged during through the coding process. All participants reporting a positive overall perception of implementing a $15 living wage but there were mixed responses regarding the influence on organizational outcomes. Some leaders shared several organizational outcomes such as retention and vacancy rates that they felt were positively impacted, while other leaders indicated that there was no impact, and others were unclear of the impact the implementation of the $15 living wage had on organizational outcomes.

Chapter 5 includes interpretations of the findings, limitations of the study, recommendations for future research, and implications of the results. This chapter also includes interpretation of the findings and how they correlate with the existing research. Next it includes details on the limitations of the study followed by recommendations for practitioners, leaders, and researchers. A summary and closing remarks with conclude this chapter.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative case study was to explore leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. A purposive sample of 10 leaders at a health care organization whose leadership had implemented a $15 living wage participated in the study. I conducted this study to gain insight into the perceptions of leaders regarding how implementing a $15 living wage influenced organizational outcomes in the health care industry. I analyzed the data collected during the interviews to identify themes and categories. I used the resultant themes and categories to guide the interpretation of the results and discussion of the findings. As noted in Table 2, the study revealed three major themes and 16 categories that provided insight into leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. This chapter includes a detailed discussion of the findings of the study, which includes the themes and categories, the interpretation of the findings, and how the findings relate to the current literature. In this chapter, I also discuss the limitations of the study; offer recommendations for future research; consider the study's implications for social change, scholarship, and practice; and provide a conclusion to the study.

Interpretation of Findings

The findings of this study confirmed, disconfirmed, and extended the findings in the literature discussed in Chapter 2. Previous research indicated that there are mixed perceptions regarding implementing a $15 living wage (Balasingam et al., 2020; Paul Leigh, 2019). The current study supported those findings as the leaders interviewed had

varied perceptions of implementing the $15 living wage. The literature review revealed the importance of implementing a $15 living wage and provided predictions on what may happen if a $15 living wage is implemented (Hartz & Wright, 2019; Himmelstein et al., 2019; Himmelstein & Venkataramani, 2019). However, in reviewing the literature there was little understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. After analyzing the data collected from the 10 participants, I was able to address that gap and gain better insight into leaders' perceptions of how implementing a $15 living wage influenced organizational outcomes in the health care industry.

The findings from my research indicated that the participating leaders had an overall positive perception of implementing a $15 living wage. Regarding its influence on organizational outcomes, the findings were mixed and highlighted in three major themes: positive perceptions, negative perceptions, and unclear perceptions. These mixed perceptions are consistent with the previous literature and directly correlate with the Paul Leigh (2019) study, which listed improved health of employees and decreased workers' compensation cost as positive results and the cost of the implementation and wage compression as the negative results of implementing a $15 living wage. Balasingam et al. (2020) also reported mixed responses in their study exploring the perceptions of leaders and employees on minimum wage issues in the hotel industry. The researchers found that leaders perceived a small improvement in employee productivity and motivation as a negative perception and decreased turnover as a positive perception. The results of my study further these studies, contribute to existing information, and also begin to fill the

gap in research regarding leaders' perceptions of how implementing a $15 living wage influences organizational outcomes in the health care industry.

As described in Chapter 2, the efficiency wage theory (Marshall, 1920), specifically the shirking model of efficiency wages (Shapiro & Stiglitz, 1984), provided the theoretical framework for this study. A premise of the efficiency wage theory is that organizations pay wages higher than the market rates with the goal of having the increased wages improve employee productivity (Akerlof, 1982; Yellen, 1984). The shirking model proposes motivating employees to work harder by providing an efficiency wage (Tomohara & Ohno, 2013). This model explains how implementing a living wage affects employee outcomes, which in turn affect organizational performance. The emerging major themes of the study—positive perception, negative perception, and unclear perception—as well as the other key categories listed in the thematic analysis are addressed in the following sections.

