2016

Exploring Leadership Strategy Influence on Nursing Personnel Retention Within Safety-net Hospitals

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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2016

Abstract

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Carl L. Brown

MA, Webster University, 2013

MBA, William Carey University, 1997

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Frequent turnover among a hospital's nursing staff can profoundly impact organizational operating costs. With a national turnover rate of 17% in 2015, understanding the impact of management approaches on nurse attrition is vital to business success. Guided by Homan's social exchange theory, the purpose of this single case study was to explore leadership strategies used by safety-net hospital leaders to increase nursing personnel retention. Data collection consisted of semistructured interviews from a purposive snowball sampling of 8 senior directors working at a safety-net hospital in southern Maryland. Additional information collected involved documents and artifacts related to human resources management policies and guidelines. Constant comparative method enabled the analysis and identification of latent patterns in words used by respondents. Through methodological triangulation, several themes emerged. These themes included engagement and management support, education and career development, teamwork and work atmosphere, recognition, relationship building and communication, and health reform and innovation. According to the study results, increasing employee engagement, offering training and career development, performing technological upgrades, and developing sustainable relationships are appropriate approaches for gaining nursing personnel commitment. The findings of this study are important to senior leaders and middle managers in healthcare and other industries as they seek to attract talented staff members to sustain their organizations. The conclusions in this study may contribute to positive social change through improved nursing staff retention, leading to better patient experiences, healthier communities, and more satisfied customers.

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Dedication

I dedicate this doctoral study to my family for their unconditional love, patience, and support. I am who I am because of the prayers and words of encouragement from each of you. You gave me the space I neeeded to make this happen and understood when I never seemed to have time for you and forgave me for the many times I forgot to call on your special day. Karl and Alicia, hopefully Dad's example will serve to motivate you to strive for your highest goals in life. Remember, no sacrifice, no reward!

To all of my friends who supported me and cheered me on when I would get frustrated, I just want to say thank you for your understanding. One thing I came to learn on this lonely journey was that true friends will be there to the end.

A wise man once said, "No good man embarks upon a long and arduous journey without first invoking the aid of a deity." I thank God for his grace and mercy and supplying all of my needs during this challenging expedition.

I want to send a heartfelt "Thank You" to all nurses, especially those serving our most vulnerable populations. I continue to be amazed at your commitment to caring for others with compassion, empathy, and professionalism. We will never be able to pay you your true worth, but know that there are blessings in store. For we are reminded that "Inasmuch as ye have done *it* unto one of the least of these my brethren, ye have done *it* unto me."

Acknowledgments

I want to acknowledge and thank my doctoral study committee chairperson Dr. Jamie Patterson, for her astute guidance and motivation throughout this process. I would also like to thank my second committee member, Dr. Jon Corey and university research reviewer Dr. Jim Savard for their sage advice and support in bringing this project to fruition. Finally, a special thanks to Dr. Jacquie Payne-Borden for her outstanding support in helping me to gain access to research participants. You were truly a blessing!

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Section 1: Foundation of the Study

Skilled employees are a critical asset and indispensable to organizational success. Businesses must develop long-term strategies to compete for qualified workers while retaining trained staff in a highly competitive marketplace (Kossivi, Xu, & Kalgora, 2016). To remain viable, employers have to effectively manage and motivate current employees to engender long-term commitment while developing competences essential to growth and business sustainment. A leadership focus on employee retention fosters long-term worker commitment and optimal performance (Bidisha, 2013). Without qualified staff, leaders are unable to implement strategic and tactical plans.

Background of the Problem

The United States ranks last in life expectancy despite spending almost double on health care compared to 16 other high-income countries (Woolf & Aron, 2013). The annual cost of uncompensated health services was $84.9 billion in 2013 (Coughlin, Holahan, Caswell, & Miller, 2014). Congress passed the Affordable Care Act (ACA) in 2010 to strengthen the safety net for growing numbers of uninsured individuals and to address quality concerns plus rapidly rising health care costs (Grant, 2014). Safety-net hospitals perform a crucial role in delivering healthcare to uninsured and low-income populations, especially in hard-to-staff rural and urban areas.

Nursing personnel are vital contributors in sustaining operations in a medical organization. Nurse managers and hospital administrators must safeguard appropriate staff-to-patient levels to provide safe care to patients (Davis, Mehrotra, Hall, & Daskin, 2013). Healthcare planners anticipate a shortage of nursing staff to care for a projected 75 million aging baby boomers by the year 2020 (Hussein, Rivers, Glover, & Fettler,

2012). Organizational decisions to reduce labor costs by downsizing or restructuring might exacerbate nurse shortages by contributing to employee job insecurity (Karkoulian, Mukaddam, McCarthy, & Messarra, 2013). High-performing healthcare systems depend on adequate staffing and employees with above-average levels of job satisfaction (Nica, 2013). Within this study, I explored strategies used by leaders in safety-net organizations to increase nursing personnel retention.

Problem Statement

Leaders within healthcare organizations must seek strategies to mitigate the cost consequences associated with high turnover rates among nursing personnel (Bothma & Roodt, 2012). The financial cost for a hospital to replace one registered nurse was approximately $88,000 in 2010 (Li & Jones, 2013). The general business problem was that safety-net healthcare organizations face increased operating expenses due to challenges in retaining nursing personnel with specialized skills. The specific business problem was that some safety-net healthcare managers lack strategies to increase nursing personnel retention.

Purpose Statement

The purpose of this qualitative single case study was to explore strategies safety-net healthcare managers used to increase nursing personnel retention. The population in this study was nurse directors in a safety-net medical facility in the state of Maryland. This population was appropriate because nursing-related functions and management decisions contribute to approximately 25% of a hospital's operating costs (Maenhout & Vanhoucke, 2013). The implications for positive social change include the possibility that nursing staff retention would positively influence the experience that patients have,

creating healthier communities and more satisfied customers. Managers who recognize the importance of retaining nurses are more likely to foster a work environment with stronger supervisor-subordinate relationships, engagement, patient-centered care, and productivity (Lowe, 2012).

Nature of the Study

The three major research approaches are qualitative, quantitative, and mixed methods (Venkatesh, Brown, & Bala, 2013). In this study, I chose the qualitative method in order to use open-ended questions when exploring the leadership strategies used to increase employee retention. The qualitative method provides more interpretive explanations and seeks to explain particular phenomena or conclusions (Mukhopadhyay & Gupta, 2014). Additionally, the qualitative approach allows researchers to gain a detailed understanding of and insight into complex phenomena (Macur, 2013). In contrast, researchers testing hypotheses or seeking cause-and-effect relationships use a quantitative method to draw conclusions about the impact of one variable on another (Baskarada, 2014; Orcher, 2014). Mixed methods combine both qualitative and quantitative approaches within one study (Bazeley, 2015). Due to time and resource constraints, a mixed methods approach was not appropriate for this study.

I considered four research designs for exploring leadership strategies: (a) case study, (b), phenomenological, (c) ethnographic, and (d) narrative. In this investigation, I chose case study as the research design suitable to address the phenomena under investigation. Case study design is a linear yet iterative process that allows researchers to search for *how* and *why* answers relating to a contemporary phenomenon (Yin, 2014). A phenomenological study describes the *what* and *how* of lived experiences but does not

fully address *why* the event occurred (Moustakas, 1994). Ethnographic design allows for the observation of a particular group or culture over a prolonged period with a focus on collective behavior, language, and interactions (Dhar, 2014). Exploring cultural aspects of a specific group, however, was not the focus of the study. Narrative research involves the collection of stories from individuals about their lived experiences through autobiographical self-reflection, biographical data, and representation constructions (Bold, 2012). However, a narrative design was not appropriate for this study.

Central Research Question

The review and analysis from this study may provide insight into retention strategy selection. The following research question shaped the emphasis of this study: What strategies do safety-net healthcare leaders use to increase nursing personnel retention?

Interview Questions

The following open-ended questions supported gathering information from participants about their leadership experiences in support of the central research question:

1. What strategies do you use to increase nursing personnel retention?
2. What factors have you identified as contributors to nursing staff attrition?
3. What staff retention programs does your organization offer?
4. What obstacles, if any, have you encountered in implementing retention strategies for nursing personnel in the organization?
5. What process does your team use to identify candidates for advancement to positions of increased responsibility?

6. What impact, if any, have health-reform-related innovations had on staff morale?
7. How does your organization determine funding, and who is selected for training opportunities?
8. What additional information would you like to add to help me better understand how your organization addresses employee retention?

Conceptual Framework

The conjectural basis for this study was social exchange theory (SET). Homans (1961) developed SET as a theoretical framework based on the works of Thibaut and Kelley (1959), who emphasized a psychological approach, as well as earlier philosophers with a utilitarian concentration. Homans sought to explain how individual perceptions of power, conformity, status, and leadership shaped human interactions. SET represents the convergence of sociology and social psychology theories into one theoretical framework (Emerson, 1976). There are two distinct branches of SET: economic and social (Chiaburu, Munoz, & Gardner, 2013). Business researchers may find SET useful in exploring the function a leader fulfills in promoting a sense of employee obligation and positive work attitude (Blau, 1964). Perceived organizational support and leader-member exchange, tenets of SET, are valuable in investigating worker interactions. Perceived organizational support emphasizes organization-employee interactions, and leader-member exchange measures the quality of reciprocal exchange among employees (Banks et al., 2014). Homan's (1961) and Blau's (1964) social exchange theories aligned with this study, in which I sought to explore the strategies that safety-net healthcare managers used to increase nursing personnel retention.

Operational Definitions

Operational definitions clarify key terms, jargon, and particular words used in a doctoral study. Researchers use operational definitions to provide precise terms for measuring an operation (Hinkel, Nicholls, Vafeidis, Tol, & Avagianou, 2010). This section focuses on critical leadership and healthcare-related phrases typically not found in analogous research.

Disproportionate share hospital: Disproportionate share hospitals (DSH) are safety-net hospitals that provide uncompensated care to low-income and uninsured populations (Neuhausen, 2013).

Employee engagement: Employee engagement refers to individual employees' psychological state and actions that bring self-fulfillment and active contributions to the organization (Kataria, Rastogi, & Garg, 2013).

Patient-centered medical home: Patient-centered medical home (PCMH) refers to an innovative healthcare delivery concept that uses a physician-led team approach to supply patient-centric care as part of ACA-related health reform initiatives (Bao, Casalino, & Pincus, 2013)

Responsible leadership: Responsible leadership (RL) is a leadership theory that melds social and environmental responsibility into leadership actions to influence ethical behavior within an organization (Miska, Hilbe, & Mayer, 2014).

Safety-net hospital: Safety-net hospitals are healthcare organizations that serve a high proportion of uninsured and underinsured populations in urban and rural locations (Flinter, 2012).

Value-Based Purchasing: Value-Based Purchasing (VBP) is a Centers for Medicare & Medicaid Services (CMS) initiative to link Medicare's payment system to a value-based practice designed to improve healthcare quality (CMS, 2014).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are self-evident conditions taken for granted by researchers (Leedy & Ormrod, 2013). I assumed that the participants understood the open-ended interview questions used in the study and would respond with information-rich and honest answers. I also assumed that respondents would freely participate without fear of experiencing coercion in any way.

Limitations

Limitations are those characteristics of a study that constrain the transferability of the results to a larger population (Simon & Goes, 2013). The study took place in a safety-net medical center located in the state of Maryland. The findings of this study were limited to the perceptions and experiences of nurse leaders who were available and willing to participate in the study. Therefore, they may not represent the thoughts and perceptions of other leaders within the facility, or in other safety-net facilities in the area, state, and nation. Additionally, perceptions may be influenced by close working relationships with smaller groups where members may be multitasked across complex roles. Buchannan et al. (2013) reported that 75% of hospital middle managers have jobs with large scopes of responsibility, unpredictable workflow, and at least 10 hours of physical presence daily.

Delimitations

Delimitations establish the investigative parameters within a research study (Koh & Owen, 2012). For instance, a demarcation of this study was viewpoints expressed by leaders related to nursing personnel who had patient contact roles with often large low-income and uninsured population. Secondly, research results based on a case sampling provide more in-depth information than can be attained with quantitative surveys, which might fail to illuminate why a decision or decisions occurred (Yin, 2014). Finally, I eliminated leaders and managers without broad management experience. This delimitation ensured that respondents possessed the breadth of knowledge necessary to comprehend organizational dynamics and interactions of the various management roles.

Significance of the Study

Contribution to Business Practice

Healthcare conveyance in the United States causes lags in the growth and development of other business sectors in the general economy (Block, 2013). Leader engagement with knowledge employees is critical for hospitals to sustain patient access, quality, and profitability (Fibuch & Ahmed, 2015). Medical leaders who identify best practices and feature modernization in their organizational vision, mission, and values statements position their businesses for success (Duarte, Goodson, & Dougherty, 2014). This study augments the body of knowledge through increased understanding of leadership strategies to improve nursing personnel retention.

Implications for Social Change

This study could prove beneficial for healthcare leaders tasked with sustaining a strong, experienced nursing staff as they face decreased federal and state funding. The

study may stimulate innovative ideas to improve care delivery, operational efficiencies, clinical outcomes, and costs associated with employee turnover (Reiter et al., 2014). The focus on new ideas and employee motivation can lead to business innovations that reach new heights in operations efficiency, thereby increasing care capacity through employees with increased organization commitment.

A Review of the Professional and Academic Literature

The purpose of this qualitative single case study was to explore the strategies that safety-net healthcare managers use to increase nursing personnel retention. The structural design of this literature review centered on four broad conceptual frameworks: social exchange theory, leadership theory, innovation theory, and motivation theory. The first section includes the theoretical foundation of social exchange theory along with discussions of safety-net hospitals, health disparities, health reforms, and pay-for-performance. The second section includes a dialogue on transformational leadership theory and responsible leadership. Also included in this section is a discussion on leadership strategies. The third section comprises a discussion of disruptive innovation theory and the importance of pioneering care delivery processes and technology to meet new health reform requirements. The final section explores motivation theory along with a discussion of staff engagement and employee satisfaction.

The literature review involved a comprehensive search using Walden University Library databases and Google Scholar. I conducted Boolean searches for peer-reviewed journal submissions from the following business and management databases: Business Source Complete, ABI/INFORM, SAGE Premier, SAGE Stats, and ProQuest. Keywords used in database searches included *safety-net hospitals, social exchange theory,*

transformational leadership, motivation theory, employee engagement, employee retention, health reform, responsible leadership, employee job satisfaction, leadership strategy, and *disruptive innovation*. Database searches yielded 113 articles from academic journals (see Table 1).

