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Walden University

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Burnette Anne Tolbert Vidal

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Walden University
2019

Abstract

Stress and Burnout: Empathy, Engagement, and Retention in Healthcare Support Staff

by

Burnette Anne Tolbert Vidal

M.Ed., The Pennsylvania State University, 1989

B.S., Messiah College, 1986

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

May 2019

Abstract

. Research on stress and burnout and their influence on empathy, engagement, and retention, in healthcare support staff is scarce in the literature. The theoretical framework for this study was the conservation of resources (COR) theory which claims that when people are stressed, emotionally exhausted, and experiencing burnout, they protect and preserve their physical and mental resources from becoming depleted by reducing their effort and withdrawing from work. The key research question was: Does burnout mediate the relationship between stress and empathy, engagement, and turnover intentions in healthcare support staff working in a Federally Qualified Health Center (FQHC)? This quantitative, non-experimental, mediation analysis included 83 female and 10 male healthcare support staff working in an FQHC. The variables were assessed using the Job Stress Survey (JSS), Oldenburg Burnout Inventory (OBI), Interpersonal Reactivity Index (IRI) – Brief Form, and the Behavioral Intentions to Withdraw Measure (BIWM). A path analysis was performed to estimate the magnitude of the relationships between the variables. The results indicate that burnout does not mediate the relationship between stress and empathy, but it does significantly predict engagement and turnover intentions. FQHCs serve vulnerable and medically complex patients in underserved communities, and when the negative impact of burnout in healthcare support staff is addressed, patients, providers, and staff can enable positive social change by achieving important clinical health outcomes for patients.

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Dedication

This dissertation is dedicated to my dad and mom. Dad was my biggest cheerleader. He was my biggest hero. He gave me endless encouragement and supported all of my endeavors with his unwavering love. He never failed to remind me that I could do anything. And when it was done, he'd say, "You've done a fine, outstanding, and commendable job!" As I conclude this dissertation journey, I can hear his voice. I am so thankful for having a man in my life that built me up, complimented me, told me I was smart and beautiful, and was always loving and kind as he guided me through life. Best of all, my dad taught me the love, forgiveness, and Salvation of Jesus Christ. He grounded me in the Scriptures and taught me to read God's Word and trust Him completely. He taught me to pray and know that even before I pray, God knows the desires of my heart. Thank you, Dad.

I also dedicate this to my mom. My mom is the epitome of love and kindness. She too, taught me the Word of God. She'd always say, "Pray all the way!" Mom, you were an example of how to be a loving and caring wife and mother. You gave your endless love and support to Hilsford, Savannah, Dominique, and Cathy. You always reached out to help lighten my load and I thank you from the bottom of my heart.
I am who I am…because of you. Thank you!

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Finally, I acknowledge all of the men and women who work tirelessly to provide quality, safe, supportive, professional health care to those in our society who have been underserved, marginalized and forgotten.

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Chapter 1: Introduction to the Study

According to the Institute of Medicine (IOM, 2010), an excellent patient experience is one that results in care that is centered on the patient, coordinated, considerate of the patient's time. The best patient care is effective in its management of the patient's conditions (Wynn, 2016). Patient-centered care results in outcomes such as patient satisfaction, adherence to treatment plans, follow-up for return visits, communication, trust between patient and provider, participation in the planning and implementation of care, and engagement in the healthcare process (Saha et al., 2008). Patient care outcomes enable patients and providers to achieve critical clinical results, but these outcomes can only be achieved when the negative impact of stress and burnout in healthcare staff is addressed (Amoafo et al., 2015). The healthcare profession is a very demanding field, and as job demands increase, more and more healthcare professionals experience emotional exhaustion, a lower job commitment, and a higher interest in leaving their employment, which threatens critically important patient care outcomes (Thanacoody et al., 2014). This study provides an important examination of the impact of stress, mediated by burnout, on empathy, engagement, and turnover in healthcare support staff working in a FQHC.

Background of the Study

FQHCs

In 1965, FQHCs, more commonly known as community health centers or safety net health centers, were formed to correct unfair gaps in healthcare that disproportionately disadvantaged America's poor and uninsured minorities (Adashi et al.,

2010). In 1965, the federal government established the Health Center Program with two clinics. The program has grown to over 1400 health centers nationwide, which serve approximately 26 million people. FQHCs are community-based healthcare providers. They are funded by the Health Resources and Services Administration to provide primary care health services in underserved areas. FQHCs must pass rigorous requirements, which include accepting payment based on a sliding fee scale and a person's income. They must also operate under a governing board on which patients serve.

While FQHCs provide quality and culturally competent care, the challenges include operating within tight budgetary restraints, collecting payment from the uninsured, and recruiting and retaining healthcare professionals. Additional hurdles include caring for the sickest populations which are isolated from healthcare facilities due to costs, language, culture, homelessness, mental health, multiple comorbidities, and the complexity of navigating the healthcare system (Adashi et al., 2010).

There are unique challenges for FQHCs that support an even more significant need for healthcare leaders to gain insights into the consequences of stress and burnout on healthcare support staff working in the FQHC setting. FQHCs were established to reduce healthcare gaps among minorities, the poor, and the uninsured (Adashi et al., 2010). In the FQHC environment, no one can be turned away, resulting in underserved populations receiving quality healthcare, regardless of their ability to pay. The challenges include large numbers of uninsured patients and patients with multiple chronic mental and physical health conditions that remain undiagnosed and untreated (Adashi et al., 2010). This research contributes to limited information on the effects of burnout on empathy,

engagement, and turnover for FQHC healthcare support staff, where stress levels are often higher due to patient complexities and limited resources (Hayashi et al., 2009).

Stress

The study of stress has a long history in health psychology research. Stress occurs in the external environment and affects a person, resulting in a decline in one's physical and mental health (Segerstrom & O'Connor, 2012). Stress is a person's response to conditions in the environment that threaten to deplete the individual's internal and external resources, which are those things, personal traits, circumstances, or motivations that a person values (Hobfall, 1989). Stressful events or conditions are called stressors. Stressors are found in circumstances and cause distress (Segerstrom & O'Connor, 2012).

Stress and its adverse effects create significant concerns for the management of all occupations and job levels in health facilities (Rees, 1995). Healthcare support staff (which include but are not limited to administrative, clerical, allied professionals, and ancillary personnel) are especially likely to develop stress-related illnesses due to the type of work and the environment in which they perform it (Rees, 1995). For healthcare support staff, stress is also strongly correlated with poor mental health, anxiety, fatigue, emotional and psychological exhaustion, and substance abuse (Thorsteinsson et al., 2014). According to Rees (1995), 40% of employees across all industries and jobs will experience the detrimental effects of stress.

One of the most common causes of work stress in the healthcare setting is high job demands and job overload (Firth-Cozens, 2001). Stress is a workplace hazard that

adversely affects employee health, emotional wellbeing, and job performance (Maslach & Leiter, 2008). Stress is known to adversely affect physical health, psychological health, behavioral health, and interpersonal relationships (Saleem et al, 2016). It is an event that causes negative emotions, worry, and repeated negative thoughts that eventually cause poor physiological balance and an increased risk of heart disease (Segerstrom & O'Connor, 2012). According to Rees (1995), administrative and clerical workers report high levels of poor health and physical symptoms of anxiety and depression due to work-related stress. Over time, unresolved stress leads to burnout, which affects not only physicians but also healthcare support staff (Bodenheimer & Sinsky, 2014).

Burnout: Exhaustion, Cynicism, and Inefficacy

Burnout research began in the 1970s and was defined as a threat for employees working in caregiver or human service jobs (Maslach, 2017). In the early 1980s, Anthony-McMann, Ellinger, Astakhova and Halbesleben characterized burnout as the end result of prolonged stress (Anthony-McMann et al., 2017). Burnout is a series of physical changes that take place as a result of long-term job stress (Maslach et al., 2001). Burnout occurs when a worker describes feeling overwhelmed, saddled with an unmanageable workload, chaos at work, powerless to gain control, a lack of wellbeing, and a lack of job satisfaction (Wallace & Lemaire, 2007). Burnout is the condition of being mentally and psychologically spent that frequently occurs in people working in a healthcare setting (Amoafo et al., 2014). When feeling burnout, people feel a low sense of achievement and accomplishment (Rees, 1995). Maslach (2017) described burnout as

inefficacy or low production or ability, little enthusiasm, and an inability to manage or change conditions.

Burnout, a prolonged response, is an unhealthy and unpleasant condition that affects individuals and organizations (Maslach & Leiter, 2008). Burnout occurs when a person is rendered mentally and emotionally unenergetic due to the demands of their job roles (Thanacoody et al., 2014). Every part of delivering care to patients can be compromised by burnout (Dyrbye & Shanafelt, 2011).

According to Maslach and Leiter (2008), there are three components of burnout: exhaustion, cynicism, and inefficacy. Exhaustion is the individual's strain that includes being overextended and depleted physically and emotionally. Exhaustion prompts people to distance themselves emotionally and cognitively from work and from other people so they can handle the excessive load. Cynicism is characterized by a negative and callous detachment from some or all aspects of the job. Cynicism enables a person to distance him or herself from the emotional investment required to be useful in the role (Maslach & Leiter, 2008; Vladut & Kallay, 2010). Maslach (2017) described depersonalization as having an inappropriate perspective about patients, irritable, and withdrawn. Inefficacy refers to a person's feelings of incompetence, lack of achievement, and lack of effectiveness (Maslach & Leiter, 2008). All of these variables can obstruct the ability of the healthcare support staff to provide quality care to patients. According to Golembiewski (1999), emotional exhaustion is more of a contributing factor to burnout than a low sense of job accomplishment or high depersonalization.

The phase model of burnout, built on Maslach's three dimensions of burnout, measures the experience of burnout, groups the dimensions into phases, produces a high or low score for each dimension, and defines a specific phase of burnout (I-VIII) for a person (Goodman & Boss, 2002). Though an individual does not have to go through each phase, the eight phases of this burnout model represent a decline toward progressively damaging burnout beginning with Phase I (low burnout) through to Phase VIII (high burnout) (Golumbiewski, 1999).

Burnout produces various employee responses on the job, including employee discontentment, lack of loyalty, frequently missed work days, and job searching (Wong & Laschinger, 2015). Burnout is attributed to several organizational factors, including workload (job demands), control (role conflict), insufficient rewards (social or financial), community (social interaction), fairness (equitable decisions), values (ideals and motivations), and job-person incongruity (Maslach & Leiter, 2008). Burnout not only obstructs employee performance and organizational effectiveness, but also interferes with one's ability to express empathy during patient interactions (Picard et al., 2016).

Empathy

Empathy is a mental process that enables a person to understand another person's reality (Frankel, 2017). Howe (2012) described empathy as one element or critical feature of emotional intelligence that is characterized as a qualitative appreciation of another person's feelings. In healthcare, empathy is an essential component in a productive therapeutic relationship or patient interaction (Wilkinson et al., 2017). Empathy enables a healthcare worker to enter the private world of the patient without

judgment and allows the staff person to relate to another's experience, communicate and confirm comprehension, and act in a way that is supportive and helpful (Gleichgerrcht & Decety, 2013). These perspectives align with the empathic communication model which characterizes empathy as a visible communication behavior, such as talk, touch, or eye contact, which occurs when someone relates to another person's situation or condition (Frankel, 2017).