Major Theme 1: Positive Perceptions

The categories that fall under the positive perception theme are an overall positive perception of the $15 living wage, improved retention, decreased vacancy rates, no impact on staffing levels, no shift in funding or increased costs, improved employee engagement, and positive impact on employee productivity. This theme and categories support past research studies that predict positive outcomes related to implementing a $15 living wage and negate other studies that listed some of these items as negatives of implementing a living wage. Che Ahmat et al. (2019a) found that increased wages improved employee satisfaction with wages which positively influenced employee

satisfaction and engagement. In another study conducted by Che Ahmat et al. (2019b), the researchers also found that implementing a living wage had a significant impact on turnover intention. A conclusion is that turnover and vacancy rates are intertwined (Che Ahmat et al., 2019b). As turnover decreases, vacancy rates also decrease because there are fewer vacancies to fill as employees are staying employed and not leaving the organization. On the same lines as turnover and vacancy rates, the category of no impact on staffing levels illustrates that the organization did not have to reduce staff to cover the cost of the living wage increase. These findings negate the research of Repetti and Roe (2018), who found that an increase in wages significantly affected changes in employment. Ferraro et al. (2018) also conflicts these points as they found that living wage adjustments had little to no effect on employee retention.

Seven of the 10 participants indicated that the health care organization did not have to take funds from other areas like new equipment purchases or supplies or to increase costs to customers to fund the living wage adjustment. This was an interesting finding as some of the top cons in the literature regarding what will occur if a living wage is implemented are about costs and the fear of losing budget dollars for other things such as purchasing new equipment and making repairs and increasing cost to customers (Allegretto & Reich, 2018; Bodnár et al., 2018). The findings in this study of no shifts in funding and no increased cost aligns with Reich et al.'s (2019) prediction of only a .6% increase in wage cost after implementing a $15 living wage. At the same time, this category (no shift in funding or increased costs to customers) does not align with existing

research by Allegretto and Reich (2018) who found that the cost to customers rose by 1.45% after a minimum wage increase.

The majority of the health care leaders interviewed noted a positive impact on employee productivity. This finding aligns with the premises of the shirking model of the efficiency wage theory and previous studies on implementing a living wage that note increased employee productivity as an actual or predicted outcome of implementing a living wage. In Weltmann's (2019) study exploring which forms of compensation were more efficient at affecting employee outcomes, he noted increased employee productivity as one of the five reasons for the existence of the efficiency wage theory. Kim and Jang (2019) found that increasing from the federal minimum wage to more of a living wage in the restaurant industry increased employee productivity. My study supports these findings by linking to similar findings based on leaders' perceptions of implementing a $15 living wage in the health care industry.

Improved employee engagement was noted by half of the health care leaders with some even noting that they experienced this outcome immediately after the living wage was announced. This finding filled a specific gap in the literature noted by Repetti and Roe (2018) in their recommendation for future research that links increasing the minimum wage to a living wage to direct employee outcomes including employee engagement.

Major Theme 2: Negative Perceptions

Increased salary budget, no impact on absenteeism, and no impact on employee engagement are the key categories that fell under the negative perception theme. The cost

of implementing a $15 living wage is listed as a con and negative perception in the literature. The increased cost of moving to a living wage and the negative outcomes that could result from the increase are noted by Fahimullah et al. (2019) as a con of implementing a living wage. Allegretto and Reich (2018) and Bodnár et al. (2018) support this prediction and list increasing prices to consumers as a strategy organizations can use to offset the increased cost. While the cost was noted as negative perception by the health care leaders, the positive perception related to no shifts in funding or increased costs to the customers reduced the negative perception as the leaders indicated that things appeared to balance out on the back end.

Eight of the 10 leaders indicated that implementing the $15 living wage had no impact on absenteeism. There is no existing research that mentions absenteeism specifically in the exploration of the impact of implementing a $15 living wage. My study introduces this item and should be further explored in the future.

The final category under the negative perception theme, no impact on employee engagement, was also presented as a positive perception by the participants. This category explores an item of research noted by Repetti and Roe (2018) that recommended future research exploring living wage increases employee outcomes such as engagement.