Table 1

Subject Matter Review

References	Books	Journal articles
Safety-net hospitals		12
Social exchange theory	2	14
Transformational leadership	1	18
Motivation theory		10
Employee engagement		16
Responsible leadership	1	12
Employee job satisfaction		16
Leadership strategy	2	11
Disruptive innovation	1	14
Total	5	113

Of the articles evaluated, 100 were peer reviewed and published within the last 5 years, representing 94 % of the literature review (see Table 2).

Table 2

Number of Sources for Literature Review

Category	Books	Peer reviewed, less than 5 years	Not peer reviewed	Total
Books	5			5
Journal articles		100	6	108
Total	5	100	6	113

Social Exchange Theory

Social exchange theory (SET) is the major foundational framework for organizational research (Choi, Lotz, & Kim, 2014). SET provides a theoretical basis for human behavior such as employment relationships that are motivated by an expected return (either financial or nonfinancial) from the parties involved. Homans was the first sociological theorist to concentrate on interpersonal exchanges within an organization (Cook, Cheshire, Rice, & Nakagawa, 2013). Homans's work on dyadic exchange created a basis for evaluating concepts of distributive justice, balance, status, leadership, authority, and solidarity within organizations (Homans, 1961, p. 62).

Organizations thrive when leaders and subordinates work in harmony. Theorists based social exchange theory on the premise that constructive associations between a supervisor and subordinate may yield positive relationships based on reciprocity (Chughtai, Byrne, & Flood, 2015). In the relationship, those with high exchange beliefs worked hard only if they felt cared for in a particular manner. Those with little exchange ideology supported the organization regardless of their feelings (Blau, 1964). Blau (1964) posited two types of exchange that occur in human relationships—social and economic. Social arrangements depend on trust and feelings of obligation. However, economic agreements place an emphasis on pay, performance, or other tangible aspects. In studies of careerism, exchange principles have served as predictors of careerism among employees who have sought to advance through impression management, networking, and non-task-related activities (Chiaburu et al., 2013). A challenge for management is to identify employees whose motives are not organization-centric but who seek advancement through means other than hard work and task accomplishment.

Organizational change creates stress among its employees due to uncertainty. Employees who have a positive attitude toward change report positive organizational citizenship behavior (Chih, Yang, & Chang, 2012). Conversely, when there is job uncertainty, employee commitment, satisfaction, and performance suffer (Giauque, 2015). Social exchange concepts help identify organizational conditions that create a positive corporate atmosphere (Giaugue, 2015).

Performance appraisal is an opportunity for exchanging information between supervisor and subordinate on their contributions to the organization. The social connection between the two partners has bearing on how the subordinate responds and provides context for the quality of the relationship (Pichler, 2012). Ratings viewed as negative impact employee beliefs regarding procedural fairness in the organization. A positive working relationship between the rater and ratee can moderate appraisal reactions and lead to greater commitment to the organization (Pichler, 2012).

Some researchers have voiced concerns with social exchange theory. Two primary criticisms of Homans's philosophies are that it is too reductionistic and lacks sufficient analysis on substitutional levels of social behavior (Cook et al., 2013). Suutari, Tornikoski, and Makela (2012) criticized the theory as projecting a consequentialist orientation. Suutari et al. suggested that for global careerists, SET's two-party relationship between the employer and employee does not fully incorporate the influence of the family on the decision-making process. For instance, when potential employees viewed displacing the family to work at a small company compared to a larger international firm, the smaller company was viewed as riskier.

Safety-net organizations. Safety-net hospitals perform an important role in the U.S. healthcare system in treating uninsured and low-income populations, including providing culturally responsive health and social services. Safety-net healthcare organizations serve 18 million people in medically underserved and health professional shortage areas and must confront current and projected shortfalls of primary care providers (Flinter, 2012). Safety-net hospitals provide trauma, burn care, and training platforms for medical and nursing students. Charity hospitals depend on reimbursements for treating uninsured and underinsured patients through the Medicare and Medicaid Disproportionate Share Hospital (DSH) program. Uncompensated healthcare was estimated to cost hospitals between $74.4 billion and $84.9 billion in 2013 (Coughlin et al., 2014). There are two means to qualify for the DSH adjustment. The primary method applies to hospitals that serve a disproportionate number of low-income patients, based on the disproportionate patient percentage (DPP; Department of Health and Human Services [DHHS], 2013). The DPP equates to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income (DHHS, 2013). DPP also includes the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A (DHHS, 2013). A special alternate exception method applies to hospitals located in an urban area that have 100 or more beds and demonstrate that more than 30% of their total inpatient care revenues come from state and local government sources for indigent care (DHHS, 2013).

Safety-net hospitals face financial challenges related to ACA-related DSH payment reductions. Amid shrinking state Medicaid budgets, DSH payment cuts, and

greater access to insurance under the ACA, safety-net hospitals must now reposition themselves in the marketplace to compete for a patient population they have traditionally served (Coughlin, Long, Sheen, & Tolbert, 2012)). Patients with newly acquired insurance now have the option to seek care at non-safety-net hospitals, increasing the risk of further revenue losses. Additionally, an Institute of Medicine report cited a possible 35% funding cut to safety-net academic teaching hospitals that would reduce physician and nurse training, jeopardizing the ability of safety-net hospitals to care for low-income populations (Boerner, 2014).

Many safety-net systems across the United States dedicate tremendous resources in an attempt to adapt and respond to changing health care dynamics. Sustainability strategies include developing integrated delivery and payment reform systems, investments in health information technology, implementing cost-cutting measures, and transforming primary and specialty care practices. Leaders who put into operation courses of action that capitalize on groundbreaking techniques position their organizations for success.

Health disparities. Socioeconomic status contributes to health outcome differences (Scott et al., 2013). Behavioral risk factors, access to treatment and preventive services, and exposure to environmental hazards contribute to dissimilarity in morbidity and mortality rates and increased health disparities (Harrington, 2013). Burdened with increasing costs, national, state, and local governments face trade-off decisions when providing care to an increasing population of uninsured individuals. At the state level, legislators need to develop laws and policies to eliminate racial and ethnic health disparities (Young, Pollack, & Rutkow, 2015). However, policy makers have

limited choices: raise taxes, cut benefits, or expand the deficit. Regardless, healthcare leaders have to deal with the financial consequences of these decisions when uninsured patients present for care.

Historically, minorities lagged behind Whites significantly in life expectancy. Data from the National Center for Health Statistics suggest a narrowing of disparity in life expectancy between Blacks and Whites (Murphy, Xu, & Kochanek, 2013). The report showed that Black life expectancy in 2010 increased to age 75.1 compared to 78.9 for Whites (Murphy et al., 2013). Similar research revealed decreases in life expectancy among segments of the U.S. population, particularly low-educated White men and women (Montez & Zajacova, 2013). The results suggest that increasing mortality rates among segments of the U.S. White population with less than a high school education were the primary cause of the narrowing of the disparity gap (Olshansky et al., 2012).

Health reforms. Healthcare is expensive in the United States compared to other countries, with little improvements in health outcomes (The Commonwealth Fund, 2014). The ACA seeks to increase the number of Americans with healthcare coverage and improved access to care. Enactment of the ACA represented the greatest change in healthcare since passage of Medicare in 1966. Health care leaders face significant challenges in overcoming staff resistance to changes in the healthcare delivery system mandated by the ACA (Delmatoff & Lazarus, 2014). Through the ACA, by 2019, 25 million uninsured individuals are expected to gain access to affordable quality care through either Medicaid expansion, employers, or the Health Insurance Marketplace (Shaw, Asomugha, Conway, & Rein, 2014). The law seeks to strengthen the nation's primary care foundation through enhanced reimbursement rates for providers and the use

of innovative delivery models such as patient-centered medical homes. Additionally, the ACA expanded the Children's Health Insurance Program to provide coverage to up to 9 million children. The Act also added a high-risk pool for a large portion of new entrants previously classified as hard-to-insure or medically uninsurable.

Expansion of the ACA substantially increased state program costs due to increased demand. Historically, government programs reimbursed hospitals nearly 65% for charity care (Coughlin et al., 2014). Health reformers projected cuts in Medicaid program funding for uncompensated care by $17.1 billion between 2014 and 2020 (Coughlin et al., 2014). This action significantly affects safety-net hospitals that depend on federal reimbursements for costs associated with providing care to indigent patients. Even though the ACA provides coverage for millions of previously uninsured individuals, there will still be a large population of uninsured individuals.

Medicaid projects federal matching rates to decline by 10% from 2014 to 2020 (Price & Eibner, 2013). When federal government officials drafted ACA legislation, they assumed that health reform would substantially decrease the number of uninsured people (Congressional Research Service, 2013). The ACA offered states new options and enhanced federal funding to create a care system that would provide a broader range of care options for people with disabilities and chronic conditions. ACA planners forecasted that as the states expanded care to the uninsured and implemented health exchanges, the number of uninsured patients treated by safety-net facilities would decrease (Congressional Research Service, 2013). However, 21 states refused to expand their Medicaid programs or failed to develop state-run exchanges and must develop plans to compensate for lost revenue or face the possibility of hospital closures, staff layoffs,

and reduced availability of care (Congressional Research Service, 2013). Nevertheless, these states must still provide coverage for the 3.2 million people who would otherwise be eligible for care under Medicaid expansion (Boerner, 2014).

The ACA implemented new allocation criteria that placed greater weight on investments in innovative primary care delivery systems. Hospitals must now require their medical staff specialists to accept a fair allotment of uninsured safety-net patients at discounted rates to be eligible for DSH payments (CMS, 2014). Reform planners sought to increase the transparency and scrutiny of charity care policies and practices used to justify nonprofit hospitals' tax-exempt status. The reform laws provided for a series of demonstration projects or waiver programs that could support the development of better safety-net access programs (CMS, 2014).

Pay-for-performance. Value-Based Purchasing (VBP) is part of the CMS's innovation efforts to improve healthcare quality by linking Medicare's payment system to a cost-driven system (CMS, 2014). The program uses advanced acquisition concepts to shift from a volume-driven payment system that accounts for the largest share of Medicare spending in 3,500 hospitals across the country. Participating hospitals receive payment for patient care rendered based on the quality of outcomes, not just the quantity of services they provide.

Under VBP, Medicare holds onto 1% to 3% of total Medicare payments and hospital payments allocated based on performance against a set of quality measures (Chatterjee, Joynt, Orav, & Jha, 2012). A significant portion of each hospital's performance score is determined using metrics of patient-reported experience contained in the Hospital Consumer Assessment of Healthcare Providers and Systems survey

(CMS, 2014). The performance score is critical for safety-net hospital leaders who depend on DSH reimbursements.

VBP presents a risk for safety-net hospitals that must rely on performance-based payments, according to research published in the *Archives of Internal Medicine*. In a study comparing safety-net to nonsafety-net hospitals, the results showed that charity hospitals performed more poorly on nearly every measure of patient experience (Chatterjee et al., 2012). Medical leaders must be aware of the consequences of negative patient experience data connected to value-based payment criteria for safety-net facilities.

Transformational Leadership Theory

Burns (1978), a political scientist, conceptualized transformational and transactional leadership theories when documenting the traits of world leaders. Burns explained transformational leadership as a process whereby a person engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower. Bass (1985) expounded upon Burns' conceptualization of transformational leadership by describing specific behaviors reflective of transformative leaders. Bass included actions such as being a model of integrity and fairness, setting clear goals, having high expectations, stirring emotion and passion, and committing to organizational priorities (Caillier, 2014). Avolio, Walumbwa, and Weber (2009) described transformational leadership as leader behaviors that transform and inspire followers to perform beyond expectations while transcending self-interest for the sake of the organization.

Transformational leaders focus on changing the ethical ethos of their society and promoting intellectual stimulation through inspiration (Choudhary, Akhtar, & Zaheer,

2013). Transformational leadership includes four dimensions: intellectual stimulation, idealized influence, individualized consideration, and inspirational motivation (Bass & Avolio, 1994). *Intellectual stimulation* takes place when leaders stimulate, encourage, and inspire creativity by developing and nurturing innovative and independent thoughts (Bass & Avolio, 1994). *Idealized influence* occurs when transformational leaders demonstrate ethical behaviors and attitudes that cause followers to emulate their example. *Individualized consideration* refers to the scale of support demonstrated in meeting follower needs as a mentor or coach. *Inspirational motivation* occurs when the leader capably articulates a vision and motivates staff members toward accomplishment of organizational goals. Transformational leaders instill a sense of confidence in employees that creates respect and trust, leading to increased productivity and dedication to work among employees (Bass & Avolio, 1994). Workers in a transformative environment are encouraged to ask questions, seek innovative solutions, and create opportunities for shared learning (Jha, 2014).

Leaders promote the vision, aspirations, and goals of the organization. The vision must establish a sense of urgency and a willingness to change in employees. Studies on leadership style are important and help to provide feedback on leader values and subordinate perceptions (Gonos & Gallo, 2013). Leaders should develop a new vision or import innovative techniques in response to environmental changes (Arya, 2012). The focus has to be on modifying behavior versus merely conveying a conceptual aspiration that no one embraces. Bottomley, Burgess, and Fox (2014), proposed a framework that identified four wide-ranging behaviors for effective leaders: (a) vision builder, (b) developer, (c) standard-bearer, and (d) integrator. Bottomley et al. posited that the most

useful measurement of a leader was in terms of success and organization sustainability. Leaders that used a transformational leadership style to motivate workers tended to yield positive benefits in the form of improved enterprise performance (Choudhary et al., 2013). Economic, social, political, and technological innovations are the forces driving the organizational changes accomplished by leaders well versed in transformational leadership. Transformation and asset reconfiguration depend on senior leaders' ability to persuade employees to undertake different courses of action and willingly adopt different states of mind in response to changes (Helfat & Peteraf, 2014).

Healthcare organizations are complex with intricate internal operations that cross a plethora of specialties and disciplines. Unlike other industries, healthcare leaders must deal with intransigent and powerful professionals who are often resistant to change. Implementing transformational changes without a strong alliance with leaders, managers, clinicians, and allied health professionals present even the most seasoned leaders with an arduous test (Arya, 2012). Arya suggested that leaders contemplating policy changes must account for politically motivated challenges. Mandatory healthcare reforms placed additional demands on leaders to develop strategies and goals to sustain their organizations in an already fiscally constrained environment. Leaders had to adapt by adopting new management approaches to meet the demands of customers and survive in an increasingly competitive environment. To address these challenges, leaders should be competent in the skills necessary to convince employees to accept new business practices and work more effectively as teams. To inspire workers, transformational leaders must adeptly create an environment that emphasizes teamwork (Irshad & Hashmi, 2014).