Burnout leads to lower levels of empathy and hinders the expression of empathy, an essential component of healthcare professionalism, which is associated with lower quality of care and service (Paro et al., 2014; Picard et al., 2016). Burnout is a response to prolonged job-related stress characterized by depersonalization, which results in healthcare professionals psychologically separating from the patient (Rees, 1995; Sargent, 2012; Schrijver, 2016). Empathy connects one's own personal experience with the experience of another person (Wilkinson et al., 2017). When healthcare professionals psychologically separate from patients due to long-term stress and burnout, they cannot develop and exhibit empathy, which requires making a connection to and building a relationship with a patient (Larson & Yao, 2005).

Engagement

William Kahn proposed the term engagement in 1990 and defined engagement as an employee moving toward what matters to them and expressing themselves in tasks that connect people to people and their work (Kahn & Fellows, 2013). Engagement is people expressing themselves while they perform their job role. Disengagement occurs when people separate or disconnect from their work roles to defend themselves

physically, mentally, or emotionally from stressors in the environment (Kahn, 1990). When people are engaged in their work, their behaviors show a full effort, hard work, involvement, focus, energy toward what they are doing, and drive to move their work tasks forward (Kahn & Fellows, 2013).

Employees engage in their job based on how they perceive three psychological conditions: meaningfulness, safety, and availability (Anthony-McMann et al., 2017). Employees unconsciously ask themselves how meaningful and safe is it to invest themselves in the job performance. Engagement occurs and is sustained when employees feel psychological safety or positive and trusting interpersonal relationships at work (Anthony-McMann et al., 2017). The concept of engagement proposes that engaged workers feel worthwhile, useful, and valuable (Rakovec-Felser, 2011). According to Warmington (2011), engagement is demonstrating attentiveness to the patient, conducting respectful dialogue, and committing to action to improve health or alleviate suffering. By practicing engagement and infusing empathy into clinical communication, patients receive more humane care (Warmington, 2011).

Engagement, which is the investment of mental, physical, and emotional energies into job performance, is not merely about vigor but occurs when employees say what they think and feel, rather than withhold, defend, or withdraw their opinions or ideas from the consideration of others (Kahn & Fellows, 2013). People who are fully engaged are attentive and alive to what is around them as well as connected and joined to the broader mission, purpose, and people. They are integrated, making their ideas, thoughts,

feelings, intuitions, and energies available to the work, and absorbed, focused, and preoccupied with the job (Kahn & Fellows, 2013).

Engagement, a motivational state, varies based on the employee's perception of valued resources (Anthony-McMann et al., 2017). The needs-satisfaction framework, which was used to guide this research study, suggests that the presence or absence of resources or psychological conditions like feeling safe, valued, and worthwhile influences employees to engage or disengage in work (Kahn, 1990). When stressed, employees will minimize net loss of resources, or decrease their engagement level so as to avoid threatening resources (Halbesleben et al., 2014). The presence or absence of job meaningfulness, safety, and availability determines the extent to which an employee engages or disengages (Kahn, 1990). This study examined the effects of stress mediated by burnout on healthcare support staff employees' engagement or disengagement due to the presence or absence of valued resources.

Burnout and Engagement

Burnout and work engagement are opposites (Maslach, 2017). Burnout erodes work engagement and worker wellbeing, health, self-efficacy, job enjoyment, decreased turnover intentions, and organizational commitment (Kanste, 2011). Engagement is characterized by energy, dedication, and focused concentration (Firth-Cozens, 2001) as well as a high level of enthusiasm, mental toughness, effort input, commitment to overcoming obstacles, inspiration, pride, and positive involvement in work (Kanste, 2011). When healthcare staff experience burnout, emotional exhaustion can adversely affect their ability to perform their job at a high level (Wei et al., 2016). Over time,

healthcare professionals may begin to treat people as objects, disengage from their patients, colleagues, trainees, and loved ones, and find little meaning in their work (Wei et al., 2016).

Burnout, also characterized by emotional exhaustion, is the state of lacking energy and feeling depleted, debilitated, and fatigued (Maslach, 2017). This emotional exhaustion inhibits engagement which is demonstrated by vigor for the work (Kanste, 2011). Burnout left unaddressed smothers engagement, but building employee engagement is the best burnout prevention strategy (Maslach, 2017).

Engagement is essential for organizations to cultivate because the opposite outcome, disconnectedness or withdrawal, results in employee demotivation (May et al., 2004). Leeds and Nierle (2014) identified a significant correlation between higher employee engagement and business results. Where employees are engaged, programs produce better results, employees take fewer sick days, and staff file fewer complaints and worker's report compensation cases (Leeds & Nierle, 2014). According to Maben (2017), healthcare professionals must be engaged because patients want meaningful human face-to-face engagement that subsequently drives dignity, empathy, and emotional support.

Turnover

Turnover occurs when employees choose to leave a job because the work causes mental or psychological strain (Tett & Meyer, 1993). Retention is a worker's intention and willingness to remain in the job or at their current organization (Hayashi et al., 2009). There are four types of employee turnover or organizational withdrawal. Employee

turnover is voluntary (when the employee leaves on his/her own accord), or involuntary (when the employee is asked to leave or laid off). It can also be categorized as internal (due to a promotion or transfer) or external (when the employee exits the organization entirely (Collini et al., 2013).

Turnover is costly for organizations because of the continual financial investment and disruptive impact on patient outcomes (Brewer et al., 2015). Burnout impacts turnover intentions, so employee exhaustion increases the likelihood that the worker will leave the job to escape the exhaustion (Saleem et al., 2016). A satisfied employee increases the likelihood that an employee's intention is to remain in the position or organization (Brewer et al., 2015). Job enjoyment, organizational loyalty, and promotional opportunities are related to intention to stay with the organization (Nowak et al., 2010). Employee engagement is also a predictor of turnover and turnover intention (Collini et al., 2013).

Burnout and Turnover

Unalleviated stress leads to burnout, and one of the ways in which employees cope with burnout is to leave the organization voluntarily (Goodman & Boss, 2002). Employees who turn over show more signs of depersonalization (Firth & Britton, 1989). Employees who turn over involuntarily or are terminated may reach a high level of burnout and attempt to cope by demonstrating behaviors that negatively impact their work performance, resulting in termination (Goodman & Boss, 2002). In healthcare, dedicated professionals who perceive themselves as becoming less empathetic, disconnected, or hardened with their patients may be experiencing burnout and

subsequently make conscious decision that changing employment is the most appropriate solution (Firth & Britton, 1989).

Employees who leave the job have much higher burnout scores than those who stay (Goodman & Boss, 2001). In community health centers, the stress of working with society's most challenging patients with limited resources may be contributing to elevated stress, higher burnout, and increased turnover. Burnout adversely affects turnover because dissatisfied healthcare professionals may choose to leave the organization or field of medicine, which may result in delays in patient care, as well as significant recruiting and retraining costs to healthcare organizations (Parry, 2008). Left unaddressed, burnout among healthcare professionals results in disengagement, threatens employee retention, and inhibits an organization's ability to deliver consistent, high-quality, and well-coordinated patient-centered care (Kanste, 2011). Employees with burnout are overwhelmed, unmotivated, negative, and poor performers (Maslach, 2017). When a healthcare professional experiences a low sense of personal achievement and little job satisfaction, the employee's job commitment goes down, the intention to leave the position or organization goes up, and the organization's retention risk increases (Thanacoody et al., 2014). Employees who turn over likely experience high levels of burnout (Goodman & Boss, 2002). Intent to leave the organization is the final step in a series of withdrawal thoughts and actions that eventually lead to actual turnover (duPlooy & Roodt, 2010; Tett & Meyer, 1993).

Statement of the Problem

There is an absence of literature that investigates the relationship between stress, burnout, empathy, engagement, and turnover for healthcare support staff in the FQHC environment. This study focused on the impact of burnout on empathy, engagement, and turnover to provide health center leadership with information that could be useful in retaining support staff who are engaged in the work, empathetic with patients, and committed to providing excellent patient-centered care. This study addresses the problem that the adverse effect of stress and burnout have on one's ability to act helpfully, willingness to connect with and invest in the work, and desire to remain in the job and organization. This study collected data that could be used by FQHC leaders in making decisions to strengthen patient care and achieving clinical outcomes through empathetic, engaged, and committed support staff. This study has filled a significant gap by focusing on healthcare support staff as there is no research which investigates the relationship between stress, burnout, empathy, engagement, and turnover in healthcare support staff and FQHCs.

Purpose of the Study

The purpose of this study is to analyze stress as a predictor variable and burnout as a mediating variable on the criterion variables of empathy, engagement, and turnover among healthcare support staff working in an FQHC. These staff members may be more vulnerable to stress and burnout because of the job demands of their frontline role with patients, supporting role to physicians and nurses, and healthcare delivery challenges of FQHCs. The physical, mental, and emotional labor involved in daily healthcare results in

healthcare workers experiencing considerably higher job stress compared to the broader labor pool (Wells, 2011). These healthcare team members also play an essential role in patient care. However, researchers give little attention to the impact of stress and burnout on them, and this inattention may be due to their lower professional status or because of the hierarchical position of the physician and nurse on the primary care team (Bruner et al., 2011). The gap in the literature provides an opportunity to gather empirical data that can be used to inform the decision-making processes of community health organization leaders.

Research Questions and Hypotheses

With the following research questions in mind, related hypotheses were proposed to measure the relationship between stress and burnout on empathy, engagement, and retention amount healthcare support staff.

RQ1: Does burnout mediate the relationship between stress and empathy in healthcare support staff working in an FQHC?

$H_0 1$: Burnout is a mediator in the relationship between stress and empathy.

$H_a 1$: Burnout is not a mediator in the relationship between stress and empathy.

RQ2: Does burnout mediate the relationship between stress and engagement in healthcare support staff working in an FQHC?

$H_0 2$: Burnout is a mediator in the relationship between stress and engagement.

$H_a 2$: Burnout is not a mediator in the relationship between stress and engagement.

RQ3: Does burnout mediate the relationship between stress and turnover in healthcare support staff working in an FQHC?

$H_0$3: Burnout is a mediator in the relationship between stress and turnover.

H_a3: Burnout is not a mediator in the relationship between stress and turnover.

To answer these questions regarding the relationship between burnout and empathy, engagement, and turnover among healthcare support staff in an FQHC setting, I used a mediational analysis. I also collected demographics.

Theoretical Framework for the Study

I used the COR theory to ground and guide this study. The COR theory suggests that when people are stressed, emotionally exhausted, and experiencing burnout, they protect and preserve their physical and mental resources from becoming depleted by decreasing their effort and withdrawing from work. In 1989, Hobfall and other stress researchers conceptualized burnout as physical, emotional, and mental exhaustion caused by one's participation in chronic taxing situations (Anthony-McMann et al., 2017). According to Hobfall (1989), stress is a response to three conditions in the environment: the loss of new resources, the net loss of resources, and no resource gain after having invested one's resources. Hobfall described resources as valued belongings, personal characteristics, conditions, or energies (Hobfall, 1989). Burnout is the result of chronic draining of a person's resources as a result of the buildup of stress (Anthony-McMann et al., 2017). Burnout results from the prolonged exhaustion of a person's resources due to exposure to stress, and it is not immediately reversible (Demerouti et al., 2009).