Major Theme 3: Unclear Perceptions

Under the theme unclear perceptions, lack of awareness of how the organization overcame challenges, too many other factors to determine how implementing the $15 living wage affected organization results, and lack of understanding on how the $15 wage implementation influenced budget, organizational outcomes, funding shifts or increased

costs, and vacancy rates were the key categories. The leaders having an unclear perception of the effects of implementing a $15 and its influence on organizational outcomes in the health care industry supports the literature and the variety of predictions that are made regarding the outcomes of implementing a living wage. The unclear perception of the leaders also supports the gap in the literature regarding leadership perceptions. Having insight into what leaders did not know after a $15 living wage was implemented will help guide future research and practice as it provides items for areas of focus for research and education regarding implementing a living wage.

Other Key Categories

Selecting $15 as the amount of the living wage and compression are two themes that were expressed many times during the interviews. While these categories are not directly tied to organizational results, they do align with the findings of the past research on living wages. The living wage literature provides anecdotal reasoning on why $15 was selected as the appropriate amount for a living wage in the United States. According to Luce (2015) $15 seemed like a good safe number to go with as it was higher than some of the existing living wages but below $20 which organizers felt was just too much to ask for. The lack of a prescribed formula behind a $15 living wage is presented as con to implementing a $15 living wage in the literature (Wicks-Lim, 2016) and the interviews conducted with the health care leaders presented similar findings. Seven of the 10 leaders interviewed stated that $15 is not enough for a living wage.

Wage compression was noted eight times during the course of the interviews as a negative perception of implementing a $15 living wage. The leaders interviewed felt that

while the $15 living wage was a wonderful compensation strategy, the move to $15 significantly decreased the wage gap between entry level employees and employees with experience. This perception supports the finding of Howell (2019) and Wong (2018) that found that increasing the minimum wage led to wage compression and decreased pay equality. While wage compression is not directly linked to organizational outcomes, it is still an important category as wage compression is noted to have a negative effect on increased turnover and decreased employee engagement (Steward, 2020).

Limitations of the Study

The current study was an exploration of the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. In addition to the limitations listed in Chapter 1, the current study had other limitations specifically sample size and generalizability. A purposeful sample of 10 leaders at a health care organization that were employed at a health care organization pre and post $15 living wage adjustment and had employees that were affected by the living wage was used for the study. While the sample size is appropriate for a qualitative study and allowed the researcher to achieve data saturation, small sample sizes are noted to lead to the lack of generalizability of the results (Boddy, 2016). The representation of the sample and the geographical location of the study also limits generalizability. The study was conducted a one health care organization in the southeastern United States. While the study was able to achieve its purpose and provide insight into the leader's perceptions, the findings may not apply to leaders from other health care organizations, industries, or areas of the country.

Recommendations

With living wages being a hot topic in organizations, politics, and social advocacy groups additional research is needed to continue the exploration of outcomes of implementing a $15 living wage. With the limitations of my study, sample size and generalizability, I recommend that additional research is conducted in other geographical areas in the United States. The research from new studies could be compared to the results of this study to determine if there are similar findings in different areas of the country. The cost living varies differently across the country and there is sometimes variability within the same state (Glasmeier & MIT, 2020). While the results of my research indicated that the majority of the leaders interviewed felt that $15 was not enough for the living wage it would be interesting to see how this sentiment applies in other geographical areas. This may also show insight into whether or not living wages should be established at a national, state, or more local level.

My research sought to understand perceptions of leaders in the health care industry. There is existing research in the retail/trade and manufacturing (Romich et al., 2020), hotel (Balasingam et al., 2020), and restaurant (Repetti & Roe, 2018) industries. In addition to the existing studies insight into leaders' perceptions in other industries such as automotive, construction, and transportation is important to determine the perceptions across a wide variety of industries. With the findings of my research and the existing research presenting positive, negative, and unclear perceptions, having insight into other industries will assist in determining if there are any similarities or differences based on

industry. This insight will assist scholars and practitioners on their living wage research across industries.