Transformative leaders depend on middle-managers to solicit feedback and provide stability during organizational changes. Riaz and Khalili (2014) showed that transformational leadership, transactional leadership, and knowledge management processes positively predicted rational decision-making. Studies of Instrumental Leadership concepts proved useful in extending the transformational-transactional leadership paradigm to accomplish organizational-level goals (Rowold, 2014). Additionally, the organization experienced increased innovation and creativity through improved worker engagement.

Theorists widely acclaim transformational leadership theory; however, critics cite shortcomings in some applications. One criticism is transformational leadership lacks management focus on external and internal markets, competitors, and opportunities (Yukl, 2011). Yukl posited that leaders should include this information in the formulation of strategies for resource use, milestone development, and responsibility delineation. Bacha and Walder (2013) challenged the relationship between transformational leadership and employee's perceptions of fairness. The authors stated that leadership research failed to account for employee perceptions of justice and fairness, which can affect morale, performance, and commitment to the organization. Some researchers also speculated that industry structure and company history influenced organizational success more so than leadership influence (Silva, 2014).

Leaders should focus on developing collaborative relationships to encourage interdependence, trust, and initiative to drive group performance. Persons in charge no longer function as the sole guardians of the vision, mission, and organizational change process (Osula & Ng, 2014). The key to leadership success lies in the ability to instill a

sense of ownership in the follower for the benefit of the organization. Lastly, revolutionary leaders have to recognize signs of emotional exhaustion and turnover intention. Transformative leaders reduce emotional fatigue and turnover intention by knowing and rewarding workers to strengthen group cohesion and organizational commitment (Green, Miller, & Aarons, 2013).

Responsible leadership. Scandals by top leaders can have a detrimental impact on the reputation and financial performance of an organization. The action of top leaders can provide insight into the ethical culture of the organization. Responsible leadership (RL) or ethical leadership represents the blending of social responsibility and leadership in a context where they influence ethical behavior within an organization (Waldman & Balven, 2015). Waldman and Galven identified five areas for future examination: (a) responsible leadership processes and outcomes, (b) stakeholder priorities, (c) training and development, (d) globalization and macro-level forces, and (e) measurement and assessment.

Proponents of RL theory recognize the importance of senior-level involvement in the infusion of ethical principles throughout the organization (Waldman & Balven, 2015). A primary concern with responsible leadership is shifting the focus so much on ethics that employees are distracted from other company goals, such as financial performance (Chun, Shin, Choi, & Kim, 2013). Globalization also presents significant difficulties in implementing RL strategies in multinational corporations due to the diverse nature of their business and the multiplicity of different cultures (Pless, Maak, & Stahl, 2011).

Hospital organizations must meet new health reforms by increasing their performance and becoming more efficient. Kalshoven and Boon (2012) conjectured a

positive relation between ethical leadership and employee well-being. Leaders face constant scrutiny from media and government regulators to demonstrate beneficial behaviors and advance a culture of principled conduct in their organizations (Hartog & Belschak, 2012). Hartog and Belschak speculated that workers develop a sense of obligation to model supervisor and manager behavior when they observe superiors keeping their promises and commitments. However, motivation and organizational commitment suffered when juniors observed unethical or inauthentic Machiavellian behavior.

Leadership strategies. Strong leadership postures an organization for success (Cliff, 2012). Leaders should develop a new vision or import innovative techniques to lead transformational change (Arya, 2012). Visionaries have to create a sense of urgency and a willingness to change in employees. The focus must be on executing organizational change versus merely articulating some abstract vision that no one embraces. When developing modernization strategies, health system leaders ought to create cost-effective approaches to improving patient outcomes and dealing with regulatory and financial constraints (Duarte et al., 2014).

Healthcare organizations are dynamic entities with interdependent subcomponents that function as one unit. High strategic human resources (HR) management systems provide a vital link between HR practices and firm performance (McDermott, Conway, Rousseau, & Flood, 2013). Managers who exercise effective leadership practices, influence the emergence of psychological contracts that aid in firm performance. Psychological contracts help to align employee behavior with strategic goals (McDermott et al., 2013). When developing strategic objectives, planners should be mindful of the

managers' ability to convey the business strategy and garner lower-level employee buy-in.

Firms have to be capable of responding to a myriad of challenges when operating in dynamic environments. Effective leadership involves identifying and leveraging opportunities and threats. Leaders set a vision and foster employee commitment to meet internal and external demand. However, excessive strategic planning creates inertia and constant change causes frustration and slow adaptation and learning (Lewis, Andriopoulos, & Smith, 2014). Often inertia develops from a fear of failure that reduces decision-making and innovation.

Hospitals need to seek collaborative partnerships to improve clinical and financial outcomes, just as companies in the business world. Successful hospital-physician alignment requires establishing integrated systems with mutually beneficial objectives (Salas-Lopez, Weiss, Nester, & Whalen, 2014). Business models should be patient-centered to improve quality and contain costs. New alignment and integration contracts allow continued physician autonomy but require the delivery of evidence-based care.

Salas-Lopez et al. (2014) suggested four models to meet both doctor and hospital needs: (a) medical directorship, (b) professional services agreement, (c) co-management services agreement, and (d) lease arrangement. In the medical directorship model, the hospital contracted with one specialty group to serve as medical directors of a clinical area. The professional services model allowed hospitals to contract for a particular clinical service. Co-management services agreements enabled the hospital to contract with one specialty group to co-manage all services with the specialty service line. For lease arrangements, the hospital purchased the group's physicians, staff, office space, and

paid all expenses. Additionally, the hospital managed operations and appointed leadership positions (Salas-Lopez et al., 2014). The most popular alignment model involved hospitals acquiring physician practices and hiring medical providers in the local community (Salas-Lopez et al., 2014).

The physician-nurse relationship is complex with physicians desiring professional autonomy and nurses seeking parity. In a patient-centered environment that values high-functioning teams, both parties must learn to work as collegial and respectful partners. Physician shortages in urban and rural communities necessitate that advanced practice practitioners often fill the void. It is essential for executive leaders to incorporate these new partners within strategic plans to improve coordination of care, enhance quality and service, and control costs (Burroughs & Bartholomew, 2014). Additionally, clinical challenges, organization complexity, technological innovations, and new regulations demand the development of new service delivery models (Keenan et al., 2014). Strategic plans require integrated leadership models that synthesize multiple disciplines into coherent and well-functioning teams (Keenan et al., 2014). An essential component of this integrated workforce is the establishment of recognized professional relationships between nurse practitioners and primary care and specialty physicians (Newhouse et al., 2012). To transform health care and meet the demands of underserved populations, requires the removal of practice barriers for advanced practice practitioners that impede their ability to operate autonomously (Hain & Fleck, 2014). These changes recognize the competence of advanced practice professionals and provide consistency in practice standards between the states.

Healthcare executives establish the strategic direction, business plan, and implementation guidance for the organization. Working in concert with business unit leaders, they prioritize initiatives and allocate resources to meet performance objectives (Delaveris, 2015). Creating an integrated team that operates collaboratively for the benefit of patients is an important leadership challenge. Service lines that typically compete for high-margin services and market share must now realign their efforts around organizational goals based on a patient-focused care delivery model (Delaveris, 2015). To succeed, health care organizations must design and align their processes from a systems perspective that addresses costs and markets (Sheppeck & Militello, 2014). Only then can they realize the full value that each of these independent units contribute to overall organization functioning.

Disruptive Innovation Theory

Christensen (1997) coined the term disruptive innovation to describe the process by which a product or service takes root initially in simple applications at the bottom of a market and then eventually displaces established competitors. Disruptive innovation theory became popular when Christensen published *The Innovators Dilemma* in 1997. The initial features of disruptive innovation focused on the ability of companies to operate initially at lower margins in smaller markets using simpler products and services that early on may not appear as attractive as existing products or services. Christensen showed that while major change could be disruptive for organizations, it often resulted in better products and services. Mihailescu, Mihailescu, and Carlsson (2013) cautioned that structural influences could affect the pace of innovation adoption within organizations.

Within the healthcare industry, there are innumerable opportunities for improvements in medical care delivery and cost reduction through technical and service innovations (Griffith & Gobble, 2014; Hughes & Hamer, 2012). Health care markets need disruptive innovation to deliver cost-effective primary and value-based healthcare services (Block, 2013). Decision-makers need tools to aid in linking innovation investments to reimbursement strategies. One such tool is the Net Benefit Probability Map that helps leaders to estimate the payoff time for technology investments (McCabe, Edlin, & Hall, 2013). Health leaders may benefit from novel service delivery best practices demonstrated by Malcolm Baldrige National Quality Award winners. Winners successfully developed groundbreaking practices in information technology, telecommunications, and operations for their organizations (Duarte et al., 2014). The award-winning results showed how incorporation of innovation practices into company vision, mission, and values statements foster a pioneering culture (Duarte et al., 2014).

Accountable care organizations (ACOs). High costs and mediocre patient outcomes afflict the U.S. healthcare system (Ewing, 2013). The ACA gives states the option of providing care to Medicaid beneficiaries with chronic conditions through an innovative health home model. The Medicaid state option permits Medicaid enrollees with at least two chronic conditions to designate a provider as a health home. States that implement this option receive enhanced financial resources to support health homes in their Medicaid programs.

The patient-centered medical home concept uses a physician-led team approach to delivering patient-centric care. Teams composed of nurse practitioners, physician assistants, registered nurses, licensed practical nurses, and administrative assistants

provide a combination of services tailored to patient needs. Instead of the traditional in-office visits, care may involve virtual interactions to manage chronic conditions, administer health risk assessments, provide preventive care management, and coordination of care (Christensen et al., 2013).

Care delivery systems. Hospitals and health systems modernization efforts ought to integrate innovation into their care delivery processes to improve patient outcomes (Duarte, Goodson, & Dougherty, 2014). The Healthcare Leadership Alliance and American College of Healthcare Executives (2011) defined healthcare leadership as the ability to inspire individual and organizational excellence, create a shared vision, and successfully manage change to meet strategic goals (Cliff, 2012). To meet performance expectations, the healthcare industry should strive to inculcate innovation as a key component of organization culture.

Changes in future health concepts must be sustainable and able to provide continued reliable services, all the more so during periods of economic downturn. Healthcare leaders should encourage and reward organizational entrepreneurship even in hierarchal organizations. Innovation is a multifaceted phenomenon with several popular definitions. Akenroye (2012) developed a conceptual framework that revealed seven primary drivers behind the need for healthcare innovation: (a) changing patient needs, (b) persistent and long-term health problems, (c) budgetary cuts, (d) technological changes, (e) unstable operational landscape, (f) social concerns and (g) supply chain necessities. Akenroye's research demonstrated how leaders who adapt cutting-edge processes assume more risk, but also position their organizations for success and better long-term sustainability.

The United States health system is currently shifting to value-based care delivery to reduce costs while still maintaining quality. Alyahya (2012) examined the impact of the Quality and Outcome Framework (QOF), a pay-for-performance scheme for general practitioners in the United Kingdom. Alyahya showed how the introduction of QOF practices enhanced the use of knowledge reservoirs and reduced costs by decreasing consultations to specialized units, divisions, and departments. The research highlighted the importance of understanding organizational structure and helped guide interactions and information flow, especially when conducting change and knowledge enhancement. QOF showed that large-scale practices responded favorably to pay-for-performance initiatives due to included competencies such as human resources management (Alyahya, 2012). Initiatives such as the use of patient navigators, promoted appropriate primary care utilization and prevented or reduced primary care-related emergency department visits in the state of Texas (Enard & Ganelin, 2013). The intervention involved the use of bilingual, state-certified community health workers who were trained to counsel and connect medically underserved patients with medical homes and other appropriate services.

Fertig, Corso, and Balasubramaniam (2012) examined the benefits and costs of a free clinic. Fertig et al. used matching data from a free clinic and regional hospital within the same community to examine the feasibility of providing a free clinic to decrease costly emergency department visits. Costs for care were calculated by taking the average cost per visit from a the previous year financial report and multiplying that figure by the total number of visits. The results showed a cost savings if the clinic operated for at least three years, primarily in reduced length of inpatient hospital stays.

Competing interests among primary care physicians may stymy cooperation and transformation improvements (Goldberg, Mick, Kuzel, Feng, & Love, 2012). Collaborations between payers and providers such as the Physician Group Incentive Program (PGIP) increaseded provider buy-in and cooperation (Cohen, & Erb, 2013). One such effort was between the state of Michigan's largest health insurer, Blue Cross Blue Shield of Michigan (BCBSM) and 40 physician organizations, representing 71% of active primary care doctors and 56% of active specialists. Physician groups provided several functions for physician practices to include financial, managerial, clinical, and other support (Wise, Alexander, Green, & Cohen, 2012). The company used a novel approach by providing *pay-for-participation* dollars upfront to help in building needed infrastructure prior to the implementation of new strategies. PGIP is a *fee-for-value* physician incentive program that rewards physician organizations on the basis of their adoption and achievement of quality metrics. The initial results demonstrated success in medical home implementation, cost reductions, and quality improvements (Share & Mason, 2012). BCBSM employed the use of crowdsourcing techniques that resulted in energetic participants who viewed the company as a partner and vehicle for doing the right thing for their patients (Lemak, Cohen, & Erb, 2013). Lemak et al. identified five specific areas that contributed to successful provider engagement: (a) developing a vision, (b) fostering practice-practice partnerships, (c) using existing infrastructure, (d) leveraging resources and market share, and (e) managing program trade-offs.

Hospital leaders must be cognizant of hidden costs when undergoing transformative endeavors. Reiter et al. (2014) examined the financial implications for primary care practices engaged in transformation in Maryland. Primary care

organizations within the state were striving to comply with the Institute of Healthcare Improvement's Triple Aim goals of better health care, better health, and lower healthcare costs. The results showed that often, transformation-related activities took employees away from their regular duties for reform-related activities such as data management (managing the registry, reporting, EHR modification, pulling chart data), development and maintenance of new forms, and meeting attendance (Reiter et al., 2014). Minimal attention was given to the financial implications for making transformational changes in primary care practice (Peikes et al., 2012). In a related study, West et al. (2012) showed maintenance costs of approximately $9,553 for six primary care practices participating in Colorado's IPIP program.