The basic concept of the COR theory is that human beings are driven to guard their current resources and acquire new resources, which are things, states, or conditions that people value (Halbesleben et al., 2014). Health is also a resource needed to achieve

vital goals and meet current demands without compromising future health (Skagert et al., 2011). The COR theory provides a clear framework for this research by aligning stress and burnout as an environmental threat that when left unaddressed causes healthcare employees to respond to the threat. Employees respond by protecting and preserving their physical and mental resources from becoming depleted and decreasing their effort and pulling away from work, resulting in declines in empathy, engagement, and desire to remain with the organization (Hobfall, 1989). If stress depletes employees of valuable resources needed to engage at work, and over time stress accumulates and causes burnout, then burnout is a mediator for the negative relationship between stress and engagement (Anthony-McMann et al., 2017). This theory was used to determine if stress and burnout lead to reductions in empathy, engagement, and turnover among healthcare support staff attempting to conserve resources. Chapter 2 includes a thorough description of the theoretical framework of the study with specific attention given to the three constructs of burnout.

Nature of the Study

This research design was quantitative and nonexperimental. The study used survey research. The surveys were cross-sectional with data collected at one point in time using self-administered questionnaires. The research population was the healthcare support staff at a nonprofit urban FQHC. The healthcare support staff provides patients, family members, and visitors with general, triage, care support, and onsite services to underserved patients with a variety of challenges and needs including lack of care, multiple chronic conditions, age, mental illness, and drug/alcohol addiction.

List of Definitions

Burnout: A psychological syndrome that occurs during responses to chronic interpersonal stressors on the job. This is a condition in which workers describe feeling overwhelmed, having unmanageable workloads, feeling chaos and a lack of control, well-being, and job satisfaction (Maslach et al., 2001; Wallace & Lemaire, 2007).

Cynicism: Negative or inappropriate attitudes toward clients resulting from having become irritable, lost idealism, and withdrawal (Maslach, 2017).

Empathy: An essential component of healthcare that enables a healthcare worker to enter the private world of the patient without judgment and understand another's experience, communicate and confirm that understanding, and then act in a helpful manner (Huggard, 2003; Gleichgerrcht & Decety, 2013).

Engagement: Vigor, dedication, and absorption, as well as a high level of energy, mental resilience, willingness to invest effort in work, persistence in the face of difficulties, enthusiasm, inspiration, pride, and commitment to work (Firth-Cozens, 2001; Kanste, 2011).

Exhaustion: The state of being worn out, having lost energy, and feeling depleted, debilitated, or fatigued (Maslach, 2017).

Inefficacy: A low sense of personal accomplishment (Maslach, 2017).

Retention: The desire, intention, and willingness to remain in one's position or continue working at one's employing organization without the interest or desire to leave their job, employer, or career (Hayashi et al., 2009; Thanacoody et al., 2014).

Stress: A person's response to conditions in the environment that threaten to

deplete the individual's internal resources, defined as those objects, personal characteristics, conditions, or energies that are valued by the individual (Hobfall, 1989).

Turnover: An employee's propensity to leave the job where he or she is currently working, usually caused by mental or psychological strain (Tett & Meyer, 1993).

Assumptions

This study assumed providing an electronic web-based survey was the most efficient method for generating timely, accurate, and validated results for the research. Survey responses came from employee participants who were drawn from a convenience sample of healthcare support staff working in an urban FQHC. It was assumed study participants responded truthfully and voluntarily. This population is diverse in terms of demographics of age, gender, race, ethnicity, and years of service. It was assumed that the target population responded accurately and truthfully to communicate their experience with stress, burnout, empathy, engagement, and turnover. It was also assumed that the survey instruments were valid and reliable measures for the study.

Scope and Delimitations

The scope of this study extended to the population of healthcare support staff working in FQHCs. The population recruited for this study included receptionists, registration assistants, call center agents, customer service representatives, medical assistants, referral specialists, business office coordinators, health center administrators, and other support staff as identified.

Limitations

This study used self-reported measures. One of the limitations of self-reported measures is that the respondent is expected to report his or her beliefs, attitudes, and behaviors truthfully. In some instances, responders may be influenced to provide more socially acceptable answers rather than the honest truth. If influenced, responders can distort the findings and conclusions of the study. This study is also limited by the possibility of a low response rate. A third limitation is the generalizability of the research findings because this study was conducted in one FQHC in one city and state.

Significance

This research has filled a gap in understanding by examining the effects of the three dimensions of burnout (exhaustion, cynicism, and inefficacy) on empathy, engagement, and turnover. These findings may inform and motivate leaders of FQHCs to acknowledge stress and burnout in support staff who play an essential role in the quality and consistency of service and care that patients receive. This study may have immediate and long-term implications as empathy, a patient-centered behavior, improves communication, trust, healthcare gaps, and overall quality care. Also, low employee engagement and turnover adversely impact patient relationships, satisfaction, adherence, and follow-up (Hayashi et al., 2009). The results of this research may help quantify the scope of this issue in community health settings, specifically FQHCs, where patient populations are more difficult to manage because of socioeconomic barriers, healthcare access challenges, and health literacy barriers (Hayashi et al., 2009). Findings can help leaders evaluate relationships between burnout, empathy, engagement, and turnover,

which may increase the sense of urgency for reducing burnout while enabling empathy, engagement, and retention among healthcare support staff.

Based on these issues, the predictor variable (stress) and the mediating effects of three dimensions of burnout were investigated to determine the effects on empathy, engagement, and retention. By sharing these findings, healthcare organizations can reduce the significant and costly impact of stress and burnout on support staff. These findings enable leaders to improve the ability of their healthcare support staff to provide quality care with empathy, remain fully engaged in the work they do, and have a long, productive, and rewarding work experience in their position in the organization.

Summary

Stress and burnout have a detrimental effect on the performance of healthcare professionals at all levels. While most of psychological literature addresses the issues regarding physicians and nurses, some problems exist for healthcare staff who support physicians and nurses in the delivery of quality and safe healthcare. This study explored the adverse effect of stress and burnout on the ability and willingness of healthcare support staff to empathize, engage, and remain employed by their healthcare organization. Chapter 2 provides a review of the literature which will inform healthcare leaders and support the need for conducting this research.

Chapter 2: Literature Review

Introduction

Chapter 1 outlined concerns about the impact of stress mediated by burnout, on empathy, engagement, and retention in healthcare support staff. The chapter also described the theoretical framework for the study. Chapter 1 also presented research questions and related research hypotheses. The purpose of this quantitative nonexperimental research study is to analyze stress as a predictor variable and burnout as a mediator variable on the criterion variables of empathy, engagement, and retention among healthcare support staff working in an FQHC.

The literature review in Chapter 2 examines the nature of stress and burnout and the impact of burnout on the research questions and hypotheses stated in Chapter 1. The literature search found numerous gaps in information regarding stress and burnout among healthcare support staff and even less for healthcare support staff employed in FQHCs or CHCs. While the literature contains a large quantity of research on the consequences of stress and burnout among physicians and nurses, little has been done to research the impact of stress and burnout on performance factors like empathy, engagement, and retention among healthcare support staff.

Chapter 2 presents an overview of the research on stress and burnout. A brief discussion on the consequences of stress and burnout follows. Literature is provided on the COR theory. A discussion of empathy, engagement, and retention is also provided in the literature review. The chapter concludes with a summary of the review of the literature.

Literature Search

Using the PsycARTICLES, PsycINFO, and Academic Search Complete psychology databases, a review of the literature was completed using these search terms: stress, burnout, empathy, engagement, retention, turnover, and healthcare. Articles were collected in either print or electronic versions. This literature review investigates prior research on the subjects of stress and burnout, and the implications of these conditions on empathy, engagement, and retention among healthcare support staff working in an FQHC. The theoretical framework discussed in this literature review and used to guide this research study is the COR theory.

Federally Qualified Health Centers

This study took place at an FQHC. FQHCs are safety net providers that provide services in an outpatient clinic setting. FQHCs include community health, migrant, public housing, and homeless health centers. These health centers were established to reduce and healthcare gaps that affected racial and ethnic minority groups, the poor, and the uninsured (Adashi et al., 2010). FQHCs also include health centers operated by a tribal organization or urban Indian organization. FQHCs are paid based on the FQHC Prospective Payment System (PPS) for medically-necessary primary health services and qualified preventive health services delivered by an FQHC provider. The PPS pays the FQHC a predetermined reimbursement amount for each medically necessary service provided. FQHCs fill a critical need in the healthcare delivery system by providing care to the poorest and most vulnerable patients in society. FQHCs face numerous challenges in achieving this important objective.

To be certified as an FQHC, healthcare practices that receive federal grant dollars must serve a designated medically-underserved area or population. Also, an FQHC must offer a sliding fee scale to persons with incomes below 200% of the federal poverty level and be governed by a board of directors, of whom a majority of the members receive care at the FQHC (Adashi et al., 2010). The sliding fee scale approach enables any person to receive quality healthcare regardless of their ability to pay. This commitment to care presents a tremendous challenge in the financial management of the cost of services and resources provided during patient care. Many FQHC patients are uninsured and unable to pay standard rates. Even with the support of a sliding fee scale, many patients have difficulty paying the income-based copay for services received. As a result, FQHCs are challenged with collecting outstanding unpaid balances for services rendered.

An FQHC visit is a medically-necessary, face-to-face, medical, dental, or behavioral health exam or a qualified preventive health appointment between the patient and a physician, nurse practitioner, physician assistant, certified nurse midwife, or social worker. Multidisciplinary teams made up of primary care providers, dental professionals, behavioral health professionals, pharmacists, nutritionists, and case managers are on staff to help patients address a broad range of health challenges (Adashi et al., 2010). A visit by a registered professional nurse or a licensed practical nurse to a homebound patient also qualifies. FQHCs must provide the same quality and standard of care as other healthcare organizations, so the cost-effective management of patient services is critical. Cost constraints, budget limitations, and limited resources only make the job of treating

disadvantaged and noncompliant patients with multiple chronic conditions even more difficult.

Ever since the inception of CHCs and FQHCs, these healthcare organizations have demonstrated that they can provide quality, affordable, and culturally competent patient care in a coordinated manner (Adashi et al., 2010). Of course, FQHCs have their fair share of challenges, including growing numbers of uninsured people, reimbursement rates and policies, recruiting and retaining healthcare professionals, collaborating with specialists who choose not to see uninsured patients, and the need to integrate health information technology into practice (Adashi et al., 2010). FQHCs are challenged with finding patients who have avoided care, treating the sickest patients who for years have neglected their chronic conditions, engaging patients in care so they adhere to treatment and return for follow up, and maintaining the dignity of patients when mental health or substance abuse has caused them to live as outcasts. FQHCs and other types of CHCs attract dedicated healthcare professionals who are committed to removing barriers to healthcare and give their lives to improving the quality of life for the underserved and forgotten. The result is a high level of stress and eventually burnout which is a detriment to one's ability to show empathy, engage with patients and colleagues, and remain with the organization.

Stress

The topic of stress has a long history in the psychological literature. Walter Cannon researched stress in people, and he concluded that chronic stress leads to a decline of one's physical systems (Hobfall, 1989). In the mid-1950's, Hans Selye

developed the General Adaptive Syndrome (GAS) model of stress which suggests that a person, faced with a challenge or stressful situation, goes through three states of physiological response – alarm, resistance, and exhaustion (Selye, 1975). Lindemann (1944) pioneered research which focused on the psychology of stress which could occur after being confronted with stressful events. According to Segerstron & O'Connor, (2012), stress is in the environment, it is dynamic, and it happens to people with different personalities and temperaments. People experience and respond to stress differently. The stressors experienced when working in an urban FQHC can cause alarm (i.e., a patient who is under the influence of a substance which is threatening violence), result in resistance (an employee voluntarily resigns) or exhaustion (an employee changes jobs to avoid further exposure to the stressful situations).