Additional qualitative studies that focus on human resources professionals to gain insight into how living wages are implemented within organizations will also be beneficial to the body of knowledge on living wages. While my study sought more insight into leaders' perceptions of how the $15 living wage influenced organizational outcomes, it did not provide details on how the organization implemented the $15 living wage. When the health care organization in this study implemented the $15 living wage, they did so in phases. The organization already had a $12 living wage in place so the cost to get them to $15 was not as costly as it would be for organizations that still paid the current $7.25 minimum wage. In the first phase they moved to $14 and then 6 months later they moved to $15 at the beginning of their fiscal year. In an attempt to decrease the effects of compression, instead of moving everyone to $15 the organization moved to $15 and then applied what they referred to as a feathering affect. The feathering affect provided additional moderate increases to maintain the variances that existed based on existing market differences and the employees' years of experience and past merit-based increases in their roles. The living wage adjustment affected approximately 9,000 employees and a cost of about $15 million annually. Even with the feathering the leaders interviewed still noted compression as an issue. Exploring how other organizations have implemented a living wage may assist in providing knowledge on how to decrease the effects of compression when a living wage adjustment is implemented.

My study took a qualitative approach to exploring the perceptions of the leaders and provided a plethora of data and gave voice to the leaders at a health care organization that has implemented a $15 living wage. Even with this insight it is recommended that future researchers conduct quantitative studies to gain a better understanding into the relationship between implementing a $15 living wage and organizations results. With retention, absenteeism, vacancy rates, staffing levels, employee productivity, and employee productivity presented and key categories, analyzing these key metrics pre and post $15 living wage implementation will further the results of my study.

Implications

The current study's findings contributed to filling the gap in the literature regarding leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry. The current results are impactful at the individual, family, organizational, and political level and can be used to guide scholars and practitioners in the field of management and human resources, politicians, and social advocacy group in their plan to implement or promote a $15 living wage.

Social Implications

The current minimum wage of $7.25 is not enough for a single adult to live on let alone raise and support of family (Hill & Romich, 2018). With inflation at an all-time high and the costs for goods and services consistently increasing the natural progression seems to be increasing wages for employees, but sadly the federal minimum wage has not been increased since 2009 (Fair Minimum Wage Act of 2007, 2007). Increasing the federal minimum wage and/or moving to a living wage has been a heavily debated social

initiative for over a decade (Adams, 2017; Brennan, 2019; Brown, 2018; Lesica, 2018), and the COVID-19 pandemic accelerated the conversations on living wages as many employees deemed as essential were not paid a living wage (Hecker, 2020).

Recovering from the pandemic when the restrictions were lifted, the issue was also noticed when non-essential employees were called back to work. These employees were also not paid a living wage and to address major staffing issues many organizations are making quick decisions to pay higher wages without understanding how it will affect their organization. Having insight into leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry is a motivator for positive social change and addressing the significant problem of the working poor in the United States.

Theoretical Implications

The findings of this study have contributed to the existing body of literature utilizing the efficiency wage theory as a framework to examine how paying wages higher than the market rate affects employee productivity (Morris Morant & Jacobs, 2018). Revealing the three major themes positive perception, negative perception, and unclear perceptions and the 16 categories the findings of my study provided insight into leader's perceptions of implementing a $15 living wage and its influence on organizational results in the health care industry. Of the 16 categories; improved retention, decreased vacancy rates, no impact on staffing levels, improved employee engagement, positive impact on employee productivity, no impact on absenteeism, and no impact on employee engagement directly support as well as negate the premises of the efficiency wage theory

that indicates paying higher wages reduces shirking at work. Having this variety of insight provides a framework for future studies on living wages and its influence on organizational results.

Practice Implications

In practice at the organizational level the insights discovered during my study can be used guide organizations in the strategic compensation decision to implement a living wage. The overall cost of implementing a $15 living wage is often listed a con or reason why organizations cannot implement a living wage (Brennan, 2019; Werner & Lim, 2016). Utilizing the understanding of leader's perception of paying a $15 living wage and its influence on organizational results in the health care industry provides a foundation human resource professionals can use to put parameters in place that will reduce the impact of the cost of a living wage increase. Similarly at the political level this research can be used by politicians and social advocacy group to promote the move to the $15 living wage. The unclear perceptions that were discovered during the research illustrate the need for organizations to provide additional guidance, training, and communication pre and post living wage adjustment to ensure that leaders understand how implementing a living wage influences organizational outcomes. Having this insight will assist in guiding future changes in strategic compensation practices.