Technological innovation. Health Information Technology has the potential to improve the efficiency, quality, and safety of medical care. The federal government set aside about $27 billion in financial incentive payments to healthcare organizations under the Health Information Technology for Economic and Clinical Health Act (HITECH). The program encourages the adoption and use of health information technology (Feldman, Horan, & Drew, 2013). Technology such as electronic health records facilitate patient care and help clinicians by improving access to information throughout the care continuum. Computer provider order entry along with clinical decision support tools may decrease medication ordering errors. The tools can be configured to generate alerts and reminders, clinical guidelines, order sets, patient data reports and dashboards, documentation templates, diagnostic support, and clinical workflow (Hoonakker, Khunlertkit, Tattersal, & Keevil, 2012).

Conversely, Song, McAlearney, Robbins, and McCullough (2011) examined the role of business case analysis in healthcare organizations' decisions to invest in ambulatory electronic heath record systems. The results of their research failed to demonstrate a strong business case for adoption of an EHR system. Song et al. found the most compelling reasons for investing in a new system centered on quality and the clinical benefits such as tracking quality indicators, population health, and disease management. The results illustrated the importance of well-thought-out resource allocation policies and comprehension of financial and clinical performance metrics.

Motivation Theory

Maslow's hierarchy of needs forms the foundation for job satisfaction theory (Bhatnagar & Srivastava, 2012). Maslow (1943) presented *A Theory of Human Motivation* in *Psychological Review* followed by *Motivation and Personality*, a book on psychology in 1954. Maslow proposed a hierarchical pyramid of human needs ranging from *physiological*, *safety*, *love*/*belonging*, *esteem*, *self-actualization* to describe the patterns in human motivation progressions. Maslow's theory is systematic, compared to similar theories espoused by subsequent researchers. The hierarchy of needs theory starts with physiological needs such as survival needs and progress to those related to self-development. Hierarchy theory, surmises that needs follow a logical sequence with some needs usurping others. Only after meeting the most fundamental needs, can a person progress to safety needs. After the fulfillment of safety needs, individuals may progress towards meeting their desires for love, affection, and belonging. Ultimately, inspired individuals attempt to satisfy the highest levels of motivation through the attainment of

elevated self-esteem from the actualization of personal goals (Babic, Kordic, & Babic, 2014).

Employee engagement. Employee engagement occupies a vital role in the success of an organization. Kahn (1990) was one of the first to coin the terms personal engagement and personal disengagement. Kahn characterized the concept of employee engagement through three dimensions: a physical dimension (energy), an emotional dimension (dedication), and cognitive dimension (absorption; Kahn, 1990). In the personal engagement model, Kahn depicted how workers brought certain aspects of their personal lives into workplace role performance. When workers are disengaged, they maintain an emotional detachment and cognitive distance between work and personal roles (Kahn, 1990).

Engaged employees are optimistic, focused on task accomplishment, energetic, and go above the norm to ensure organizational success (Jose & Mampilly, 2012). A cross-sectional study conducted at the Nizam's Institute of Medical Sciences, India highlighted the positive link between job engagement and affirmative outcomes for the organization (Bulkapuram, Wundavalli, Avula, & Reddy, 2015). Bulkapuram et al. estimated that disengaged employees cost U.S. companies between $250 and $350 billion dollars annually. In similar job engagement related research, the results showed companies with engaged employees had lower absenteeism, less turnover intention, increased citizenship behavior, and improved bottom-line financial results (Jose & Mampilly, 2012). The importance of employment engagement is a global phenomenon with implications for both industrial and developing countries. A cross-sectional study of 309 Namibian workers showed work-role fit and job enrichment as an important

antecedent of employee engagement and positive contributor to organization performance (Rothmann & Welsh, 2013).

High-performing healthcare organizations with significant investments in complicated technology require employees with greater technical and professional skills. Organizational effectiveness becomes hard to achieve without the commitment of its employees. Top performing companies recognize the long-term value of retaining committed employees. Three drivers tend to influence employee loyalty: fulfillment, fairness, and care and concern for employees (Shahid & Azhar, 2013). Shahid and Azhar hypothesized that staff members in organizations with high levels of trust and reciprocal employers led to more dedicated and productive workers. Shahid and Azhar further posited that organizations benefited from engaged employees through increased corporate citizenship, reinforced productivity, enhanced corporate gratification, and identification of change management champions. Furthermore, company investments into professional development opportunities yielded employees with expanded perspectives, elevated status, increased problem-solving involvement, and elevated confidence (Shahid & Azhir, 2013).

Healthy and engaged employees enable the maturation and full exploitation of individual capacity necessary for company success (Lowe, 2012). Within the Canadian healthcare system, 10,000 workers completed a multi-item scale survey to define engagement drivers and measurements. The results showed a positive correlation between employee engagement and retention, patient-centered care, patient safety culture, and employee's assessment of the quality of care rendered (Lowe, 2012). By

strengthening the people-performance link, leaders foster an environment that elevates hospital performance.

Active leader communication shapes employee awareness of trust expectations in an organization (Tuan, 2012). Transformational leaders that effectively conveyed an image of high ethical behavior positively reinforced worker perceptions of leader acumen and fairness (Tuan, 2012). The links between leadership, trust, and business ethics contributed to the ethical culture of the organization. Researchers studying leadership influence in Thailand found management commitment had a positive influence on organizational performance and level of employee engagement (Nasomboon, 2014). Organizations whose employees demonstrated optimistic job and work attitudes were more resilient and tended to exhibit higher levels of productivity (Robertson, Birch, & Cooper, 2012). Additionally, the analysis showed that employers who focused on the psychological wellbeing of their workers saw positive business outcomes from increased employee engagement (Robertson et al., 2012).

In a study on the effects of organizational psychological ownership (OPO) and organization-based self-esteem (OBSE) on positive organizational behavior (POB) in Chinese production workers, the findings indicated OPO and OBSE as positive predictors of POB (Pan, Qin, & Gao, 2014). Pan et al. speculated that management played an important role in enhancing the employee's psychological connection to the organization. In a similar job insecurity study of middle-eastern workers in Lebanon, Karkoulian, Mukaddam, McCarthy, and Messarra (2013) found supervisor-subordinate trust relationships as a positive indicator of worker perceptions of power or powerlessness in the workplace. Managers who addressed employee concerns in a candid manner

encouraged an environment of open communication and nurtured employee confidence (Karkoulian et al., 2013).

Employee satisfaction. The retention of skilled health professionals is vital to the success of a strong functioning organization. High turnover rates among medical providers are a concern for hospitals and healthcare systems due to the impact on profitability, patient safety, quality of care, and organizational culture (Fibuch & Ahmed, 2015). The American Association of Medical Colleges projects a shortage between 46,000 to 90,000 physicians in the United States by 2025 (Fibuch & Ahmed, 2015). The job satisfaction of clinical doctors also influences the performance of team members involved in the patient care continuum (Mazurenko & O'Connor, 2012). Hospitals worldwide should aim to prevent doctors from changing hospitals through strategies that take into account worries about job satisfaction and workload, evaluation methods, career progression and organizational management (Kato et al., 2012). Dotson, Dave, Cazier, and McLeod (2013) identified professional autonomy, pay, and task responsibilities as contributing factors to provider job satisfaction and organizational commitment.

Job satisfaction is simply how people feel about their job or aspects of their employment. Knowledge of these factors is important in recruiting and retaining nursing professionals in urban and rural areas that tend to have challenges appealing to and maintaining skilled providers (Dotson et al., 2013). Dotson et al. identified four distinct clusters when examining nursing decisions to work in rural areas: (a) those wishing to keep their current job and stay in the nursing profession, (b) those ambivalent about their current job and the profession, (c) those who wanted to leave the job and profession, and (d) those who wished to leave current job but stay in the business. The results suggested

that a sense of altruism, job satisfaction, stress, and value congruence were major factors in their decisions.

Staff perceptions may affect the successful execution of change management objectives that aim to improve quality of care. Aarons et al. (2012) identified problems with the lack of available instruments to capture staff perceptions of barriers to change. A nationwide study of clinician attitudes toward change in 100 U.S. acute care mental health institutions showed that organizational climate and staff perceptions of their environment affected work attitudes (Aarons et al., 2012). In London, a nurse researcher interviewed 32 mental health staff members to measure the relationship between barriers to change and job satisfaction using a locally developed measurement tool called VOCALISE (Laker et al., 2014.). The VOCALISE framework helped promote the involvement of nurses as stakeholders in their clinical areas (Laker et al., 2014). The core principle of VOCALISE was to translate participant views into psychometrical measures designed to capture nursing staff perceptions of impediments to change.

In a survey examining physician dissatisfaction and burnout conducted by The Beryl Institute, hospital executives found the most efficient way to improve the patient experience was to have engaged and satisfied staffers (Shannon, 2013). The data on physician satisfaction supported the supposition that staff contentment improved patient satisfaction. Physician leaders can improve the long-term sustainability of their organizations through close monitoring of practitioners for signs of burnout (Shannon, 2013).

Study data indicated that taking care of healthcare employees reduced attrition and significantly improved hospital financials. The American Hospital Association gave

details in a 2011 report that showed 60% of health care expenditures go to caregivers (Sadatsavfavi, Walewski, & Shepley, 2015). Issues such as discrimination and harassment affect employee attitudes and perceptions of fairness in the workplace (King, Dawson, Dravitz, & Gulick, 2012). King et al. found that perceptions of unfairness diminished social relationships and resulted in negative feelings toward the organization, to include increased disharmony among workers.

Positive job satisfaction supports the quality of life of a society and contributes to increased commitment, attendance, and performance. Other variables that contribute to achievement include compensation, training, working conditions, and economic factors (Miller & Bird, 2014). Within the National Institute of Health in the United Kingdom, recruiters along with nursing managers employed a new strategy that assessed new applicants based on compatibility with institutional values and fit within the organizational culture (Miller & Bird, 2014). According to Miller and Bird, nurse supervisors reported less turnover, higher morale, lower abscences rates, and better patient care after implementation of the new procedures.

To achieve excellence in work performance requires a comprehension of domains of work that are necessary for job satisfaction among clinicians. Within the hospital setting, Bhatnagar and Srivasta (2012) offered that investigating job satisfaction served to gain a better understanding of the association between level of motivation and patient satisfaction. For this reason, Shannon (2013) advanced that strategies for financial sustainability in this era of health system reforms must incorporate steps to improve physician well-being.

Astute company principals recognize that success is dependent on the performance of its employees, even though research on motivation received scant empirical or theoretical attention over the last 15 years (Zamecnik, 2014). Employers need to recognize the value of engagement in forming the basis for breakthrough research as companies seek solutions to increase employee motivation and job satisfaction (Sanyal & Biswas, 2014). Organizational researchers in China and Tanzania demonstrated the importance of providing professional development opportunities. The positives included improved training and performance skills, a more cohesive working environment, and salary raises (Hung, Shi, Wang, Nie, & Mengm, 2013). Hung et al. posited that regardless of the business, leaders who addressed employee disengagement, positioned their organization for long-term sustainability and better bottom-line performance.

Transition and Summary

In this qualitative study, I explored the leadership strategies safety-net healthcare managers used to increase nursing personnel retention. Section 1 included the background, problem and purpose statements, nature of the study, research question, and interview questions. Section 1 also examined the conceptual framework, operational definitions, assumptions, limitations, delimitations, the significance of the study, implications for social change, and review of the literature. Section 2 contains the methodology and design selected for the study. The section provides the purpose, role of the researcher, study participants, and ethical considerations. Additionally, Section 2 contains the research design, population and sampling methods, data collection instruments, data organization and analysis techniques, finishing with reliability and validity. In Section 3, I provide the study findings and potential implications for social

change. I also make recommendations for action and further study, along with a summary of the entire study.

Section 2: The Project

In Section 2, I presented information on the research method and design used to address the business problem, guided by the research question: What strategies do safety-net healthcare managers use to increase nursing personnel retention? I also discussed the role of the researcher and participants, along with the justification of the selected methodology and design. Additionally, the section included data related to population and sampling techniques, ethical concerns, data collection instruments, and strategies to assure reliability and validity.

Purpose Statement

The purpose of this qualitative single case study was to explore strategies used by safety-net healthcare leaders to increase nursing personnel retention. The population in this study was nurse directors in safety-net medical facilities in the state of Maryland. This population was appropriate because nursing-related functions and management decisions impact approximately 25% of a hospital's operating costs (Maenhout & Vanhoucke, 2013). The study's implications for positive social change include the possibility that nurse retention will positively impact the experience patients have, creating healthier communities and more satisfied customers. Managers who recognize the importance of retaining nurses are more likely to foster a work environment with stronger supervisor-subordinate relationships, engagement, patient-centered care, and productivity (Lowe, 2012).

Role of the Researcher

In this qualitative single case study, I had a direct role in the research design, data collection, and analysis of the study findings. As the primary researcher, I served as the

data collection instrument (Unluer, 2012). My research interest in this study stemmed from past personal experiences in a senior leadership capacity in which I was responsible for employee job satisfaction and retention. I selected the qualitative case study method to gain an in-depth understanding of the strategies that managers use to increase nursing personnel retention.

Researchers must account for ethical dilemmas when conducting investigations. To ensure that I understood my ethical responsibilities and adhered to Belmont Report protocols, I completed the National Institutes of Health Human Research Participants training course, as recommended by Strause (2013). There is considerable debate among authorities on the usefulness of ethics codes in management research, in comparison to social research in disciplines such as psychology or sociology (Bell & Bryman, 2007).

Perceived researcher bias is a concern when conducting qualitative research and can place an entire study at risk. When study design, analysis, and reporting produce distorted findings that unduly point in a particular direction, researcher bias is present (Shepperd, 2015). Investigators must demonstrate care when conducting interpretive research where a priori knowledge and background exist (Kooskora, 2013). As the primary researcher, I sought to reduce bias by remaining neutral, minimizing personal inconvenience during data collection, and ensuring adherence to proper data collection procedures.

The manner in which researchers interview participants may influence the data provided (Brown et al., 2013). I conducted all interviews using the same data collection technique for each participant. To mitigate bias associated with my personal views, I used an interview protocol during data collection. The interview protocol consisted of 10

steps: (a) introduction, (b) purpose of the study, (c) description of why they were participating, (d) description of participation benefits, (e) discussion of confidentiality, (f) follow-up questions to determine any concerns, (g) transition to interview questions, (h) conducting the interview, and (i) wrap up and thank you. I conducted each interview onsite in a location that presented a comfortable and professional atmosphere for the participant and interviewer. I respected participants' time by being organized and on time to allow for the completion of all interview questions within a reasonable time.