Most scholars agree that stress is an antecedent of work exhaustion or burnout and includes work overload, role clash, few rewards, and energy loss due to job demands (Saleem, Ahmed, and Saleem, 2016). Stress occurs when there is a discrepancy between employee skills, abilities, and the pressure/demands of the work environment (Narainsamy & Van Der Westhuizen, 2013). (1995) found that stress was a significant problem across all job categories, including office staff, secretarial staff, allied health professionals, physicians, and nurses, and the stress experience of these staff members had many similarities (Rees, 1995). In any group, researchers agree that 40% of the workers in the group will experience the adverse effects of stress (Rees, 1995). Stress researchers have identified three sources of stress which employees sometimes experience in their job role: role ambiguity (a lack of clarity about the aspects of their

work role), role conflict (conflicting demands placed on an employee in the work role), and role overload (excessive workload that cannot be accomplished in the time available) (Wunder, Dougherty, & Welsh, 1979). Most of the psychological literature has examined these factors in doctors and nurses. However, there is a significant gap in the literature which prevents us from understanding the effects of stress and burnout on healthcare support staff whose work is critical to the operation of a health care delivery system.

Work stress is defined as the response that occurs when the job requirements don't match the employee's ability to do the job (Narainsamy & Van Der Westhuizen, 2013). Job stress is a significant occupational hazard that adversely affects one's physical health emotional well-being, and work performance or productivity (Maslach & Leiter, 2008). Job stress is related to poor health, including nervousness, emotional instability, and tiredness, as well as higher turnover intentions (Thorsteinsson, Brown, & Richards, 2014). Job stress is also associated with lower job satisfaction and higher turnover retentions (Thorsteinsson, Brown, & Richards, 2014). When the equilibrium between job demands and resources provided is disturbed, job stress occurs (Narainsamy & Van Der Westhuizen, 2013). If healthcare workers are experiencing high job stress, there is the potential hazard of medical errors, communication errors, patient complaints, staff shortages and increased medical claims.

Stress involves too much, too many pressures and too many demands on a person. Stress is characterized by over-engagement, over-reactive emotions, physical damage, and panic (Rakovec-Felser, 2011). Burnout, on the other hand, is about not enough -- not

enough motivation, feelings of emptiness, and a state of being that is beyond caring. In burnout, emotions are blunted, a person feels demoralization, ideals, and hope is lost, there is a sense of helplessness and hopelessness, and detachment (Rakovec-Felser, 2011). Excessive stress is analogous to drowning in responsibilities while being in burnout is analogous to being all dried up (Rakovec-Felser, 2011). Healthcare support staff play a critical role in managing patient flow, providing a caring patient experience, helping to resolve patient concerns, so preventing support staff burnout should be a priority for healthcare leaders.

Healthcare professionals face the added and unique job stress of dealing with patients who may feel sick or caretakers who may be distressed because a loved one is sick, resulting in a difficult situation, which requires important potentially life-altering decisions (Rees, 1995). Providers and support personnel experience stress and burnout as a result of the work environment and the pressures of the healthcare field (Hayashi, Slia, &McDonnell, 2009). Wells (2011) supports the well-recognized research that health professional experience more work-related stress on a daily basis compared to the broader workforce, with doctors and nurses reporting the most stress of all. Several studies confirm that healthcare workers have a greater chance of developing job stress, burnout, and other emotional disorders (Fiabane, Giogi, Sguazzin, and Argentero, 2013). Patient incivility also produces job stress for healthcare support staff as many employees are constrained to interact with unfriendly, rude, or mentally/emotionally challenged patients (Taddei & Contena, 2015). Ultimately, stress affects a person's health by directly impacting the physiological response and by indirectly changing a person's

health behaviors (Segerstron & O'Connor, 2012). Health centers can't operate successfully without caring, motivated engaged support staff who support both providers and patients to heal and live a better quality of life.

Burnout

Burnout History

In 1974, the word burnout was used by psychologist Herbert Freudenberger (Miller, Stiff, & Ellis, 1988). Burnout research began in the 1970s as burnout was considered a hazard for human service workers or people employed in caregiving roles (Maslach, 2017). The concept of burnout originated among healthcare staff and is defined as exhaustion that occurs because of organizational stress which includes depersonalization and reduced personal achievement (Hall, Johnson, Watt, Tsipa & O'Connor, 2016). Earliest definitions of burnout include to break down or to become physically and emotionally drained due to excessive draws on resources (Freudenberger, 1974). The consensus in the research concludes that the key dimension of burnout is emotional exhaustion or the physical and psychological depletion of a person (Wright & Cropanzano, 1998). Emotional exhaustion is widely viewed as the key ingredient for burnout (Blau, 2007). Though the concept of burnout originated in healthcare, the conversation and research on the detrimental effects of stress and burnout have largely excluded healthcare support staff. These research study aims to change that.

Burnout is a type of progressive exhaustion that often occurs in people who work with people (Maslach & Jackson 1981). Early research work produced a definition that includes three components of burnout – exhaustion, cynicism, and a decline in

professional efficacy. Exhaustion is characterized as being worn out, with little or no energy, depleted, debilitated, and fatigued (Schaufeli & Bakker, 2003). Emotional exhaustion is considered the most important contributor to burnout (Goodman & Boss, 2002). Cynicism is represented by irritability, being withdrawn, and a negative or inappropriate attitude towards customers, clients, or patients. Inefficacy manifests itself as reduced productivity, low morale, and an inability to cope (Maslach, 2017). In addition to the personal consequences caused by exhaustion, cynicism, and inefficacy, staff burnout puts patients at serious risk of experiencing patient care errors and injuries.

Burnout is work-related fatigue (Thorsteinsson, Brown, & Richards, 2014). Burnout, considered a syndrome, is exhaustion and cynicism that frequently occurs among healthcare professionals and results in a negative impact on patient perceptions of outcomes (Amoafo et al., 2014). According to Miller, Stiff and Ellis (1988), the intensive, focused, communication and use of empathic behaviors in working with clients and patients may facilitate the onset of stress and burnout. Burnout, also referred to as work exhaustion, is a state of being that arises out of a boring, stressful and frustrating work environment, and it is a key factor leading to the turnover intentions among employees (Saleem, Ahmad, and Saleem, 2016). Symptoms of burnout include diminished creativity, disorganization, untidiness, procrastination, and an inability to handle complex tasks (Matthews, 1990). Disorganization, untidiness, and procrastination on the part of healthcare support staff will only result in errors, safety breaches, chaotic patient and staff schedules, and unmanageable workloads.

Burnout Antecedents

Research literature consistently demonstrates that a stressful environment cultivates burnout (Landrum, Knight, & Flynn, 2012). Maslach, a pioneer in burnout research, established that the burnout continuum begins when energy turns into exhaustion, engagement and interest turn into cynicism, and professional effectiveness is not meaningful (Gazelle, Liebschutz, & Riess, 2014). Researchers agree that perceived work overload is the main cause of work exhaustion and burnout as employees are expected to meet unrealistic workloads and deadlines (Saleem, Ahmad, and Saleem, 2016). However, decades of burnout research have led to the conclusion that situational, environmental, workplace context, social relationships, as well as personal variables are all important for a thorough understanding of the causes of the problem of burnout (Maslach, 2017). When support staff deal with difficult patient situations, threats in the healthcare environment, and incivility in the workplace, stress and work overload inhibit quality patient care.

Burnout involves being physically spent, feelings of powerless to change the circumstances, having a negative sense of self-work, and a critical attitude towards work, life, and other people (Wilkinson, Whittington, Perry, and Eames, 2017). Burnout is the prolonged strain that occurs when a person does not have adequate physical or psychological resources to address and resolve the stressful situation they face (Wright & Cropanzano, 1998). In the general working population in western countries, burnout occurs in 13% to 27% of the population, while healthcare professionals experience an even greater risk of burnout (Wilkinson, Whittington, Perry, and Eames, 2017). People

burnout slowly, progressing along a continuum until they reach a limit where their capacity is depleted, and burnout becomes evident (Matthews, 1990).

Burnout is caused by an ongoing, unresolved, stress-inducing, problematic relationship between the employees and the work environment characterized by six situational characteristics: 1) chronic excessive workload; 2) an inability to exert control; 3) inadequate recognition; 4) a toxic environment; 5) unfair and inequitable decisions; and 6) conflicting values and ideals (Maslach, 2017). When an imbalance occurs between the requirements of one's job and important unresolved issues caused by a change in the working relationship that the employee considers to be unacceptable, stress and burnout occur (Fiabane, Giogi, Sguazzin, and Argentero, 2013). When workloads and deadlines are unattainable, the employee's mental and physical capabilities are overstretched, and burnout occurs (Saleem, Ahmed, Saleem, 2016).

Burnout Consequences

According to Rakovec-Felser (2011), burnout manifests itself mentally, physically, behaviorally, socially, and attitudinally. Mentally, a burned-out person feels that they are at the end of their rope, a sense of failure, diminished tolerance, and an inability to concentrate. Physically, a burned-out person may experience headaches, nausea, muscle pain, back pain, insomnia, and loss of appetite. Behavioral manifestations can include violent outbursts, increased alcohol consumption, and hyperactivity. Socially, a burned-out person may have interpersonal conflicts, withdraw from others, isolate him or herself, and experience spill over into home life. Attitudinal

manifestations can include indifference, derogatory comments, stereotyping others, and hypercritical mistrust of the organization (Rakovec-Felser, 2011).

Excessive workload (quantitative and qualitative) leads to fatigue by using up the resources a person needs to perform his/her job, and if not corrected, leads to high levels of cynicism and inefficacy (Vladut & Kallay, 2010). Role conflict and ambiguity cause employees to feel they have insufficient control to improve the work process or results (Kahn & Fellows, 2013). Inadequate or inappropriate rewards or a lack of recognition lowers the value of the employee, lowers the value of the work being performed, and diminishes professional satisfaction and intrinsic pride (Kahn & Fellows, 2013). A toxic environment, or a lack of community, is associated with low supervisor support, exhaustion, underachievement, and inefficacy, while a sense of camaraderie, even in the absence of organizational support buffers the effect of unfairness (Vladut & Kallay, 2010). Fairness is based on the employee's perception about inputs (time, effort, and expertise) and outputs (rewards and recognition). Those who perceive their supervisors to be fair are less likely to burnout or turnover. Values represent the ideals that attract a person to their job, so when the job aligns with an employee's values, the likelihood of burnout and turnover are reduced (Vladut & Kallay, 2010).

Professional staff who work in various types of human services spend significant time in interactions with patients and clients that are focused on the patient’s current physical, mental, or social problem, and these interactions are often charged with feelings of anger, embarrassment, pain, fear, or hopelessness (Rakovec-Felser, 2011). Over time,

due to an unhealthy balance, burnout occurs from exhaustion as well as disturbances in the social environment in which people work (Rakovec-Felser, 2011).