Conclusion

This qualitative case study sought to explore the understanding of leadership perceptions of paying a $15 living wage and its influence on organizational outcomes in the health care industry to fill the gap in the literature regarding leaders' perceptions of

implementing a $15 living wage. While some of leaders were unclear on how implementing the $15 living wage influenced organizational outcomes, the overall concept of implementing a $15 living wage was perceived in a positive manner but the perceptions regarding the impact on organizational results varied. On the positive side, the leaders perceived that implementing the $15 living wage positively influenced retention, vacancy rates, employee productivity, and employee engagement all which directly affect organizational outcomes. On the con side, there was still consensus among the leaders that implementing a living wage higher than the current federal minimum wage was the right thing to do, but the comment that $15 is not enough for the living wage was noted several times during the interviews. Along with questioning the amount of the living wage, the resulting increased salary budget, and no impact on absenteeism and employee engagement were also noted as negative perceptions.

In summary, leaders do perceive that implementing a $15 living wage both positively and negatively influences organizational outcomes in the health care industry. These findings emphasize the need for additional research on the topic to assist organizations in the planning process of implementing a compensation philosophy to pay a living wage, with the goal of ensuring that there are strategies in place to neutralize or reduce the potential negative effects.

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Appendix A: Letter of Agreement

November 21, 2022

VIA ELECTRONIC MAIL
Mary Richardson
mary.richardson1@waldenu.edu

Re: Proposed Study – *Leadership Perceptions of $15 Living Wage and Its Influence on Organizational Outcomes*

Dear Ms. Richardson,

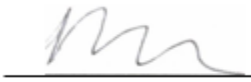
This letter is in regard to the above-referenced study (the "Study"), which you intend to conduct in connection with your enrollment as a student at Walden University ("School") and therefore outside the scope of your employment with The ABC Health Care System. I have been notified that the Study has been approved by the School's Institutional Review Board (the "IRB"). Accordingly, I am providing you this letter to confirm that you may proceed with the Study on the following conditions:

- Study activities must be conducted during personal time and not during work time.
- Study activities must be conducted using School accounts and resources (e.g., using School email and School Zoom account).
- Performance of the Study must be done in strict compliance with all requirements, restrictions, and/or limitations imposed by the IRB and in strict compliance with all applicable laws and regulations.
- No protected health information or other individually identifiable information of Study subjects or patients ("PHI/PII") may be disclosed to or accessed by anyone in connection with the Study other than you. PHI/PII shall be stored and disposed of in strict accordance with the policies and requirements of ABC Health.
- Confidential or proprietary information of ABC Health or its affiliates may not be used or disclosed without appropriate organizational approval.
- You may not publish or disclose information that identifies (or could be used to identify) ABC Health, its affiliates, or their employees.

Please acknowledge that you have read and agreed to the above requirements by signing below and return a signed copy to me via email.

Sincerely,
VP Research Officer, Clinical Research Integration Officer, and
Assistant Vice Chancellor for Clinical Research

READ, ACKNOWLEDGED, AND AGREED:



Mary Richardson

Appendix B: Email Invitation for the Pilot Study

Subject line:

Pilot Study – Pilot Study - Interviewing healthcare leaders with employees that were directly affected by the $15 living wage adjustment

Email message:

There is a new study about healthcare leader's perceptions of the $15 living wage and its influence on organizational outcomes in the healthcare industry. For this pilot study, you are invited to review and provide feedback on the research questions that have been drafted for the study. The researcher will utilize the feedback provided to revise and refine the interview questions as needed.

About the study:

- One 45-60 minute Zoom interview that will be recorded
- To protect your privacy, the published study will mask the name of the organization and the participants

Volunteers must meet these requirements:

- Have employees that were directly affected by the $15 living wage
- Been employed with the healthcare organization in a leadership role pre and post $15 living wage adjustment

This pilot study is part of the doctoral study for Mary Richardson, a Ph.D. student at Walden University. Interviews will take place during January 2023.

Please respond to this email to let the researcher know of your interest.