To decrease bias, I selected a health care facility with which I had no affiliation, and in which I had no previous working relationship with any participants. Further, member checking and transcription validation allowed respondents an additional opportunity to expand upon supplied information and achieve data saturation. I used triangulation techniques to lessen personal bias. The aim of the research was to broaden my understanding of the retention strategies that healthcare leaders used while curtailing the influence of my personal lens during data collection. It is important for qualitative researchers to make use of triangulation techniques and supplemental data sources to verify the accuracy of data acquired from key informants (Homburg, Klarmann, Reimann, & Schilke, 2012). It is also important for qualitative researchers to draw upon key informants who are familiar with problems and concerns besetting the organization (Homburg et al., 2012).

Participants

I interviewed safety-net healthcare leaders who supervised or provided oversight of nursing personnel in safety-net healthcare facilities located in Maryland. When considering participants, investigators must use a reflexive process to mitigate data

compromises associated with power relationships, challenges in obtaining access, and gaining informed consent (Frechtling & Boo, 2015; Wallace & Sheldon, 2015). The healthcare leaders contacted in this study were pivotal in providing staff direction and had ultimate decision-making authority within their departments. All research participants demonstrated experience in implementing policies and strategies to increase nursing personnel retention and willingly participated in the study. Researchers often face difficult barriers in recruiting and accessing participants (Bengry-Howell & Griffin, 2012; Browne-Yung, Ziersch, & Baum, 2012; George, Duran, & Norris, 2014). In order to facilitate participant identification, I contacted hospital leadership for permission to recruit and interview research contributors who met requisite participant criteria. I explained the nature of the research project and my interest in this particular subject and ascertained whether hospital Institutional Review Board (IRB) approval was required (Sanjari et al., 2014). Additionally, I provided details about my background in healthcare leadership and personal experiences in motivating healthcare employees. My goal was to foster a positive relationship with leadership to gain access to participants by showing the applicability of the research to the organization. After I received approval to contact informants, all participants received a copy of the consent form prior to scheduling times and locations to conduct interviews.

To promote a positive working relationship with contributors, I provided a copy of the purpose statement to clarify the intent of my research. Participants signed a consent form that explained their rights in relation to confidentiality. I explained the use of alternative identification measures instead of names to categorize respondent comments. For example, the first participant is known as Participant 1, the second as

Participant 2, and so on. All pre and post meeting interactions focused on achieving accurate and substantive data (Halbe, 2012). Finally, I made participants feel at ease by creating a comfortable and natural environment.

In consideration of possible competing paradigms, I used a participatory approach to reduce any tensions that might emerge involving other stakeholders in the organization (Thomas & Hollinrake, 2014). For all interviews, I dressed in business casual attire. Research representatives should dress and speak professionally, especially when interviewing a high-level contributor (Gill, Steward, Treasure, & Chadwick, 2008). Gill et al. (2008) stated that when designing an interview, it is best to start with questions that participants can answer quickly and then proceed to more difficult or sensitive topics. I used a conversational approach to foster trust so that respondents felt comfortable answering follow-up questions instead of solely adhering to a rigid set of predetermined questions. Lastly, to ensure that respondents fully understood all interview questions, I had professional medical colleagues evaluate them for clarity and ease of comprehension prior to their administration to study participants.

Research Method and Design

I used a qualitative case method involving a single organization to study a safety-net hospital's approach to leadership retention strategies. Social exchange theory formed the conceptual framework for exploring the strategies used to increase employee engagement. Tracy (2013) showed the importance of the qualitative paradigm as an appropriate research method to gain a detailed understanding of complex phenomena. Venable and Baskerville (2012) posited that the appropriateness of a particular research method depends on its suitability and application to the specific purpose, contexts, and

contingencies in which it is developed. In essence, researchers have flexibility based on their research problem and investigation strategy.

Method

Qualitative research occupies an important position in the business research continuum (Bernard, 2012). The qualitative approach allows a researcher to examine individual experiences in detail (Litosseliti & Leadbeater, 2013). Qualitative examiners often use research techniques such as interviews, focus groups, observation, content analysis, visual methods, and life histories to explore phenomena (Hennink, Hutter, & Bailey, 2011, p. 8). Within the healthcare setting, researchers may conduct in-depth personal interviews to identify success factors that medical leaders can put into practice during change initiatives (Khan et al., 2014). An advantage of the qualitative method is that it allows researchers to ask open-ended questions and analyze participant responses regarding a particular phenomenon using a holistic approach (Khan, 2014). When investigating organizational change in international companies, the qualitative approach has proven useful in uncovering new phenomena, creating and testing new hypotheses, and generating new research methodologies for managing change (Garcia & Gluesing, 2013).

The quantitative method allows the exploration of knowledge attainment through tangible, predictable, and measurable investigation (Dharmendra & Patel, 2013). The quantitative approach supports an ontological view that correlates with a constructivist worldview (Dharmendra & Patel, 2013). Medical researchers often use the quantitative approach to address questions concerned with *how many* or *how much* for health-related occurrences in communities, organizations, and individuals (McCusker & Gunaydin,

2015). Quantitative analysis is useful in providing a snapshot of a group or institution; however, it does not offer an in-depth understanding of the thoughts, feelings, and opinions within that group or institution (Tracy, 2014).

The mixed method is suitable for tackling research problems that quantitative or qualitative methods inadequately address alone. Mixed method proponents advocate mixing quantitative and qualitative methods to yield a complete picture of a phenomenon due to their active links (Allwood, 2012). Within the health sciences field, scientists use numerous strategies and research methods to examine complex processes and outcomes (Zhang, 2014). The decision on whether to use a single method or mixed method depends on the research question, purpose, and context (Venkatesh et al., 2013). However, for purposes of this study, time constraints made a mixed method approach unsuitable for exploring strategies used by healthcare leaders for increasing nursing personnel retention.

Research Design

Qualitative research approaches prevalent in social science investigations include (a) narrative, (b) phenomenology, (c) ethnography, and (d) case study. For this study, I chose a case study design because it allowed me to gather information from healthcare managers regarding their retention strategies through the use of open-ended questioning (Granatino, Verkamp, & Parker, 2013). Yin (2014) noted case study as an appropriate design to explore phenomena involving individuals, organizations, processes, programs, and neighborhoods. Yin identified three types of case studies: exploratory, descriptive, and explanatory. In studies of the adoption of innovative practices in the healthcare field, the case study method yielded multiple perspectives on the complexities surrounding

implementing new care delivery processes (Chambers et al., 2013). For this investigation, a case study was well suited for investigating a contemporary phenomenon in depth within its real-life context (Yin, 2014).

Researchers use narrative design to explore the lives and experiences of individuals through storytelling. Descriptions provide context through the creation of relationships between thoughts. However, the use of stories tends to represent a one-dimensional view of the management perspective during change-related activities (Vickers, 2008). For this reason, the narrative approach did not provide the breadth of understanding I sought in addressing the research topic.

Ethnography is a participant-observational approach that involves observing social interactions in an organization or culture-sharing group (Dumitrica, 2013). Ethnographers are fascinated with the moral, social, and cultural boundaries of groupings. Zhao (2014) spoke to the importance of ethnography in understanding human causation among groups. Through in situ observations, ethnographers gather information about a group in the setting where members work or live (Wolcott, 2008). Due to the extensive time required to conduct an ethnographic study, this approach was unsuitable for my investigation.

Phenomenological research centers on the lived experiences of several people within a group or organization. Inquirers seek to develop a picture or tell the story of the experiences of all individuals related to a particular phenomenon but do not provide an explanation or any analysis (Moustakas, 1994). In the context of evaluating leadership actions, the phenomenological approach can identify key personality traits useful in predicting future behavior (Bucur, 2012). The phenomenological method draws

primarily from the experiences of several participants, which was not feasible for this study due to the limitation of not being able to conduct multiple in-depth interviews.

Population and Sampling

The population for this study consisted of active leaders in safety-net hospitals. I identified participants using a purposive snowball sampling method. Snowball sampling allows researchers to identify and solicit a targeted audience and then use chain referrals to recruit eligible contributors from their professional network (Derera, Chitakunye, O'Neill, & Tarkhar, 2014; Martinez & Kim, 2012; Meyer, Hsiao, Vigliore, Mihura, & Abraham, 2013). After consultation with senior management in the organization, I sought research participants who were experienced, knowledgeable, available, and well versed in organizational policies and retention planning efforts. Additional contributors included the human resources director, nursing education director, and department directors with oversight responsibilities. Prior to any contact with potential participants, I ensured management had granted permission to contact employees and efforts were made to minimize disruptions in participants' work schedule.

My goal was to select and interview enough participants to sufficiently address the research question for this study. I used a purposive sample of leaders who were capable of providing detailed answers and rich information on the topic based on their experience implementing employee retention strategy. To ensure data saturation, I conducted research interviews to collect accurate and valid data to a point that no new information was forthcoming and high-quality evidence had been obtained (Burmeister & Aitken, 2012; Dworkin, 2012; Fusch & Ness, 2015). There is ongoing debate on how many samples should be collected using a qualitative research method (Frambach, van

der Vleuten, & Durning, 2013). Francis et al. (2010) suggested a sample size of 13 to 15 interviews to satisfactorily reach saturation. However, O'Reilly and Parker (2012) posited that the time spent on interviews was a more accurate determinant of data saturation as opposed to the number of interviews.

There are approximately 700 nursing personnel in the targeted safety-net organization, with 55 senior personnel. I targeted a sample size of 6 to 10 interviewees to gain a better understanding of the research question for this investigation. A sample size of eight leaders proved sufficient in achieving the data saturation necessary to address the study research question. Yin (2014) suggested six sources of evidence in a case study: documents, archival records, interviews, direct observation, participant observation, and physical artifacts. I conducted direct participant observation, reviewed physical artifacts, and examined organizational documents to gain a comprehensive understanding of relevant policies and procedures.

I sought opinions from participants with different backgrounds, ages, genders, and experiences. Researchers must assess the diversity of the population when determining the sampling strategy to ensure the transferability of results. Additionally, diversity of the sampling pool reduces sampling error and allows for the capture of rich data. All interviews were conducted in a location that was quiet and conducive to open communication. All windows and doors were closed to provide privacy and a confidential environment. Participants had the option for interviews to be accomplished at the work location or a neutral site, depending on their preferences. All participants chose the work location to minimize disruptions.

Ethical Research

Ethics are the principles and values used by decision-makers when addressing conflicts or competing values (Heimer, 2012). Business researchers need to consider power relationships, access, conflicts of interest, and cultural influences when evaluating ethical dimensions in an organization (Wallace & Sheldon, 2015). Guta, Nixon, and Wilson (2013) proposed Foucauldian theory as a mitigation strategy against the bureaucratization of research ethics boards and institutional review boards. Employees should have an awareness of ethics and clarity about the moral basis of different approaches to leadership, especially when implementing changes (By, Burnes, & Oswick, 2012).

The Walden University IRB reviewed and approved this study (Approval number 07-15-16-0489074) to ensure the research met university and federal ethics criterion. Standards governing medical research originated in the 1930s after Nazi biomedical experiments led to the Nuremberg Code in 1949 (National Institute of Health, 2012). The World Medical Association's Declaration of Helsinki (1964) followed with a standard that required informed consent for research participants (National Institute of Health, 2012). Researchers must weigh the ethical implications of their research and ensure the protection of all participant rights regarding ethical treatment and confidentiality (Ekberg, 2012; Jeffery, 2014). All research in association with this study complied with Walden IRB standards.

I conducted all interviews and analysis of data. All participants signed a consent form and had the right to withdraw from the meeting at any time without prejudice (Bellone, Navarick, & Mendoza, 2012). The consenting process encompassed 10 topics.

The specific topics included (a) background information on the study, (b) procedures, (c) confidentiality, (d) voluntary nature of the study, (e) compensation, (f) benefits of participating, (g) risks of participating, (h), contacts for questions, (i) statement of consent, and (j) researcher statement. The informed consent can be found in Appendix A. Participants received no monetary or tangible incentives for participating in the study (Matheson, Forrester, Brazil, Doherty, & Affleck, 2012). I used numerical identifiers such as Participant 1, Participant 2, and so on, to protect the confidentiality of all respondents (Moore, 2012). I secured all research-related data on a password- protected external drive where it will remain for 5 years. I will destroy the data after the conclusion of the 5-year period.

Data Collection

Data Collection Instruments

As the principal researcher in this qualitative case study, I was the primary tool for data collection. In qualitative research, the researcher serves as the data collection instrument due to their direct observation and interpretation of the data (Denzin & Lincoln, 2014; Marshall & Rossman, 2016). Additionally, I used a semistructured interview technique in the collection of information related to the strategies used to increase nursing personnel retention. A semistructured interview technique allows constructivist investigators to elicit facts and knowledge about a phenomenon occurring in the organization (Mojtahed, Nunes, Martins, & Peng, 2014; Pezalla, Pettigrew, & Miller, 2012). Furthermore, the use of a semistructured interview technique is an appropriate instrument that allows participants to expand and elaborate on interview questions (Yin, 2014).

All interview questions supported the central research question for the study. The interview protocol can be found in Appendix B. I provided each participant with a copy of all forms granting leadership consent to conduct interviews. I asked each participant the same set of open-ended interview questions. I held all interview sessions on-site and within a short timeframe to prevent inconsistencies related to changes in the organization. I used a recording device to capture participant comments. Additionally, I utilized note taking during interviews. Face-to-face interviews allow qualitative researchers the ability to capture participant reactions and nonverbal clues compared to quantitative surveys. Interviews along with observations, questionnaires, surveys, and reviews of existing literature enable researchers to gain a complete picture of the experiences of employees in the organization (Seidman, 2013).

Data Collection Technique

In this qualitative single case study, I served as the primary data collection instrument. I used semistructured interview technique as the primary data collection method for managers to answer open-ended interview questions. A semistructured interview technique allows researchers to gain a deeper understanding of a phenomenon through the sharing of rich information related to the phenomena being investigated (Mojtahed et al., 2014). The interview questions for this study are located in Appendix C. I enhanced my understanding of the organization by using additional sources of evidence, such as reviewing historical documents, physical artifacts, and policies. Triangulation refers to using various data sources to provide a more complete understanding of phenomena (Carter, Bryant-Lukosios, DiCenso, Blythe, & Neville, 2014; Patton, 1999). Denzin (1978) and Patton (1999) suggested five types of

triangulation when doing case studies: (a) data triangulation, (b) investigator triangulation, (c) theory triangulation, (d) methodological, and (e) environmental triangulation. I used methodological triangulation to review human resource management documents, organization mission and vision statements, and policies of ethical behavior. Yin (2014) classified six sources of evidence appropriate for a case study methodology to include (a) documentation, (b) archival records, (c) interviews, (d) direct observation, participant-observations, and (f) physical artifacts. Within this study, archival records proved useful in conjunction with other data collection methods in helping the researcher understand how data quality could influence information credibilty (Yin, 2014). I kept a journal to track my observations, feelings, and reactions. To make certain my study was credible, I employed member checking as the quality control process to validate participant thoughts and feelings (Awad, 2014; Harper & Cole, 2012; Peake et al., 2014).