For healthcare support staff and ancillary personnel, burnout can result from long-term stressful interactions during which employees force oneself to display positive emotions and camouflage negative emotions (like anger or frustration) while serving customers (Taddei & Contena, 2010). In community health centers, established to care for the poor and undertreated, limited organizational and systems resources, such as space and supplies, can cause stress for clinicians and staff (Hayashi, Selia, McDonnell, 2009).

The consequences of burnout fall into two categories: job performance and individual health. When burnout affects job performance, the result is absenteeism, and intention to leave. When burnout affects individual health, the result is illness, such as substance abuse, anxiety, depression and decreased self-esteem (Rakovec-Felser, 2011). Absenteeism disrupts the management of the practice and creates additional stress for healthcare workers who are relied upon to maintain the daily operations.

Burnout threatens the delivery of primary care and the operation of the entire healthcare system (West & Hauer, 2015). Burnout comes with serious costs including physical strain, social disruption, and organizational ineffectiveness which over time results in employee disengagement (Maslach, 2017). Burnout has been linked to health practitioner errors, lower patient safety, and frequency of near misreporting (Hall, Johnson, Watt, Tsipa, & O'Connor). The most common disadvantages of stress and burnout are high turnover, absenteeism, frequent lateness, and impaired work productivity and quality, all of which are employee coping or escape strategies (Rees,

1995). The detrimental effect of staff burnout can also extend to client services and patient engagement resulting in patients reporting less satisfaction in the care they received (Landrum, Knight & Flynn, 2012). While numerous studies document the negative effects of burnout on physician retention, patient care, patient non-compliance, and medical errors, studies also show that physician stress and burnout contribute to staff turnover, low morale, and lack of cohesion across the entire healthcare team (Gazelle, Liebschutz, & Riess, 2014).

Stress and burnout among healthcare workers differ from other industries because of the emotional labor required in the daily delivery of health services (Wells, 2011). Burnout among health workers is linked to role confusion, poorly staffed teams, work-life pressures, exclusion from decision-making, and an absence of social support at work (Fiabane, Giogi, Sguazzin, and Argentero, 2013). Some stress and burnout research has identified the development of physical symptoms in support staff employees, resulting from long sitting times, low physical activity, such as obesity, weight problems, muscular fatigue, pain, and skeletal trouble, increased risk of diabetes, heart problems, and circulatory problems (Taddei & Contena, 2010).

Stress and burnout also have detrimental effects on patient care and can result in patient complaints, claims and medication errors (Firth-Cozens, 2001). Another important outcome of burnout is the deterioration of occupational commitment (Miller, Stiff, & Ellis, 1988). Additional risks of stress and burnout in the healthcare workplace include low morale, negative attitudes toward patients, absenteeism, turnover, patient dissatisfaction, patient non-compliance, higher workplace injuries, turnover, and mistakes

(Fiabane, Giogi, Sguazzin, and Argentero, 2013). Stress and burnout are reported to affect patient care in the form of tiredness, pressure from overwork, anxiety or depression, irritability, a lowered standard of care and errors or accidents (Firth-Cozens & Grennhalgh, 1997). Burnout, or emotional exhaustion, also has significant implications for workers, in that it is associated with some health conditions including colds, stomach problems, headaches, and disrupted sleep (Wright & Cropanzano, 1998).

From a healthcare organization's perspective, research has found a relationship between burnout and turnover intentions, unproductive work behavior, job engagement, and work results (Wright & Cropanzano, 1998). In a study of healthcare workers, employed in a variety of positions including clerical, maintenance, administrative, medical secretaries, nurses and doctors, staff reported experiencing more pressure and more frequent use of coping strategies (Rees & Cooper, 1992). Healthcare support staff reported high scores for poor health, especially as it pertains to anxiety and depression (Rees, 1995).

Stress was initially associated with people working in the helping professions; however, more recently the phenomenon has been expanded to all professions that involve contact with other people (Taddei & Contena, 2010). As the use of technology in healthcare to serve patient needs has grown, so has the use of calls centers. Stress has also been associated with this healthcare support function indicating that the prolonged and continuous exposure to stress is related to the development of burnout symptoms (Taddei & Contena, 2010). For call center employees, the expectation to show positive emotions or to hide negative emotions, especially when dealing with unfriendly or rude

patients, causes stress and can lead to burnout. There may also be a connection between the continuous stress of call center work, the long sitting times required for telephone and computer-focused support roles, the limited opportunity for physical activity, health problems such as weight increases, muscle fatigue, and back problems, and possible increased risk of diabetes, heart disease, and circulation problems (Taddei and Contena, 2010).

For healthcare reform to accomplish high-quality medical care for all, efforts to identify and improve stress and burnout among physicians and staff are vitally important for patients to experience compassionate care from caring committed healthcare workers (Dyrbye & Shanafelt, 2011). Burnout blocks the achievement of the triple healthcare aim which includes population health to achieve quality outcomes, improved patient experience, and decreased cost of care. It is also the result of continuous regulatory and business pressures that threaten the mission and integrity of medicine (Wei, 2016; Bodenheimer & Sinsky, 2014).

COR: A Response to Burnout

There is one guiding theoretical framework used in this study: the COR model developed by Stephen Hobfall. In Hobfall's COR stress model, he suggested that people work hard to keep, defend, and grow their resources, and when stressed people protect themselves and their resources against what might take their valued resources (Hobfall, 1989). According to the COR theory, stress happens in three situations: when resources are at risk when resources are lost, and when people don't get the expected return on their resource investment (Shaukat, Yousaf & Sanders, 2015). The COR theory is a coping

theory and coping is characterized as the cognitive and behavioral efforts or strategies used to adapt to stress (Morimoto, Shimada, & Tanaka, 2015).

Hobfall defined resources as those things, attributes, circumstances, or energies that are valued by a person such as mastery, self-esteem, socioeconomic status and employment (Hobfall, 1989). COR theory includes food, shelter, positive self-evaluation and social ties as primary resources (Shaukat, Yousaf & Sanders, 2015). Objects are of value perhaps because of their rarity or expense such as a home or a mansion. Condition resources like being married, seniority and job position, are also valued. Personal characteristics, which can help a person resist stress, including having a positive personal view of the world and perceiving situations as best for one's growth. Energy resources include things like time, money and knowledge and are valued because they help an individual acquire even more resources (Hobfall, 1989). Even meaningful relationships and social connectedness are considered resources that people defend and protect, so relationship conflict, distress, and strain in the workplace are threatened resources that may cause employees to disengage and withdraw (Shaukat, Yousaf & Sanders, 2015). Organizational support, the way an organization values an employee’s contributions and well-being, is also considered a social resource because it carries the feeling of being esteemed, cared about, and rewarded by the organization (Marchand and Vandenberghe, 2016).

A similar theory was presented in the Person-Environment Fit theory, which like COR suggest that an imbalance between job demands and individual resources will initially lead to job stress but if left unaddressed over time, will progress into emotional

exhaustion, burnout and other unhealthy outcomes (Wright and Cropanzano, 1998). The COR theory, however, extends the research of the P-E Fit theory to describe what people will do to minimize loss and why people do it when they are experiencing burnout (Wright and Cropanzano, 1998).

The Conservation of Resources theory, formulated to explain the relationship been job stress and their outcomes, suggests that even employment and job satisfaction are important resources for employees to conserve. When threatened, other resources like well-being, energy, and vigor are lost. As a coping strategy, employees redirect resources away from the current job and towards searching for a new job (Mauno, DeCuyper, Tolvanen, Kinnunen, Makikangas, 2014). The COR Theory suggests that people are limited in the number of physical and emotional resources, and when stressed, they will leverage any remaining resources to prevent further resource depletion (Thanacoody, Newman, & Fuchs, 2013). When there is no stress, people develop and collect resource surpluses to guard themselves against possible future loss, resulting in the sense of positive well-being (Hobfall, 1989).

When people are confronted by stress, they try to minimize the loss of these valued resources with self-protective behaviors (Hobfall, 989). When stress is present, and employees progress to burnout, they deploy coping strategies that will improve their ability to handle the stressful environment (Rees, 1995).

Empathy

Empathy officially became an English word in 1909 and was coined by British psychologist Edward Titchener, yet there continue to be numerous differing and

conflicting definitions of the term (Frankel 2017). Empathy is the feeling that people or objects awake in us when we project our feelings and thoughts into their experience, and it is evidenced when we stop and think that I might be you (Spiro, 1992). Healthcare professionals are expected to learn and behave in a manner that is receptive and empathic when interacting with clients and patients (Morimoto, Shimada, & Tanaka, 2015).

Empathy is what we feel when we see a picture that moves us or the emotion generated by the image, as well as an interpersonal process that involves imagining what is significant and meaningful from another person's perspective (Main, Walle, Kho, Halpern, 2017). Freud conceptualized empathy as the mechanism by which we are enabled to take up an attitude towards another life, while Jung described empathy as a merging of the viewer with the view and Harries call empathy a feeling of being at home with the object contemplated as a friend and not a stranger (Spiro, 1992). Empathy is best characterized as a dynamic process that involves cognitive and emotional discoveries about another's experience, not a singular point in time of mutual affective experience (Main, Walle, Kho, Halpern, 2017).

Davis (1980) conceptualized a model that characterizes empathy as a distinct but related set of four constructs, which include: 1) Fantasy (the tendency to imagine feeling and acting like someone else; 2) Perspective taking (the spontaneous adoption another person's viewpoint); 3) Empathic concern (feelings of sympathy for unfortunate others); and 4) Personal distress (feelings of personal anxiety).

Empathy, defined as feelings of concern for others that motivate one to help, is associated with improved patient satisfaction and compliance with treatment

(Gleichgerrcht & Decety, 2013). Over the past 10 years, researchers have developed a comprehensive definition of empathy which includes: 1) empathic arousal (relating to the experience of another; 2) understanding (identifying with another's emotional state); 3) empathic concern (feeling for someone in need; and 4) emotion regulation (the control one's emotion) (Gleichgerrcht & Decety, 2013). There is a link between empathy and quality of care (Huggard, 2003). Empathy describes the ability to understand, communicate, confirm that understanding, and act in a helpful manner (Gleichgerrcht & Decety, 2013). This study aims to evaluate if stress and burnout interfere with the ability of healthcare support staff to exhibit empathy in their interactions with patients and clients.

Empathy involves mental and emotional discoveries about other people's experiences (Main, Walle, Kho & Halpern, 2017). Empathy underlies the quality of a humanistic healthcare professional, and it should serve as the framework for all of the skills that healthcare workers use in caring for and providing service to patients (Spiro, 1992). In demonstrating empathy, the healthcare professional uses feedback from the other person and continuing curiosity about their experience to achieve an appreciation of the other person's perspective (Main, Walle, Kho & Halpern, 2017)

Healthcare workers are trained and expected to behave in an empathic way toward patients (Morimoro, Shimada, Tanaka, 2015). However, burnout reduces the ability of healthcare professionals to respond empathically, and empathy requires significant personal resources which cause burnout (Wilkinson, Whittington, Perry, and Eames, 2017). Healthcare professionals are also affected by the concept of client/patient-related

stress, one of the newest fields of stress research characterized by direct contact with people (Taddei & Contena, 2010). As burnout occurs, the emotional resources of workers are drained, and they cannot empathize or give of themselves psychologically, which can lead to staff viewing patients/clients as somehow deserving of their troubles (Maslach & Jackson, 1981).