Appendix C: Interview Protocol for the Pilot Study

Introduction Script

Hello, may name is Mary Richardson, I am a doctoral candidate working on my dissertation at Walden University. I would like to thank you for participating in this pilot study. Your organization implemented a $15 living wage for employees in 2019, and I will be asking questions related to your perceptions of the $15 living wage adjustment and its influence on organizational outcomes in the healthcare industry. The purpose of the qualitative case study that this pilot study is being conducted for is to explore the understanding of healthcare leader's perceptions of paying a $15 living wage and its influence on organizational outcomes in the healthcare industry. To facilitate the accuracy of data collected, I would appreciate your permission to record this session. I will take notes during the interview and will be asking for your feedback on the questions to ensure that the questions asked will fulfill the purpose of my research study. This session will last approximately 45 – 60 minutes. Please let me know if you are at any time uncomfortable with my question, and also feel free to interrupt at any time to provide feedback. Per the provided informed consent provided you have the right to stop the session at any time. Let's get started

- Good morning/afternoon
- How are you today

I will start the session by asking some general questions followed by questions specific to purpose of the study. With COVID-19 pandemic there has been a lot going on in the

healthcare industry, in your responses to these questions I am going to ask to you provide responses that only relate to the living wage and not the pandemic response.

1. Please describe your position with ABC Healthcare System.
2. When did you start working for ABC Healthcare system?
3. What are your perceptions on the healthcare system implementing a $15 living wage?
4. Can you describe an experience you had with an employee that received a pay increase as a result of the $15 living wage adjustment?
5. Do you think implementing a $15 living wage influenced organizational outcomes?
6. If so, which specific outcomes do you feel the $15 living wage affected?
7. If not, why do you think the $15 living wage did not influence organizational results?
8. If you noticed an influence on organizational outcomes, at what point after the $15 living wage adjustment did you notice the influence?
9. How do you feel implementing a wage influenced vacancy rates?
10. How do you feel implementing a $15 living wage influenced retention rates?
11. Did your staffing levels fluctuate as a result of the $15 living wage implemented? If so, did it increase or decrease? How did you react to those fluctuations?
12. How were you absenteeism rates affected by the $15 living wage adjustment?
13. How do you feel implementing a $15 living wage influenced your budget?

14. Did implementing a $15 living wage result in you removing funds away from other departmental initiatives or increase the cost of services?
15. How did implementing the $15 living wage influence employee productivity?
16. How did implementing the $15 living wage influence employee engagement?
17. What challenges did the health care system face when the $15 living wage was implemented?
18. How did you overcome these challenges?
19. What else would you like to share about implementing a $15 living wage that we have not addressed in the previous interview questions?

Ending Script:

Thanks again for your participation in my pilot study. I will utilize the data collect to revise and refine the interview questions as needed. Once again thank you for your time and participation. If you are interested in learning the results of the study, I am willing to share the result after completion and acceptance by Walden University. I will stop the recording now. Please feel free to contact me if you have any questions. Thank you!

Appendix D: Email Invitation for the Final Study

Subject line:
Interviewing healthcare leaders with employees that were directly affected by the $15 living wage adjustment

Email message:
There is a new study about healthcare leader's perceptions of the $15 living wage and its influence on organizational outcomes in the healthcare industry. For this study, you are invited to describe your perceptions of the $15 living wage and its influence of organizational outcomes in the healthcare industry.

About the study:

- One 45-60 minute Zoom interview that will be recorded
- To protect your privacy, the published study will mask the name of the organization and the participants

Volunteers must meet these requirements:

- Have employees that were directly affected by the $15 living wage
- Been employed with the healthcare organization in a leadership role pre and post $15 living wage adjustment

This interview is part of the doctoral study for Mary Richardson, a Ph.D. student at Walden University. Interviews will take place during February 2023.

Please respond to this email to let the researcher know of your interest.

Appendix E: Email Invitation Reminder for the Final Study

Subject line:
REMINDER: Interviewing healthcare leaders with employees that were directly affected by the $15 living wage adjustment

Email message:
There is still time to participate in the new study about healthcare leader's perceptions of the $15 living wage and its influence on organizational outcomes in the healthcare industry. For this study, you are invited to describe your perceptions of the $15 living wage and its influence of organizational outcomes in the healthcare industry.