Data Organization Techniques

Participant responses to semistructured interview questions served as the data for this study. I used Nuance Dragon speech recognition software to transcribe audio notes. Researchers code text to explore relationships between concepts (Crowston, Allen, & Heckman, 2012). After dictation, I exported the transcribed information into NVivo 11 Pro computer-assisted qualitative data analysis software (CAQDAS). CAQDAS allows researchers to organize and analyze unstructured data for themes and trends (Kuo-Pin & Graham, 2012; Sinkovics & Alfoldi, 2012). I created files and computer folders for each participant along with the informed consent form, voice recordings, transcribed journal notes, and interviews.

I saved all interview responses and any policies and procedures on a secure hard drive. I secured the hard disk in a locked desk drawer in my home office where it will remain for 5 years. I will dispose of all data by shredding after the 5-year period.

Data Analysis Technique

Qualitative researchers seek rich descriptions of reality without compromising validity, reliability, and objectivity (Cambra-Fierro & Wilson, 2011; Takhar & Chitakunye, 2012). The interview questions used in this study addressed the overarching question: What leadership strategies do safety-net leaders use to increase nursing personnel retention? The qualitative approach relies on analytical generalizations to draw conclusions about a larger population. Yin (2014) identified five techniques appropriate for analyzing case studies: (a) pattern matching, (b) explanation building, (c) time-series analysis, (d) logic models, and (e) cross-case analysis (p.132). I chose pattern matching as the strategy to analyze the data in this study. I used constant comparative method (CCM) to identify latent patterns in words used by different respondents. CCM includes open/descriptive coding, axial/topic, and selective/analytical coding (Baskarada, 2014). After data collection, I used Nuance Dragon speech recognition and QSR NVivo software to transcribe, organize, and develop themes.

Qualitative researchers generate information through interfacing with participants familiar with the phenomenon under investigation. Study design, researcher assumptions, theoretical leanings, and methodological preferences all influence the analysis of the data (Irwin, 2013). Investigators employing the qualitative approach use data analysis for interpreting or getting behind the meaning of what participants mean or feel about a situation. Through inductive reasoning, I described the textual data in a

manner that captures the setting or feelings of the person supplying the information. I used member checking to verify the accuracy of my descriptions. For this study, participants had the opportunity to agree or disagree that the interview summary reflects their views, feelings, and experiences (Lincoln & Guba, 1985).

Reliability and Validity

The terms r*eliability* and *validity* represent the measures of quality in a study. Quantitative researchers most often use these concepts to measure repeatability and truthfulness of results, respectively (Yin, 2014). However, qualitative examiners frequently identify terms such as trustworthiness and rigor to establish the credibility of study results (Lincoln & Guba, 1985). Lincoln and Guba (1985) proposed using alternative terms such as credibility, transferability, dependability, and confirmability to differentiate qualitative and quantitative validation. Within this section, I describe the methodology for ensuring reliability and validity of study conclusions.

Reliability

Reliability relates to the soundness of the methodology and integrity of the researcher findings (Noble & Smith, 2015). For this study, I used snowball sampling to generate a representative sample group. To preserve the reliability of this study, I (a) used the same open-ended interview questions for each participant, (b) maintained a reflective journal to document all decisions, (c) validated respondent answers, and encouraged participant comments of interview transcripts; (d) used triangulation to produce comprehensive conclusions, and (e) utilized computer-aided coding software to reduce researcher bias.

I had the interview questions validated by five impartial healthcare leaders to ensure they were high quality, rigorous, and easily understood. The leaders did not participant in my study and only offered opinions on the clarity and applicability of the interview questions. Individuals considered experts in their field can determine if the questions constitute a valid instrument (Ison, 2011). I rewrote the questions based on panel feedback. I stratified the final queries and aligned them with my research problem by ranking.

Narrative analysis requires organizing and keeping track of meaningful text. The use of rigorous procedures during systematic sampling, data collection, and data analysis increases the dependability of study findings (Hanson, Balmer, & Giardino, 2011). I sought to improve reliability by accurately auditing policies and procedures, maintaining detailed documentation, and appropriately scrutinizing all research-related materials.

Validity

Validity refers to the *accuracy* or *trustworthiness* of research findings (Richie & Lewis, 2003). Qualitative researchers must demonstrate great care in maintaining the credibility of findings (Street & Ward, 2012). Investigator experiences and viewpoints may skew participant perspectives, leading to bias and a discredited study (Noble & Smith, 2015).

Qualitative researchers use coding to organize data for interpretation through the development of themes (Kuo-Pin & Graham, 2012; Mangioni & McKercher, 2013; Sinkovics & Alfoldi, 2012). Additionally, to make certain that collected data accurately reflects participant perspectives, I provided a copy of the transcribed interview for their validation and comments. Member checking allows the participant to authenticate all

findings and address the adequacy of my data and conclusions (Harper & Cole, 2012). Finally, I took copious notes to capture descriptive and reflective information to supplement interview data (Emerson, Fretz, & Shaw, 2011).

I used purposive snowball sampling to garner a diverse group of participants with the ability to provide plentiful details related to my research problem. The sample size is important in ensuring the validity of my findings (Burmeister & Aitken, 2012). Additionally, I obtained in depth information to the point of saturation to confirm the adequacy and quality of the data collected during the investigation (Fusch & Ness, 2015; Robinson, 2014; Walker, 2012). Saturation occurred when no new information was derived from additional interviews and the data proved sufficient to address the research problem for the study (Walker, 2012).

I used triangulation to increase the credibility and confirmability of my study results for future readers and researchers. Qualitative researchers employ triangulation through using multiple sources for data collection to ensure the credibility and believability of the findings (Lincoln &Guba, 1985; Nielsen, 2012). Some methods commonly used include in-depth interviews with the main management informants, on-site observations, and member checking for the correctness of descriptions and operational practices (Mysen, 2012). I compared data from additional sources such as archival records and direct observation to support any conclusions I reached based on participant feedback.

Transition and Summary

In Section 2, I discussed the research and design of my study. I addressed my reasons for thinking regarding the selection of a qualitative case study design to explore

the phenomenon of employee engagement and retention. I explained the role of the researcher, the participants, and purposive sampling technique. I also discussed the data collection method, ethics, reliability, and validity of the study. In Section 3, I supplied recommendations for action and further study, along with a summary of the research.

Section 3: Application to Professional Practice and Implications for Change

In this section, I describe themes that emerged from personal interviews with healthcare leaders focusing on leadership strategies used to influence nursing personnel retention. Section 3 includes an overview of the study and specific findings. I also provide manager feedback in an effort to gain an understanding of how the findings might apply to professional practice, the implications for social change, and recommendations for leadership actions. Finally, this section ends with reflections, a summary, and conclusions related to the study and research process.

Introduction

The purpose of this qualitative single case study was to explore the leadership strategies used by nursing leaders to increase nursing personnel retention. The study findings may be useful in identifying effective leadership strategies for nurse leaders in their efforts to increase staff organizational commitment. During the study, five main themes emerged as central to improving nursing personnel retention: (a) engagement and management support; (b) education and career development; (c) teamwork and work atmosphere; (d) recognition, relationship building, and communication; and (e) health reform and innovation.

Presentation of Findings

The overarching research question for this study was the following: What leadership strategies do safety-net organization leaders use to increase nursing personnel retention? Some leaders face difficulties in retaining skilled nursing staff, which impacts productivity, patient safety, and quality. I used semistructured interviews and a review of

business documents and artifacts to gain an understanding of the strategies used by experienced leaders to increase employee satisfaction, commitment, and retention.

Participants' experience, backgrounds, and education varied, including a mix of traditional nursing and nonnursing educational accomplishment (see Table 3). Fifty percent of participants possessed a graduate-level degree, 75% possessed an undergraduate-level degree (with one pursuing a graduate degree), and 12% possessed an associate-level degree (currently pursuing an undergraduate degree).

Table 3

Participant Demographics

Participant	Position level	Years in healthcare	Gender	Education	Number of leadership positions
P1	Director	23	F	Undergraduate (pursuing graduate)	10
P2	Assistant director	24	F	Associate (pursuing undergraduate)	3
P3	Director	42	F	Graduate	6
P4	Director	35	F	Undergraduate	1
P5	Assistant director	6	F	Graduate	1
P6	Director	12	F	Graduate	3
P7	Director	30	M	Undergraduate	12
P8	Director	17	F	Undergraduate	3

The participants in this study were eight senior leaders from inpatient and outpatient departments representing a cross-section of nursing leaders from throughout a safety-net hospital. All members were located within the same organization in the state of Maryland. After IRB approval, I arranged interview sessions with each department leader after introducing myself and asking for their participation in the study. I sent

invitation letters along with a copy of the consent form to potential participants through email, and the eight agreed to take part in the study. I collected data from each participant via semistructured interviews and a review of hospital documentation. I asked each participant eight semistructured, open-ended interview questions using the interview protocol (Appendix B) as a guide. Each participant answered all questions. At the end of each interview, I thanked the participant for their input. I then transcribed the data and emailed a copy of the transcript to each participant for review and validation of the responses. After achieving data saturation, I entered the transcribed data into NVivo 11 Pro for coding and analysis. The following five main themes emerged from the data analysis: (a) engagement and management support, (b) education and career development, (c) teamwork and work atmosphere, (d) recognition, relationship building and communication, and (e) health reform and innovation. As depicted in Figure 1, the top 25 recurring words identified by participants may be useful in formulating retention strategies to increase nursing personnel retention.

Figure 1. Word cluster of top 25 recurring words in the study.

Theme 1: Engagement and Management Support

The first theme to emerge from the data collection was the importance of employee engagement and management support. The three most frequently mentioned words within the node related to this theme were *retention*, *leadership*, and *training* (see Table 4). Srivalli and Kanta (2016) highlighted the significance of creating a climate of openness, support, reward, value, and usefulness to positively influence job satisfaction and perceptions of organizational support. Employee engagement supports Homan's (1961) social exchange theory, which posits that expected return (either financial or nonfinancial) from the relationship motivates employees.

My personal observation of all participants in the study reflected leaders with a positive attitude and deep commitment to growing strong work teams. Participants expressed support for worker participation in educational offerings as a strategy to mitigate staffing concerns in their workplaces (Kochanowski, 2011). Participants recognized the need for engaging with employees to create the psychological bond necessary for increased organizational commitment. A positive work environment leads employees to increase their level of effort and align their actions around the goals and strategies of the organization (Allen, Erickson, & Collins, 2013).

Retention strategies such as management involvement, training, and career development reinforce the social exchange concept that employers' actions influence employee stay-or-leave decisions (Allen & Sjhanock, 2013; Mignonac & Richebe, 2013). Further, workers place a high value on how exchange outcomes shape perceptions of fairness, backing, and treatment (Paille, 2013). P5 noted, "It comes down to being fair, which I feel is very important ... what you do for one you must do for all. You must

always treat other people as you want to be treated." Manager awareness of how employees might interpret their treatment in relation to other staff members may prevent feelings of favoritism. Sensitivities related to fair-mindedness when it comes to relationship interpretations are necessary mechanisms in influencing commitment decisions.

Poor nurse staffing increases the incidence of readmission for medical and surgical patients (Tubbs-Cooley, Cimiotti, Silber, Sloane, & Aiken, 2013). Tubbs-Cooley et al. in their research on readmission rates among children admitted for common colds, showed an association between nurse staffing ratios and readmission rates. P1 noted, "For staff retention, it still falls back on the manager. It lies with the manager to know the employees, engage with them, know what they want, and do what's best. I feel empowered to try new things." P3 stated, "Staff satisfaction with the directors and managers. The relationship with them is a huge factor in getting staff to stay. The people leave mostly because they are not happy with their manager." The following participant comment reflects their sentiment and opinion on how management could better support nurse retention through strategic initiatives:

> We need to come up with a strategic plan on how to retain people. We need to partner with local colleges and implement a transition program to prepare them for what it is like to work in a high stress hospital environment. (P7)

Akila (2012) defined *employee retention* as the actions taken by a business or institution to garner a commitment for task accomplishment over a period of time. Businesses accomplish this through creating a supportive environment based on mutually beneficial relationships that dissuade staff from departing to competing organizations (Nazia &

Begum, 2013). Nazia and Begum posited that company policies focused on enhancing job satisfaction were the best strategy for shrinking the expenses associated with recruiting, training, and incorporating new staff members, which reinforces retention.

Nazia and Begum (2013) noted two important models of employee retention in their research, the Zinger model and the employee retention connection (ERC) model. In the Zinger model, businesses direct retention efforts toward goal accomplishment through a strategy emphasizing employee connection and organizational alignment. All efforts focus on creating a full work experience for the worker based on authenticity. Further, the model stresses the importance of crafting a retention strategy grounded on personal and professional growth through company support. Businesses offering courses to employees who develop their "strengths, value, visibility, and engagement create a strong organization supported by healthy and fully productive individuals" (p. 363). ERC's model concentrates on three fundamental drivers of worker commitment: (a) making work stimulating through a host of assignments, autonomy, resources, and support; (b) motivational leadership, whereby leaders embrace change and openness to new ideas as a part of the organizational vision; and (c) recognizing employees for their contributions and rewarding them for a job well done (p. 363).

Table 4

Word Frequency Related to Engagement and Management Support

Word	*n*	% of frequency
Training	66	105%
Retention	67	82%
Leadership	41	52%

Note. n = number of times mentioned.

Theme 2: Education and Career Development

The second theme to emerge was education and career development. The three most frequent words by node within this theme were *education*, *encouragement*, and *opportunities* (see Table 5). Organizational investment in staff development training and education prepares associates to meet the job demands of working in a high-stress environment. Education forms the bedrock of human growth and development (Iqbal & Hashmi, 2015). When making career decisions, fluent employees are more apt to feel psychologically empowered and view the organization positively when there is demonstrated investment in their growth (Iqbal & Hashmi, 2015). Several participant inputs supported Ratna and Chawla's (2012) contention that employee retention is more important than hiring. Six respondents voiced praise for organizational efforts to boost retention through investments in education (P1, P2, P3, P4, P5, P6, P8).