Some researchers consider empathy to be a cognitive capacity that resides in individuals which are exhibited at varying levels based on workload. With job immersion and increasing stress, workers may have a lower capacity for empathy, and reduced empathy may adversely affect the employee's ability to relate to the patient's experience (Frankel, 2017). According to Ioannidou and Konstantikaki (2008), empathy is a key element of emotional intelligence because it involves regulating one's emotions and qualitatively appreciating another person's feelings. Empathy is also a communication that occurs when a healthcare worker identifies and responds to a patient's suffering (Frankel, 2017). Empathic communication includes recognizing emotions, assigning meaning to the behavior, responding with reassurance and support, and listening to the person suffering (Frankel, 2017). Empathy occurs when there is focus on the meaning of the other person's emotion (Halpern, 2007).

Employees in helping professions like healthcare are required to perform emotional labor, which is an ability to empathize with a client or patient, identify his/her needs, and coordinate or provide the proper care (Ducharme, Knudsen & Roman, 2008). Empathy benefits patients, resulting in them being more adherent to treatment and experiencing a better quality of life, while for physicians the use of empathy generates

more professional satisfaction (Thirioux, Birault & Jaafari, 2016). Though people who work in helping occupations have been characterized as sympathetic and understanding, that empathy can turn to apathy and a desire to escape if burnout sets in (Miller, Stiff, and Ellis, 1988).

Engagement

Burnout research helped develop the concept of work engagement (Maslach, 2017). The concept of engagement was developed to explain that employees contribute varying degrees and dimensions of themselves according to some internal decision or computation (Kahn & Fellows, 2013). Engagement, the opposite of burnout, is characterized as a positive experience at work, with high efficacy and accomplishment, vigor, dedication, and absorption, and few or no signs of exhaustion or cynicism (Leiter & Maslach, 2017; Schaufeli & Bakker, 2004). Engagement research suggests that people who are engaged in their work can more effectively cope with and recover from stressful challenges; thus, building an engaged workforce is the best approach to preventing burnout (Maslach, 2017). When employees are engaged and have opportunities to provide input toward changes that affect them directly, stress levels decrease (Landrum, Knight, & Flynn, 2012). Engaged workers are energetic, and they strongly identify with their work (Kanste, 2011).

Leeds & Nierle (2014) define engagement as a connection between employees and their work, their organization, and the people they work for or with. Engagement is being psychologically present, allowing the full range of senses to inform what we do, and working in a manner that is attentive, connected, integrated, and absorbed (Kahn &

Fellows, 2014). The benefit of employee engagement, found in federal agencies but of interest among healthcare leaders, is that increased engagement improved outcomes and produced better program results. Also, employees are absent due to sickness less, filed fewer grievances, and experienced fewer work-related injuries (Leeds & Nierle, 2014). An employee's engagement level is determined at the time when they choose how much of themselves or their energy, effort, and commitment they wish to contribute to the performance of their job role (Kahn & Fellows, 2014). Engagement manifests itself when employees use their voices to express themselves, instead of withdrawing their thoughts, ideas, and opinions from the process (Kahn & Fellows, 2014).

Engagement requires intensity and focus that is difficult to sustain amidst conditions of stress and burnout (Kahn & Fellows, 2014). Most employees are looking for organizational leaders to enable conditions in the workplace that lead them to choose to engage and feel that they have made the best decision. The three conditions for employee engagement are a sense of job meaningfulness, safety to voice ideas and opinions, and psychological availability (Kahn & Fellows, 2014). The most important condition for engagement is a sense of job meaningfulness, and there are two sources of meaningfulness that influence a person's choice to engage at work – foundational (the work role) and relational (relationships with others).

People experience meaningfulness when they feel worthwhile, useful, valuable, and not taken for granted (Kahn, 1990). People experience psychological safety when they can express themselves without fear of reprisals and damage to their image, status, or career (Kahn, 1990). People experience psychological availability when they feel they

have the physical, mental, and psychological resources needed to perform the role successfully (Kahn, 1990).

Derycke et al. (2012) researched the concept of an employee's workability, which is the employee's perception of the work demands and their ability to cope (physically, mentally, and socially) with the demands of the work. When one's workability, which is dynamic, changes in a negative direction, an employee's job satisfaction, job and employer commitment, and turnover intentions also change in a negative direction (Derycke et al., 2012). An employee's ability to perform their work can also be adversely affected by the stress of work-family conflict which becomes evident when the employee lacks sufficient physical, mental, and emotional resources to devote to the needs of work or family (Vanderpool and Way, 2013). Related work-family research indicates that the stress of work-family balance impacts job anxiety, job performance, engagement, and turnover intentions (Vanderpool and Way, 2013).

Engagement, energetic connection with work, is not a constant personality trait but it is a persistent and pervasive mental attitude (Ravalier, Dandil, & Limehouse, 2015). Engagement is the movement toward what matters to a person (Kahn & Fellows, 2014). Employee engagement also referred to as staff satisfaction, consists of beliefs, attitudes, and behaviors towards a person's work and is linked to higher performance, higher commitment, job retention, and better timeliness and attendance (Landrum, Knight, & Flynn, 2012). On the other hand, engagement can be an employee's steady state of functioning that is interrupted by periods of disengagement (Kahn & Fellows, 2014).

Kahn (1990) established engagement as the employment and expression of a person's true self in behaviors that connect them to work and to others. Since Kahn's original idea, four frameworks of engagement have emerged in the literature. The Needs-Satisfaction Framework (Kahn, 1990) suggests that the presence or absence of resources (meaningfulness, psychological safety, and psychological availability) influences employees to engage or disengage. The Burnout-Antithesis Framework defines engagement as the opposite of burnout or disengagement. The Job Satisfaction Framework defines engagement as employee involvement, satisfaction with and enthusiasm for work. Multidimensional Frameworks suggest that job characteristics, leadership actions, and personality traits are all antecedents to employee engagement (Anthony-McMann, Ellinger, Astakhova, & Halbesleben, 2017).

The Job Demands-Resources (JD-R) model suggests that every job has demands that require sustained physical or mental effort and every job has related physical and psychological job resources, which are the sole predictor of an employee's work engagement (Du Plooy and Roodt, 2010). The most observable behaviors that suggest employee engagement is energy, effort, staying involved, showing up for work, and remaining focused (Khahn and Fellows, 2014). However, true engagement includes employees speaking up, expressing what they think and feel, pursuing answers to do the work in the best way possible, and not remaining silent (Kahr and Fellows, 2014).

Healthcare workers feel less stressed when they consider themselves to be part of a good team with necessary support and role clarity (Firth-Cozens, 2001). Healthcare workers (clinicians and staff) experience more job satisfaction when their organizational

culture emphasizes quality and communication; when there is little chaos in the office atmosphere; and when there are minimal obstacles to providing safe, high-quality care (Alidina, Rosenthal, Schneider, Singer, & Friedberg, 2014). Burnout is reduced, and engagement is increased when healthcare practices are appropriately staffed when employees are included in participatory decision making, and when team members are positioned to work to the top of their competency level (Helfrich et al., 2014). Healthcare professionals might seek to detach or disengage from rather than to emotionally engage with patients to protect themselves from burnout, improve concentration, ration their time, and remain impartial or objective (Huggard, 2003). Disengagement is the process of disconnecting or detaching oneself from work roles physically, cognitively or emotionally (Kahn, 1990). Disengagement from work leads to relationship conflict, poor performance, cynicism, and withdrawal (physically and psychologically) from work (Shaukat, Yousaf, & Sanders, 2015).

Shaukat, Yousaf & Sanders (2015) researched the impact of employee conflict and its negative consequences on workers and organizations, which include worker stress, frustration, poor job performance, low job satisfaction, reduced productivity, and decline in commitment and ultimate intention to leave. Negative social relations in organizations inhibit engagement and have been shown to negatively impact behavior, organizational effectiveness, and worker commitment (Shaukat, Yousaf & Sanders, 2015). Engagement occurs when people in the workplace comply and cooperate with others to accomplish work goals, but when engagement is absent, turnover intentions may

increase resulting in lower productivity, the need to replace skilled workers, and the organization's loss of valuable skills and experience (Shaukat, Yousaf & Sanders, 2015).

Work engagement is associated with employee well-being, personal accomplishment, health, self-efficacy, job satisfaction, and turnover intention (Kanste, 2011). Emotional stress and physical job strain inhibit employee engagement (May, Gilson, & Harter, 2004). Managers of healthcare support staff can foster engagement by building supportive, trustworthy employee relationships and encouraging employees to solve work-related problems (May, Gilson, & Harter, 2004). For healthcare support staff, delivering quality care requires several key engagement themes including discretionary effort, passion, absorption, and a desire to perform (Leeds & Nierle, 2014). When leaders pay attention to engagement, in healthcare or other industries, they can more easily identify variations in workplace morale. They can also leverage employee relationships to more quickly diagnose and remove workplace obstacles (Leeds & Nierle, 2014). Researchers suggest that building engagement is the best approach to preventing burnout (Maslach, 2011).

Turnover

Turnover is described as an employee's propensity to leave the position or organization where the individual is employed due to mental or psychological strain (Saleem, Ahmed, & Saleem, 2016). Retention is described as a personal desire to remain in a job or with an organization. Though considerable research has been done on the turnover in healthcare and across other industries, one singular, all-encompassing definition of turnover does not exist in the literature (Derycke et al., 2012). Turnover can

be further divided into internal, external, within-organization, professional, and occupational turnover. Turnover is withdrawal behavior that ultimately has severe consequences for healthcare organizations and patients (Derycke et al., 2012).

The theory of planned behavior proposes that a person's intentions are the best predictors of their actual behavior, which corresponds to the idea that an employee's turnover intentions are a key predictor of his/her actual voluntary turnover (Vanderpool and Way, 2013). Burned out medical professionals are more likely to develop turnover intentions and eventually leave the job which in turn reduces or delays access to care (Linzer et al., 2013). Burnout is linked to increased rates of job turnover and stress-related absences (Wilkinson, Whittington, Perry, and Eames, 2017). Though research findings are inconsistent, job factors such as supervisory support and job satisfaction are important to consider when investigating low retention or high turnover because findings can enable organizations to develop strategies to intervene and reduce intention to leave as well as actual turnover (Benton, 2016).

Additional early research by Wright and Bonett (1992) defines employee turnover as voluntary withdrawal from an organization but distinguishes between intra-occupational turnover (job movement within a relevant occupational grouping) and inter-occupational turnover (movement to any job outside of the related occupational grouping (Croon, Sluiter, Blonk, Broersen, & Frings-Dresen, 2004). Psychological research supports the idea job stress and burnout that result from high psychological job demands leads to turnover among healthcare workers (Croon, Sluiter, Blonk, Broersen, & Frings-Dresen, 2004). On the contrary, satisfaction, autonomy, organizational commitment, and

opportunities for promotion are related to an employee's intention to stay (Nowak, Holmes, & Murrow, 2010).

According to Goodman and Boss (2002), stress which is not addressed leads to physical strain, which in turn leads to burnout. These researchers found evidence to support the idea burnout leads to people making a conscious decision to voluntarily leave an organization as a mean of conserving resources and coping. Individuals who are involuntarily terminated, on the other hand, may exhibit more depersonalization behaviors, which management may determine to be insubordination or inappropriate, resulting in termination (Goodman & Boss, 2002).