About the study:

- One 45-60 minute Zoom interview that will be recorded
- To protect your privacy, the published study will mask the name of the organization and the participants

Volunteers must meet these requirements:

- Have employees that were directly affected by the $15 living wage
- Been employed with the healthcare organization in a leadership role pre and post $15 living wage adjustment

This interview is part of the doctoral study for Mary Richardson, a Ph.D. student at Walden University. Interviews will take place during February 2023.

Please respond to this email to let the researcher know of your interest.

Appendix F: Interview Protocol

Introduction Script

Hello, may name is Mary Richardson, I am a doctoral candidate working on my dissertation at Walden University. I would like to thank you for participating in my study. Your organization implemented a $15 living wage for employees in 2019, and I will be asking questions related to your perceptions of the $15 living wage adjustment and its influence on organizational outcomes in the healthcare industry. The purpose of this qualitative case study is to explore the understanding of healthcare leader's perceptions of paying a $15 living wage and its influence on organizational outcomes in the healthcare industry. To facilitate the accuracy of the data collected, I would appreciate your permission to record this session. I will also take notes during the interview. Utilizing the recording and my notes will allow me to have a comprehensive record of my questions and your responses. This session will last approximately 45 – 60 minutes. Please let me know if you are at any time uncomfortable with my questions. Per the provided informed consent you have the right to stop the session at any time. Let's get started.

- Good morning/afternoon
- How are you today

I will start the session by asking some general questions followed by questions specific to the purpose of my study. With COVID-19 pandemic there has been a lot going on in the healthcare industry, in your responses to these questions I am going to ask to you provide responses that only relate to the living wage and not the pandemic response.

Position - Please describe your position with ABC Healthcare System.

Tenure - When did you start working for ABC Healthcare system?

Qualitative Question 1. What are your perceptions on the healthcare system implementing a $15 living wage?

Qualitative Question 2. Can you describe an experience you had with an employee that received a pay increase as a result of the $15 living wage adjustment?

Qualitative Question 3. Do you think implementing a $15 living wage influenced organizational outcomes?

Qualitative Question 4. If so, which specific outcomes do you feel the $15 living wage affected?

Qualitative Question 5. If not, why do you think the $15 living wage did not influence organizational results?

Qualitative Question 6. If you noticed an influence on organizational outcomes, at what point after the $15 living wage adjustment did you notice the influence?

Qualitative Question 7. How do you feel implementing a wage influenced vacancy rates?

Qualitative Question 8. How do you feel implementing a $15 living wage influenced retention rates?

Qualitative Question 9. Did your staffing levels fluctuate as a result of the $15 living wage implemented? If so, did it increase or decrease? How did you react to those fluctuations?

Qualitative Question 10. How were your absenteeism rates affected by the $15 living wage adjustment?

Qualitative Question 11. How do you feel implementing a $15 living wage influenced your budget?

Qualitative Question 12. Did implementing a $15 living wage result in you removing funds away from other departmental initiatives or increase the cost of services?

Qualitative Question 13. How did implementing the $15 living wage influence employee productivity?

Qualitative Question 14. How did implementing the $15 living wage influence employee engagement?

Qualitative Question 15. What challenges did the health care system face when the $15 living wage was implemented?

Qualitative Question 16. How did you overcome these challenges?

Qualitative Question 17. What else would you like to share about implementing a $15 living wage that we have not addressed in the previous interview questions?

Ending Script:

Thanks again for your participation in my study. The Data collected today will be transcribed using NVivo. Once the data is transcribed, I will email you a copy of the transcribed data for your review to ensure that all responses were accurately captured. If there are any errors in the transcription, please reply within one week with comments to the document. If I do not receive a response within one week, I will consider that transcribed data was accurately captured, with no errors were detected. Once again thank you for your time and participation. If you are interested in learning the results of the study, I am willing to share the result after completion and acceptance by Walden

University. I will stop the recording now. Please feel free to contact me if you have any questions. Thank you!