Table 5

Word Frequency Related to Education and Career Development

Word	*n*	% of frequency
Education (development)	98	100%
Opportunities	42	53%
Encouragement	69	46%

Note: *n* = number of times mentioned.

The hospital advanced exchange principles by devoting significant resources to the growth and development of nursing employees through full scholarship offerings that allowed registered nurses with associate's degrees to earn bachelor's degrees in nursing. Additionally, the hospital offered reimbursement for nurses obtaining a master's degree. Employers that offer tuition reimbursement programs have an 80% retention rate (Manchester, 2012). All employees have access to the health system's learning management system as a platform to meet their education and certification needs.

To gain a better understanding of the hospitals' learning resources, I reviewed online information related to the learning system mentioned above, which revealed a comprehensive software suite of clinical and nonclinical offerings including live streaming and training-program administration. Additionally, the hospital system operates two high-tech simulation centers that provide in situ simulation services and a complete American Heart Association program in pediatric life support, advanced cardiac life support, and basic cardiac life support training.

All eight participants had high praise for the organization's education cohort, tuition reimbursement program, and company furnished computer-based learning

platform and were strong education advocates for their personnel. P1 noted, "They push for the staff to use the SiTel system." P7 commented, "I like to really promote education because I think that it is very important for retention and having the knowledge to do your job." P4 spoke about her experience with the company's reimbursement program, noting, "I did the BSN cohort and the master's program. With the tuition reimbursement you have to give back a certain amount of time, but I think it is fair since the company has invested in you."

According to the U.S. Department of Health and Human Services (2010), the median age of registered nurses in the United States was 47 years of age. Hospitals have to create training and development programs targeting mature nurses to increase their job commitment (Armstrong-Stassen & Stassen, 2013). Moreover, job design and training requirements need to be reevaluated to strengthen work-related attitudes to influence intent-to-remain decisions (Armstrong-Stassen & Stassen, 2013). Participant inputs confirmed Homan's (1961) exchange theory, which indicates that employees who feel that the organization values their contributions are likely to view leadership decisions positively (Blau, 1964).

During a discussion of the impact of technological changes' on staff morale, P6 noted, "I won't say it has impacted morale but it has created more patient focus. I try to help more seasoned nurses to understand that our health care system and model has changed." P4 commented, "I think that it has made it harder, especially for older nurses that are so focused on hands-on care for the patient and now they have to step back to do documentation." The investigation results align with Leppel, Brucker, and Cochran's (2012) research on the necessity for organizations to invest in training older employees

due to rapid technological innovations. In a study of workers born in 1964 and earlier, Leppel et al. used a job characteristics model developed by Hackman and various colleagues (1987) to explain the determinants of positive job-related outcomes. The model evaluated five job characteristics: (a) skill variety, (b) task identity, (c) task significance, (d) autonomy, and (e) job feedback (p. 64). The research findings suggested a positive relationship between vocational training and job satisfaction for older workers (Leppel et al., 2012).

Four of eight participants highlighted the importance of a career ladder to provide a clear career path and structure (P3, P4, P6, P8). P4 noted, "They are going to work on the clinical ladder, but it is not here yet. And that's a big thing, that I think will help people to grow and see where you are able to advance." Additionally, P8 noted, "For the new nurse residency program, they go through a whole year and a very long orientation process to help them transition from student to practitioner."

Theme 3: Teamwork and Work Atmosphere

The third theme to emerge based on participant responses was teamwork and work atmosphere. The three most frequently mentioned words in this node within the theme were *scheduling*, *think*, and *believe* (see Table 6). Nurses depend on managers to provide the appropriate resources to meet job demands (Brunetto, Shacklock, Teo, & Farr-Wharton, 2014). Retention strategies must include reasonable workloads and both monetary and nonmonetary rewards. Nonmonetary rewards include recognition from supervisors and peers, acknowledgement of a job well done, and helpful supervisors.

Participant feedback corroborated the premise of Brunetto et al. (2014) that a strong supervisor-subordinate relationship and support may obviate retention concerns.

P1 commented, "We do things such as the coffee club with a quote every day to build teamwork. My people see me out there, it helps to foster teamwork. Emphasizing teamwork and engagement helps to build a strong and committed team." P2 offered, "We get a lot of information in our staff meetings on how we can improve communication. We promote teamwork at all times." The next passage highlights the importance of building strong relationships and trust with staff members:

> I am a relationship builder. I try to build relationships that are fair and consistent across the team. My goal is for the staff to know that when they are busy, I will come in and help them wherever I can and that makes a big difference for a lot of nurses. (P3)

Family friendly policies are significant in mediating staff turnover (Kim, 2012). Multiple participants noted the importance of flexible scheduling to prevent burnout and encourage a stronger work-life balance. Alternative schedules and flex time along with other human resource management practices such as salary increases, bonus programs, enhanced benefit programs, telecommunicating, and improved IT programs increase employee retention (Kim, 2012, p. 259).

Five of eight participants voiced concerns relating to financial challenges associated with reduced Medicare reimbursements. In response to the interview question on what obstacles they faced in trying to implement staff retention strategies P4 revealed, "It is frustrating to the staff when you are only allowed to hire so many people, where having more people would give more scheduling flexibility." P6 articulated, "It is difficult to get more people due to compensation. I've had a few nurses decline offers because of the compensation." P3 stated, "financial support from the organization can be

an obstacle, sometimes I would like to give monetary recognition, but most of the recognition I give comes out of my own money."

Researchers in Pakistan found a significant relationship between work environment and job satisfaction among workers in the education, banking, and telecommunications industries (Raziq & Maulabakhsh, 2015). The findings align with Herzberg, Mausne, and Snyderman's (1959) Two Factor Theory, where both Hygiene and Motivation factors showed a positive relationship and influence on employee satisfaction. P3 noted "The staff should also be satisfied with the environment that they work in." The following participant comment brings to the forefront how these motivational factors may inspire employee allegiance to the organization.

> I think that comparing this facility to working at the hospital center, just the general atmosphere and environment here, is a very pleasant place to work. Everyone pretty much gets along and enjoys each other's company, a lot of teamwork to get the job done, and to be honest that's why I'm here working because of the atmosphere and I enjoy working with everyone here as a team. Here everybody kind of knows each other, are supportive of each other, and we all want to succeed. (P8)

Management and governance decisions lead to an environment where workers flourish or are demotivated and less productive. To provide insight on the potential negative impact these policies can have on patients and staff P7 opined, "The biggest obstacle here is that it is an old building. Sometimes it can be a difficult work environment or an unsafe environment for staff." Managers should constantly evaluate environmental factors that

may negatively impact employee satisfaction and constantly provide feedback on efforts to remedy thoses situations.

Table 6

Word Frequency Related to Teamwork and Work Atmosphere

Word	*n*	% of frequency
Scheduling	85	123%
Believe	120	118%
Important	23	57%

Note. *n* = number of times mentioned.

Theme 4: Recognition, Relationship Building, and Communication

The fourth theme to emerge centered on the importance of recognition, relationship building, and communication. The three most frequently mentioned words in this node related to the theme were important, communication, and leave (see Table 7). Four participants referred to the importance of open and transparent communication through staff meetings, town hall meetings with senior leadership, and corporate communications via email and mailings sent to their home (P2, P3, P4, P5). P3 commented, "We now have staff participating on different hospital committees that increase their morale, they're being given a chance to participate and have a voice. It's important to keep them informed and communication is key!"

Table 7

Word Frequency Related to Recognition, Relationship Building, and Communication

Word	*n*	% of frequency
Important	54	63%
Leave (time off)	60	35%
Communication	35	34%

Note. *n* = number of times mentioned.

Six of eight participant responses reflected an awareness on the importance of having a strong relationship with their staff. Participant responses to the interview question on what strategy they used to increase staff retention, revealed a strong emphasis on relationship building activities (P1, P2, P3, P4, P5, P6, P7). P6 stated, "I attempt to build relationships by getting to know my staff. I do one-on-ones with them every quarter to kind of figure out what they're working on and how I can help them developmentally." In a study on the effects of positive leadership and psychological empowerment in the chemical industry in South Africa, organizational psychology researchers found a positive effect of the two variables on worker engagement and satisfaction with life (Nel, Stander, & Latif, 2015). Employees respond better to positive reinforcement from optimistic managers and supervisors that are capable of providing clear, helpful, and principled guidance. My direct observations of leaders engaging with staff revealed positive interactions between managers, staff, and other professional colleagues throughout the organization. All participants espoused an open-door policy and encouraging attitude towards their workforce.

My review of organizational documents substantiated the recognition, relationship building, and communication theme gleaned from participant interview data. The organizational document, *Employee Handbook 2016*, noted the importance of establishing a positive and truthful work environment where all associates are treated fairly, and with respect regardless of their employment status. The organization's values code centers on the acronym *SPIRIT* which stands for *Service, Patient first, Integrity, Respect, Innovation, and Teamwork*. The value statement *integrity* aligns with the theme and stresses the need for open and honest communication to build trust and conduct of the highest ethical standards. The document underscored the significance of new associates developing a partnership between hospital staff and their supervisor to ensure a successful working relationship based on (a) communication and understanding needs and expectations, (b) discussing and resolving questions and problems, and (c) sharing of suggestions to improve work processes (p. 3).

The organizational document *2015 Nursing Annual Report* verified respondent feedback related to nurse participation on various councils and the opportunity to interact with senior nursing executives. My review of the document revealed an innovative approach for generating new ideas through involvement with the Nursing Collaborative Governance Coordinating Council, Nursing Quality and Safety Council, and Nursing Practice Council, "each with distinct roles to support and facilitate collaboration among nursing professionals" (p. 4).

Theme 5: Health Reform and Technological Innovation

The fifth theme to emerge was health reform and innovation. The three most frequently mentioned words within this node relating to the theme were change,

strategies, and better (see Table 8). According to three participant responses to the interview question on what effect, if any, health reform related innovations had on staff morale, participants expressed mixed comments. Most responses did not indicate a significant long-term impact to morale after the initial transition from a paper documentation method to an electronic system.

Table 8

Word Frequency Related to Health Reform and Technology

Word	*n*	% of frequency
Change	67	61%
Better	44	67%
Strategies	24	31%

Note. *n* = number of times mentioned.

Reflecting on her experiences during the implementation of the organization's electronic health record system a few years ago P3 stated, "When we first did the electronic health records, it was hard, but now everyone embraces it. I don't know what would happen if something were to happen to the EMR." The use of health information technology to improve patient outcomes was a critical factor during health reform planning (Lopez, Patterson, & Sarkar, 2012). For hospitals dependent on reimbursement through Medicare's DSH program, capturing performance data is crucial to qualifying for quality incentive payments. P1 commented, "Recently we had to do something for Medicare for compliance." P7 stated, "I think reimbursement is a huge factor in the ability of hospitals to operate, buy new equipment, improve salaries, or improve

infrastructure of the building." The following narrative excerpt illuminates the paradoxical challenges in capturing performance data.

> The healthcare reform invasion and insurance regulations make it more difficult. Everything needs to be documented and staff that are not computer savvy have to be dragged along. We do a lot of hip replacements. Patients used to stay for five days after surgery and now they are out on day two and patients are upset. Staff are now upset. You may have the same number of patients as you did five years ago, but they're now more acutely ill or they're closer to surgery which means they have more needs. You may have the same number of patients, plus with everything that needs to be documented, it takes more time. It's not just doing physical care anymore. If it is not written down, then it didn't get done. (P4)

The increased documentation demands may drive the need for additional nurse staffing to avert further attrition, which jeopardizes care availability to uninsured populations (Coughlin et al., 2012). P8 noted, "There is a lot more documentation now that takes a nurse away from the bedside. The regulations coming down from Medicare require a lot more documentation to prove we are meeting standards so the hospital can get paid." Retaining trained nurses reduces risk to the organization and increases its' ability to compete in the marketplace.

Adopting technological innovations can improve patient outcomes and reduce staff liabilities over a period of time. An example of the importance of overcoming initial staff resistance to technological change is reflected in P2's comments when she stated, "When we switched over to the EMR from a paper system, everyone was stressed out. But now, if the doctor is within our system, they can see everything. So it benefits the

patient and the health care team." The comments support Lee, McCullough, and Town's (2013) assertion that embracing health information technology may improve patient care quality and staff productivity. Additionally, hospital information technology investments may reduce overall operating costs and improve revenue cycle management when paired with complimentary system applications such as supply chain management, accounting, and billing (Lee et al., 2013).

The tangible effects of investments in new applications are easier to quantify, compared to the outcome measures of quality from a system such as an electronic medical record. Commenting on the need for technology investment, P7 stated, "We lack up-to-date equipment, given we are designated a stroke center, that requires certain equipment." New technology investments enable the provision of improved care quality and patient safety.

Application to Professional Practice

The purpose of this study was to explore the leadership strategies used by safety-net leaders to increase nursing personnel retention. The findings include evidence from participants, analysis of organizational documents, and interpretation of results. The findings and recommendations may serve as a basis for strategy adoption by health organization leaders, regardless of population served, to improve employee job satisfaction. The applicability of the findings to professional practice may increase awareness of approaches other colleagues use to garner employee cooperation, support, and commitment.

Today's leaders have to be both competent in their profession as well as informed in employee relations and labor rules. According to research by Rafi and Andri (2015),

recruiting practices play a critical role in the long-term success or failures of new hires. If recruiters and hiring officials reasonably identify signs that a candidate is a good fit for the organization, it could positively affect co-worker morale, work production and quality (Patimath, 2015). On the other hand, a failure to recruit the right talent can cost the company precious resources through poor performance and lost production (Sutanto & Kurniawan, 2016) .

Nurses respresent one of the hospital's most valued resources. With the impending retirement of a large number of Baby Boomer nurses, healthcare leaders must resort to innovative methods to recruit and retain the next generation of caregivers (Holland, 2015). Holland posited that investments in education, leadership development, and succession planning may help to grow the next generation of nurse leaders, thereby alleviating the burden and risks of inadequate staffing in the future.