Bluedorn's 1981 turnover model suggests an order to the attitudinal and intentional constructs in a sequential turnover process beginning with job dissatisfaction, reduced organizational commitment, and the intention to resign (Wunder, Dougherty, & Welsh, 1979). Turnover intention is an employee's deliberate plan to leave the organization, and it is the last step in a sequence of the withdrawal process from the organization (Tett and Meyer, 1993). Turnover is a continual concern for employers because of the cost and impact it has on patient care and service (Brewer, Chao, Colder, Kovner, & Chacko, 2015). A number of factors influence turnover and intention to leave, however, Collini, Guidroz, and Perez (2015) identified that employee engagement, interpersonal relationships, climate of diversity, and mission fulfilment, are all key factors affecting an employee's decision to stay with or leave an organization, with engagement most consistently predicting turnover and turnover intention

Healthcare supervisors/managers describe their job role as that of shock-absorber, or one who responds to leadership demands but often without adequate support, resources, and decision rights (Skagert, Dellve, & Ahlborg, 2011). The result is stress and burnout related to overload, interruptions, responsibility, and relationships which adversely affect staff performance, supervisor motivation, and supervisor intention to leave (Skagert, Dellve, & Ahlborg, 2011). Supervisory support and the effective leadership of front-line leaders and managers play an important role in employee job satisfaction, turnover, and overall well-being (Wong & Laschinger, 2015). Turnover among supervisors in healthcare has not been thoroughly studied resulting in a lack of knowledge about turnover rates and the determinants of turnover among healthcare managers (Skagert, Dellve, & Ahlborg, 2011).

Interpersonal conflict and stressful communications are positively related to withdrawal behaviors and turnover intention, with the most important retention factors being peer relationships and employee-management relationships (Shaukat, Yousaf & Sanders, 2015). Job dissatisfaction is one of the strongest predictors of actual turnover, and an employee's intention to leave a job is just one state in a complex decision-making process that can lead to actual turnover (Derycke et al., 2012). Individuals who are can't fulfill the demands of their roles (work and family) may opt to sacrifice elements from each role. They may make decisions that are detrimental to their performance of one or both roles, or they may ultimately opt to withdraw from the job role to minimize strain and regain balance (Vanderpool and Way, 2013). An employee's perception of the work

demands and their ability to cope with the work demands also contributes to turnover intentions (Derycke et al., 2012).

Stress leads to turnover through several intervening linkages including job dissatisfaction, organizational commitment, and intention to resign (Wunder, Dougherty, & Welsh, 1979). When burnout occurs, exhausted employees to guard against further loss of resources, and eventually withdraw as a way to cope and reduce the psychological impact of exhaustion (Thanacoody, Newman, & Fuchs, 2013). Considering the costs of chronic turnover, efforts to increase retention are critically important, because the exit of trained experience staff depletes the organization of acquired knowledge and skills and reduces the overall service capacity of the agency (Benton, 2016).

Summary

Though researchers know the extent and impact of stress and burnout among doctors and nurses in the medical profession, there is surprisingly little research work that has been done to assess the impact of stress and burnout on the other healthcare workers (Well, 2011). Most stress and burnout research in the healthcare setting has been focused on providers and paid little attention to the broader team of staff persons (Fiabane, Giogi, Sguazzin, and Argentero, 2013). According to the COR theory, people work hard to gather, keep, defend, and increase the things they value (Hobfall, 1989). However, when stress and burnout occur, people defend those things by behaving in a way that protects them and preserves their resources (Shaukat, Yousaf & Sanders, 2015). For support staff working in healthcare, this research investigated the role that stress, burnout, and an

employee's conservation of resources play, in one's ability to demonstrate empathy, engagement, and intentions to remain with the organization.

Future stress and burnout research call for more focus on developing interventions at the organization level that will build engagement and use assessment tools to detect stress and burnout early (Maslach, 2011). A significant amount of literature available on stress and burnout research underscores the importance and complexity of the topics across all jobs and industries. However, researchers have not explored the moderating effects of burnout on empathy, engagement, and retention among healthcare support staff. Chapter 3 addresses the methodology and design of this research study, including the purpose, the population, the research questions and hypotheses, the instruments, as well as the statistical analysis to be used in the study.

Chapter 3: Methodology

Introduction

The purpose of this study is to analyze stress as a predictor variable and burnout as a mediating variable on the criterion variables of empathy, engagement, and turnover among healthcare support staff working in an FQHC. The study methodology, including the population, sampling procedure, recruitment, participation, data collection procedures, instrumentation, operationalization of constructs, data analysis plan, threats to validity, and ethical procedures are addressed in this chapter.

The healthcare profession is a very demanding field, and as job demands increase, more and more healthcare professionals experience emotional exhaustion, a lower job commitment, and a greater interest in leaving their employment, which threatens critically important patient care outcomes (Thanacoody et al., 2014). This study provides an important examination of the impact of stress mediated by burnout on empathy, engagement, and turnover in healthcare support staff working in an FQHC. This research contributes to limited information available on the effects of burnout (a mediator of stress) on the outcome variables of empathy, engagement, and turnover for healthcare support staff within the context of an FQHC, where stress levels are often higher due to patient complexity and limited resources (Hayashi et al., 2009). All three of these are essential for healthcare employees and organizations to provide the best quality of care to patients.

Research Design and Rationale

The focus of this research is different from previous studies on stress and burnout. In this study, I explored the impact of stress mediated by burnout on three key areas of the healthcare delivery system: empathy, engagement, and turnover. In this study, the Job Stress Survey (JSS) and Oldenburg Burnout Inventory (OLBI) were used to determine if an employee's stress level mediated by burnout is a predictor of their ability to exhibit empathy, job engagement, and turnover intentions. This is a quantitative study that examined stress and burnout and the relationship of these variables with empathy, engagement, and retention. The research design was selected based on previous stress and burnout studies, but using an understudied population (healthcare support staff) and a different selection of outcome variables (empathy, engagement, and retention). The research was conducted with a diverse population of healthcare support staff with different titles and duties, all of whom are responsible for interacting with and providing quality, timely, and professional care and service to patients.

The research used a quantitative design. Quantitative analysis enabled meto explain, predict, or investigate relationships, describe current conditions, and examine the possible impact or influences on the selected outcome variables. The study included a correlational design using descriptive and inferential statistics. Multiple regression analyses were used to assess the relationship between the independent, mediator, and outcome variables. A bivariate Pearson correlation analysis was used to measure the correlation between variables. The study did not include a direct intervention. It established baseline data regarding the effects of stress and burnout on empathy,

engagement, and retention among FQHC healthcare workers. A quantitative research design was selected with the goal of surveying a large sample of healthcare support staff and generalizing the findings to a broader population.

Quantitative research methods are used to track trends and clarify associations between variables. They are used to analyze data from research participants, and in this study, the quantitative analysis provided me with measurable results that supported or rejected the hypotheses. The purpose and design of this study supported the selection of the quantitative method to present the research.

A quantitative analysis was performed using the principles of path analysis. Path analysis allowed me to estimate the magnitude and significance of the connections and relationships between the variables. The aim of path analysis is to investigate the predictor variable (stress) mediated by burnout, and their effects on the outcome variables (empathy, engagement, and retention). The interactions between the variables are conceptualized in Figure 1.

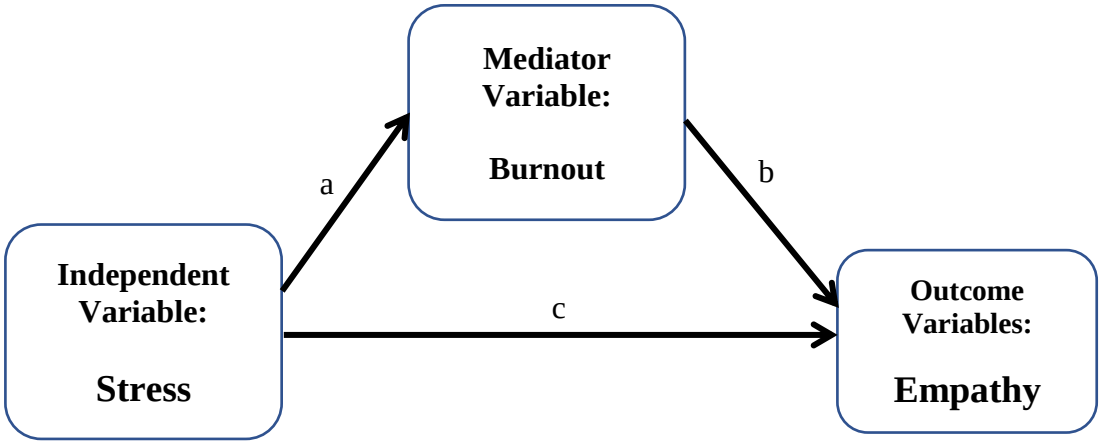

Figure 1. Interactions between Stress, Burnout, and Empathy

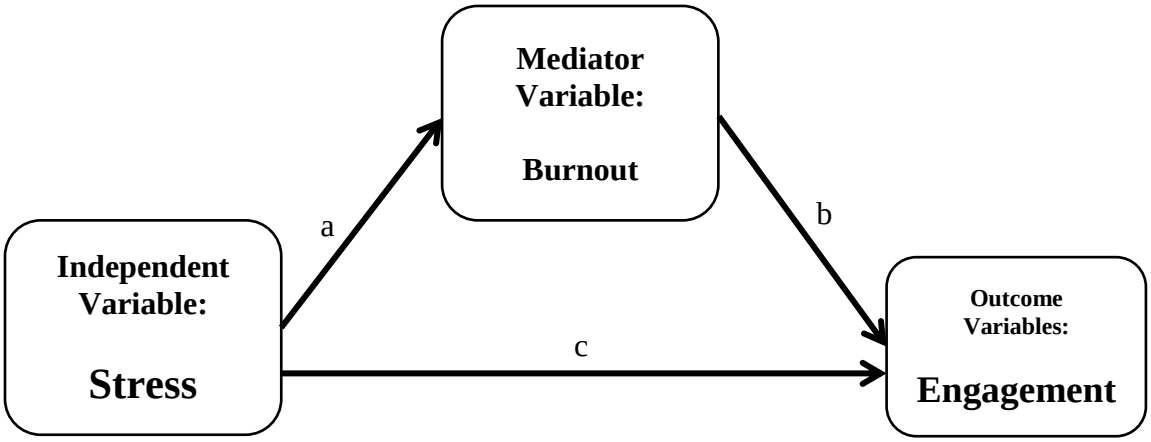

Figure 2. Interactions between Stress, Burnout, and Engagement

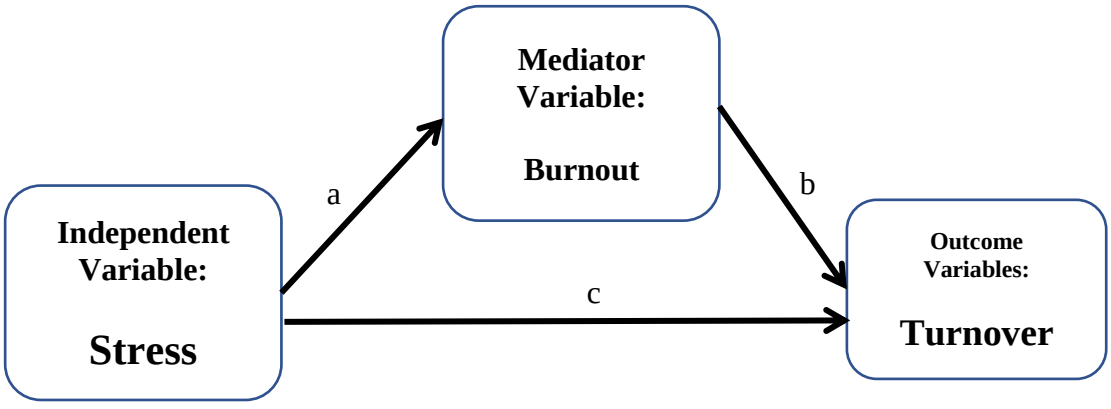

Figure 3. Interactions between Stress, Burnout, and Turnover

Research Questions and Hypotheses

The research questions and hypotheses for this research study are:

RQ1: Does burnout mediate the relationship between stress and empathy in healthcare support staff working in an FQHC?