As more people acquire health insurance, managers will have to develop strategies to lesson the workload on staff, especially in the primary care setting. Patients with chronic conditions and poor histories of treatment compliance represent a disproportionate increase in consultations, adding to the stress levels of already overworked treatment teams (Hunt, 2016). National Health Service's *England's General Practice Forward View* (April, 2016) projected future requirements of 5,000 additional doctors and a mix of 5,000 or more nurses, pharmacists, physician assistants, and mental health workers (Hunt, 2016). With an 100% increase in telephone consultations, burnout becomes a major concern and antecedent for employee attrition as employers evaluate future staffing levels (Thompson & Walter, 2016).

Implications for Social Change

The findings of this single case study has several implications for social change. Reducing nurse staff turnover lowers hospital operating costs, which increases the capacity to provide charity care and reduce health treatment disparities in disadvantaged communities. To accomplish this goal, leaders must address provider reluctance to treat particular populations to reduce racial and ethnic inequalities (Betancourt, Beiter, & Landry, 2013). Betancourt et al. contended that reducing clinical practice contributors to health treatment differences such as provider-patient communication, clinical-decision-making, and mistrust, helps to improve community health and the hospitals' identity with marginalized populations.

Safety-net hospitals often treat minority and lower-income populations with limited education and language barriers. Medical leaders who advance strategies to reduce costly emergency department visits and patient communication barriers which cause delayed and expensive care, make available extra care to local communities. Within the United States, 34.5 million Spanish-speaking individuals identify as limited English proficient (Snowden & McClellan, 2013). Individuals that speak limited or no English and cultural differences present a unique challenge for healthcare providers. Cultural considerations and health literacy can influence patient understanding of healthcare information and compliance with treatment recommendations (Snowden & McClellan, 2013). To improve the provider-patient relationship, health providers must gain an understanding of cultural differences when treating minorities. Often these groups may prefer alternate forms of cure such as homeopathic or nontraditional remedies compared to mainstream medical treatments. Future staff planning should

incorporate these considerations to heighten patient communication and understanding, thus leading to better treatment compliance and changes in social behavior.

Recommendations for Action

The findings of this study yielded evidence on methods leaders used to increase nursing staff job satisfaction, production, and retention. Based on the five themes identified from the semistructured interviews, analyzing participants' responses, and conducting methodological triangulation of responses to business documents, the following recommendations may be helpful in formulating goals and plans to improve work relationships between employers and employees.

My first recommendation is that managers and employees receive formal training in employee engagement and relationship management. According to Jha and Kumar (2016), workforce engagement drives employee performance. Research by Dale Carnegie Institute (2012) indicated that only 29% of employees are fully engaged while 26% are disengaged. Improvements in communication and performance management can boost organization productivity and profits, while strengthening employee involvement and perceptions of trust and justice (Jhar & Kumar, 2016; Molraudee, 2016).

My second recommendation is for the organization to conduct regular surveys to assess technological needs that may enhance the quality of patient treatments and safety practices. Ker et al. (2014) explored how the implementation of prescribing technologies improved medication distribution in two U.S. pharmacies. The study showed how the use of digital scanning technology coupled with lean methodology improved patient safety (Ker et al., 2014).

My third recommendation is that the organization consider adopting cloud-based human capital technology that allows for customizable dashboards, predictive analytics, and modeling tools for evaluating in-house personnel. The technology would enable senior decision-makers to use employee performance management software to track employee accomplishments and performance goals. Additionally, the employee feedback process should be formalized to ensure managers provide consistent advice and goal setting to all staff.

My fourth recommendation is for nursing leaders and human resource managers to conduct salary comparisons with competing markets. Leaders may consider adopting a tiered pay scale where current staff receive incremental pay increases to prevent perceptions of unfairness by senior nurses towards new accessions starting with comparable salaries.

My fifth recommendation is to offer additional incentives that might encourage nurses to work hard-to-staff shifts. The incentives may include increased compensation, loan repayment programs, retention bonuses, and performance bonuses.

My sixth recommendation is to implement the nurse career ladder to provide a visible career path and equitable platform for employees to plan career goals. The solution should be flexible and comprehensive to include career and succession planning along with talent profiles of staff for use by recruiters and hiring officials.

My final recommendation is to encourage nurse managers to take business classes to gain a better understanding of the enterprise's business model and how nursing decisions influence operating costs and organization sustainment. The ACA projects reimbursement reductions to safety-net hospitals failing to meet certain quality measures

such as patient readmissions within 30 days (Chatterjee et al., 2012). Sherman and Bishop (2012) insisted that pending reduced reimbursments necessitate nurses having an understanding of the relationship between treatment outcomes and the hospital's financial bottomline. The impact of practice decisions, combined with high-cost emergency room visits, make it imperative to control costs since hospitals cannot refuse uninsured patients due to the Emergency Medical Treatment and Active Labor Act.

Recommendations for Further Research

The findings of this single case study were limited to the perceptions and opinions of the nurse leaders available and willing to participate in the study. Therefore, the results may not represent the thoughts and views of a majority of the managers throughout the hospital or other health care organizations in the area, state, or nation. The results proved interesting, however, it only represents the experiences of leaders at one safety-net hospital. Core safety-net providers include:

- Public hospital systems
- Federal, State, and locally supported community health centers, Federally Qualified Health Centers, and Rural Health Centers
- Special service providers such as
    - Family planning clinics
    - School-based health programs
    - Ryan White AIDS programs
    - Some physcians who care for predominately uninsured and Medicaid patients

- Other ambulatory care sites with demonstrated commitment to serving poor and uninsured patients (Lewin & Altman, 2000)

For this reason, I recommend a multiple case study that explores the experiences of nurse leaders from different safety-net organizations in other geographical locations to inform on the leadership strategies they use to motivate and retain nursing personnel.

As this study took place in the state of Maryland, which expanded healthcare coverage to its' citizens under the ACA, future studies may examine states that refused to expand insurance coverage. Additionally, subsequent studies could focus on the experiences of workers and their perceptions relating to job satisfaction, engagement, and factors influencing intent-to-stay decisions. Finally, the findings of this study warrant further exploration of implementation strategies hospital CEOs could use to build sustainable organizations with strong cadres of happy workers.

Reflections

My passion for healthcare and meeting the needs of disenfranchised populations led me to investigate how safety-net hospitals would survive, given the political discourse on the Affordable Care Act and the fact some states refused to expand health coverage to its' most vulnerable populations. When I embarked upon this journey, my initial interest was exploring the impact of healthcare decisions in my home state of North Carolina, where state legislatures refused to expand insurance coverage. However, it became apparent as I approached data collection that logistically, collecting data in North Carolina would not be feasible.

I failed to realize the level of effort required to transcribe, code, and analyze participant data and organizational artifacts and now fully understand the importance of

limiting the number of interview questions. Meeting the participants in their workplaces, observing their interactions with staff, and conducting the interviews proved very gratifying. My exposure to the hospital setting reminded me of the many years I spent working in military hospitals. I felt a total sense of gratitude and respect for all of the employees I encountered from the receptionist at the entry of the facility to the maintenance personnel who were so willing to help me find my way around. The results of this study allowed me to examine first-hand how leaders work to overcome staffing challenges through creative scheduling, empowering middle managers, and demonstrating care and concern for their employees. Completing this research project was challenging, yet exciting. The configuration of the doctoral program provided a structured approach, that built upon each class and phase of completion. The methods supported my completion of this project.

Conclusion

The purpose of this qualitative single study was to examine the leadership strategies used by safety-net leaders to increase nursing personnel retention. The use of methodological triangulation allowed for the collection of data from four sources. Semistructured interview technique enabled me to collect the first set of data through open-ended questioning to eight nursing leaders. Next, I examined hospital human resource policies, guidelines, on-line resources, and other artifacts. Member checking provided the opportunity to verify information accuracy and gather additional data.

After coding and analyzing the data, five main themes emerged: (a) engagement and management support; (b) education and career development; (c) teamwork and work atmosphere; (d) recognition, relationship building, and communication; and (e) health

reform and innovation. I aligned each theme with the literature, existing body of knowledge, and social exchange theory. My findings of the study indicate (a) increasing employee engagement, (b) focusing on training and career development, (c) technological upgrades, and (d) developing sustainable relationships are appropriate approaches for gaining nursing personnel commitment. The findings of this study are important to chief executive officers, senior leaders, and middle managers in healthcare and other industries, as they seek to attract talented staff members capable of growing and sustaining their organizations. I plan to publicize the results of this research through various forums, scholarly journals, and business journals.

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Appendix A: Consent Form

EXPLORING THE EFFECTS OF LEADERSHIP STRATEGIES ON NURSING PERSONNEL RETENTION WITHIN SAFETY-NET HOSPITALS

You are invited to participate in a research study designed to investigate the leadership strategies safety-net healthcare leaders used to increase nurse retention. All participants are members of a safety-net healthcare facility. Please review this form and ask any questions you may have before agreeing to participate.

Background Information

This study seeks to explore the effects of leadership strategies on nurse retention as informed by participants who are acknowledged leaders with the requisite experience based on the position they hold. The criteria for participation is 1) healthcare manager in leadership or management position, 2) must include experience leading, managing, influencing nursing personnel, and 3) practical considerations, such a geographical proximity, availability, accessibility, and a willingness to participate in study. Participant interview will be held in a designated location, as determined by organizational leadership.

Procedures

Respondent involvement involves answering open-ended questions (via interview format), based on your personal experiences. The interview should last approximately thirty to sixty minutes. A short follow up interview may be necessary for member checking to ensure that I have accurately captured the data. The interview will include notetaking for use in data analysis and accuracy, if consent is provided. A copy of the transcript will be emailed to you for review and approval, after the transcription is

complete. You are asked to return any feedback or further information about the transcript to this researcher. You will be provided a participant number to replace your personal name. The results of this study will produce a doctoral study and may be published elsewhere. Your feedback may be included in such publications, but your personal identity will remain confidential. A copy of this consent form will be provided to you for your records. All interviews will be audio recorded.

Confidentiality

The records of this study are confidential. In any sort of report that might be published, no information will be included that would make it possible to identify a participant. Solely the researcher will keep research records in a secure password protected file for 5 years. The records will be maintained in accordance of the APA Manuel, and destroyed in 5 years.

Voluntary Nature of this Study

Your decision whether or not to participate will not affect your current or future relationship with the researcher or the associated University. If you decide to participate, you are free to withdraw at any time without prejudice. In the event you become uncomfortable or experience any apprehensions during your participation in the study, you may terminate your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

Compensation

Participation in this study is voluntary. You will not receive monetary compensation/reward for your participation. The personal benefits of your participation are discussed in the following section.

Benefits of Participating in This Study

There are a number of possible benefits to participating in this study. You would have the opportunity to contribute to the understanding of leadership strategies and the development of employee retention strategies. The cumulative findings of your feedback will be shared with you upon completion of the study, providing you the opportunity to review the results first hand. The results may assist you in better understanding the leadership strategies that contributed to your success while providing others the opportunity to learn and develop their own. You may experience a greater personal awareness of the significance of your leadership contributions based on your participation in this study.

Risk of Participating in This Study

There is minimal risk to participating in this study. Minimal risk herein means that the risks of harm anticipated in the proposed research are not greater than those ordinarily encountered in daily life. You should not experience any discomfort during or after your participation.

Contacts and Questions

You may ask any questions you have by contacting the researcher by telephone or email (XXX.XXX.XXX, carl.brown2@waldenu.edu). If you prefer you may contact the university's Research Participant Advocate. Her name is Dr. Leilani Endicott (X-XXX-XXX-XXX ext. XXXXXX in the USA or via email address irb@waldenu.edu). Walden University's approval number for this study is 07-15-16-0489074 and it expires July 14, 2017.

Statement of Consent:

I have read the information herein, I have asked questions and received answers, and I have received a copy of this form. I consent to participate in this study.

Signature of Participant/Subject: _____

Date: _____

Researcher Statement:

All information contained herein is accurate. I have provided the participant with a copy of this form for their records.

Signature of Student/Researcher: _____

Date: _____

This has been approved by the Institutional Review Board of

as acceptable documentation of the informed consent process and is valid for one year after the stamped date.

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Appendix B: Interview Protocol

HEALTHCARE LEADER EMPLOYEE RETENTION STRATEGIES		
Date, time, location		
Step 1	Introduction	Thank individual for taking time to participate in this study.
Step 2	Purpose	Introduce the purpose of this study is to research leadership strategies used to increase nurse retention.
Step 3	Describe why they are participating	The information acquired will support my doctoral study in partial fulfillment and requirement of the degree of Doctor of Business Administration from Walden University.
Step 4	Describe the benefit of participating	This information might add to the body of knowledge on leadership strategies and is geared towards organizational, corporate, and executive leaders, leadership training consultants, educators, and those interested in continued professional development.
Step 5	Discuss ethics	To maintain ethical standards and protect individual privacy, I am requesting your permission to keep notes on this entire session starting now – to include the opening discussion and interview.
Step 6	Discuss confidentiality	All information you provide will be confidential. Research records will be kept in a password protected database; only the researcher will have access to the records. All files will be destroyed after five years from the completion of the study. Any material results from this session will be confidential and only used for the purpose of the study to be presented in the doctoral study. Additionally, the notes will be destroyed immediately upon transcription.
Step 7	Ask if the participation has any questions	Do you have any questions or concerns as to the process just discussed?

Step 8	Transition to the interview questions	This is the semistructured interview.
Step 9	Conduct the interview Ask probing questions as required	1. What strategies do you use to increase nursing personnel retention? 2. What factors have you identified as contributors to nursing staff attrition? 3. What staff retention programs does your organization offer? 4. What obstacles, if any, have you encountered in implementing retention strategies for nursing personnel in the organization? 5. What process does your organization use to identify candidates for advancement to positions of increased responsibility? 6. What impact, if any, has health reform-related innovations impacted staff morale? 7. How does your organization determine funding for training opportunities? 8. What additional information would you like to add to help me better understand how your organization addresses employee retention?
Step 10	Wrap up	Thank you for your time. To ensure I have interpreted your data correctly, would a follow up interview be acceptable? Would it be okay to contact you for any follow-up/clarification if needed? Is there a preferred method of communication?

Appendix C: Interview Questions

The interview questions for this study are as follows:

1. What strategies do you use to increase nursing personnel retention?
2. What factors have you identified as contributors to nursing personnel attrition?
3. What staff retention programs does your organization offer?
4. What obstacles, if any, have you encountered in implementing retention strategies for nursing personnel in the organization?
5. What process does your organization use to identify candidates for advancement to positions of increased responsibility?
6. What impact, if any, has health reform-related innovations impacted staff morale?
7. How does your organization determine funding for training opportunities?
8. What additional information would you like to add to help me better understand how your organization addresses employee retention?