$H_0 1$*:* Burnout is a mediator in the relationship between stress and empathy.

Ha1: Burnout is not a mediator in the relationship between stress and empathy.

RQ2: Does burnout mediate the relationship between stress and engagement in healthcare support staff working in an FQHC?

$H_0 2$*:* Burnout is a mediator in the relationship between stress and engagement.

$H_a 2$*:* Burnout is not a mediator in the relationship between stress and engagement.

RQ3: Does burnout mediate the relationship between stress and *turnover* in healthcare support staff working in an FQHC?

$H_0 3$*:* Burnout is a mediator in the relationship between stress and turnover.

$H_a 3$*:* Burnout is not a mediator in the relationship between stress and turnover.

In this study, I used survey research to collect cross-sectional data at one point in time using a self-administered questionnaire (see Table 1).

Table 1

Overview of Quantitative Research

Purpose	Questionnaire
To measure stress	Job Stress Scale (1999)
To measure burnout	Oldenburg Burnout Inventory (1999)
To measure empathy	Empathy Measure (2016)
To measure engagement	Oldenburg Burnout Inventory (1999)
To measure turnover intentions	Behavioral Intention to Withdraw Measure (1991)

Participants

Healthcare support staff who works at an urban FQHC were the focus of this research study. The demographic characteristics of the support staff were diverse with educational levels ranging from high school diplomas to post-baccalaureate degrees. The majority of support staff workers were African American; however, all ethnicities and races were represented in the study. This population is diverse regarding age with employees ranging in age from 18 years to over 60 years of age. The majority of support staff is female; however, the representation of males in this study was adequate. The socioeconomic status of support staff is best represented as low to middle class. There are approximately 220 healthcare support staff members in the identified population. Participants in the research survey were selected from a database of all healthcare support staff in the target organization.

The participants were invited to participate in the study if they perform healthcare support staff job duties, which make them more susceptible to job stressors and burnout that adversely affect their ability to provide quality care and service to patients. Only healthcare support staff participated in the study. Healthcare providers (physicians and nurses) were excluded from the present study. The participants were chosen through convenience sampling. A convenience sample was chosen due to the accessibility and proximity of participants. This allowed for generalization to other healthcare support staff working in community health centers and FQHCs.

This population was selected because researcher has shown that healthcare professionals are susceptible to burnout due to the high-stress work environment, the

complexity of challenging patients, and difficulties of providing quality care in an FQHC setting. Support staff was defined as individuals who are frontline workers composed of receptionists, customer service representatives, medical assistants, dental assistants, registration assistants, referral specialists, call center specialists, and health center administrators.

Participants were recruited by direct invitation. Participants were those individuals who have some direct contact with patients and who work full time. Participants were of age to give consent. Participants were able to read and comprehend the self-report measures of this research study. Upon being identified for the study population, a flyer describing the study was distributed to target participants. The flyer listed a link to a website where the survey was located. The website was a secure site and only accessible by participants in the research study.

Survey Instruments

Measuring Stress: Job Stress Survey

The JSS (Spielberger & Vagg, 1999) was developed to assess generic sources of occupational stress encountered by men and women employed in a variety of work settings. The JSS scores job stress index, job stress severity, job stress frequency, job pressure index, job pressure severity, job pressure frequency, lack of organizational support index, lack of organizational support severity and lack of organizational support frequency. The survey takes 10-15 minutes to complete. The survey is used to assess individual stress levels and to offer feedback to managers about the conditions in the workplace that may be contributing to employee stress. The survey can help

management identify the sources of worker stress so they can develop action plans and change work practices and conditions to alleviate stress. The questionnaire has 30 stress events, and for each event, participants rate the frequency with which they encounter the stress event followed by the severity of the event when it occurs.

Reliability was demonstrated through internal consistency using coefficient alpha. Alpha reliability scores are consistently in the high 70s and 80s which are very acceptable levels. Evidence of validity was collected through the process of developing survey items. Survey items were subjected to extensive factor analysis to confirm discriminate power and precision. Numerous comprehensive concurrent validity studies are documented for the instrument (Plake, Impara & Spies, 2003).

The Job Stress Scale assesses the perceived severity (intensity) and the frequency of the occurrence of 30 work-related stressors. In responding to the questionnaire, participants rate the perceived severity of each stressor on a 9-point scale After rating the perceived severity, responders report how often (the approximate number of days) each stressor has occurred during the past 6 months on a frequency scale of 0 to 9+ times.

Scoring the Job Stress Scale will provide three scale and 6 subscale scores. The Job Stress Index is an estimate of the overall level of occupational stress experienced by the participant and it is calculated by combining the severity and frequency ratings of all 30 items. The Job Stress Severity scale indicates the perceived average rating of severity and is calculated by averaging the responses to the severity items. The Job Stress Frequency scale represents the average frequency of occurrence of the stressors over the

past 6 months and is calculated by averaging the response scores on the items specific to stressful job-related events.

The Job Pressure Index assesses occupational stress by combining the severity and frequency scores of 10 stressors related to stressful aspects of the job structure, design, or duties. The Job Pressure Severity subscale assesses the perceived severity of the 10 stressors most closely related to job pressure. The Job Pressure Frequency subscale assesses the average frequency of the 10 stressors related to job pressure.

Lack of Organizational Support Index measures the amount of stress attributed to lack of organizational support based on responses from 10 stressors related to supervisors, fellow workers, policies, and procedures. The Lack of Organization Support Severity subscale measures the average level of severity of the 10 stressors related to organizational support. The Lack of Organizational Support Frequency subscale assesses the average frequency of the 10 stressors related to lack of organizational support.

Measuring Burnout and Engagement: Oldenburg Burnout Inventory.

The 16-item Oldenburg Burnout Inventory (Demerouti, 1999) assesses two core dimensions of burnout: exhaustion and disengagement from work. There are eight items in the Exhaustion subscale that general query feelings of emptiness, overtaxing from work, a strong need for rest, and a state of physical exhaustion. There are also eight items on the Disengagement subscale that query distancing oneself from the object or content of work, negative attitudes, and cynical attitudes and behaviors towards one's work. In each subscale, responses are captured on a 4-point Likert-type response scale

(Demerouti, 1999). This research study used the entire 16-item Oldenburg Burnout Inventory to assess burnout and engagement.

The OLBI demonstrates acceptable reliability (test/retest reliability and internal consistency) as well as factorial, convergent, and discriminant validity (Hasbesleben & Demerouti, 2005). These findings suggest that the OLBI offers researchers an alternative measure of burnout that offers balanced wording, that can also be used to measure the opposite phenomenon (engagement) and provides an expanded conceptualization of the exhaustion component of burnout. The OLBI is based on a model similar to that of the MBI; however, it features only two scales, exhaustion, and disengagement. Internal consistency of the OLBI was acceptable; with scores ranging from .74/.87. All of the Cronbach's alpha scores were over .70. Researchers have confirmed the internal consistency, test/retest reliability, factorial validity, and construct validity of the OLBI (Hasbesleben & Demerouti, 2005).

Measuring Empathy: Interpersonal Reactivity Index (IRI) – Brief Form.

The Interpersonal Reactivity Index (IRI) – Brief Form (Ingoglia et al., 2016) is a scale widely used to measure individual differences in disposition to empathic responsiveness. The IRI is a popular assessment of empathy because it is based on a multidimensional concept of empathy. The IRI is regarded as one of the most comprehensive measures of self-reported empathic characteristics.

The 16-item questionnaire s rated on a 5-point Likert scale. Ranging from 1 (does not describe me at all) to 5 (describes me very well) (Ingoglia et al., 2016). In this research study, the IRI – Brief Form was used to assess empathic responsiveness.

Researchers developed a brief form of the instrument, tested factor structure, examined reliability, and produced evidence of construct validity. The redesign successfully reduced the length of the scale while preserving reasonable reliability and validity. Correlation coefficients and Cronbach's alpha were computed to assess internal consistency of the IRI – Brief Form subscales and the results show an adequate internal consistency (Ingoglia, LoCoco, Albiero, 2016).

Measuring Turnover: Behavioral Intentions to Withdraw Measure

The Behavioral Intention to Withdraw Measure (Davy et al., 1991) is a 2-item questionnaire designed to assess an employee's thoughts of quitting and intentions to quit. The instrument assesses the likelihood that the responder will leave their job within the next year. It also assesses the frequency with which the responder thinks of quitting their job. Responses are captured on a 5-point Likert-type scale. Reliability and validity data for this scale is not provided in the literature. This research study used the Behavioral Intentions to Withdraw Measure to evaluate turnover intentions among healthcare support staff working in an FQHC.

Data Collection

Upon approval by the Walden IRB and the Chief Executive Officer, instructions for accessing the survey instrument were provided to healthcare support staff. A set of demographic questions were given to each study participant to determine individual characteristics, including age, gender, job title, years of service, race, and ethnicity. The demographic question answer categories were multiple choice. Participants were informed that they could withdraw at any time, that confidentiality would be ensured at

all times, and that nonparticipation would not have any negative consequences for the participants. Participants were also encouraged not to place names on any research materials. Participants were invited to access the survey via the link provided. Once on the survey website, participants completed demographic information. Data collection lasted approximately one month. Additional announcements inviting employees to participate in the study were made until a sufficient number of participants were obtained.

This research study was a cross-sectional study which produced single time point data. I used Survey Monkey to collect the data. I created a web link for the survey which was the fastest and most efficient way to distribute and collect the survey instrument from employees. The survey link was distributed on a flyer to interested study participants.

To prevent impossible or otherwise incorrect values, the survey items were designed as multiple choice questions, and participants were unable to enter any option that was not listed. To prevent an excluded employee from entering the study, the survey was only be distributed to employees who met the inclusion criteria and the electronic link to the survey was single use so that it was not shared with others. To prevent duplicate employee submissions, employees were permitted to access the link once, and upon entry, employees must enter their name and job title. To prevent missing data and outliers, participants were required to provide a response to all items in the survey and were not permitted to skip items.

Once a participant accessed the survey link, the participant was instructed to complete the informed consent form. The participant was asked to indicate that they have read and understand and agree to the informed consent. The participant reviewed

instructions for completing and submitting the informed consent form and survey. The informed consent and survey were automatically sent to me.

Participants were instructed not to place their names on any forms or questionnaires submitted to ensure confidentiality. Surveys were identified by an identification number. No link between name and identification number was maintained. Participants were informed that they could choose whether or not they wish to complete the survey. Nonparticipation would have no negative consequences for individuals choosing not to participate. There was no effect of coercion even though the participants in this study were my co-workers. I informed participants of my role as researcher. There was no anticipated harm in this study as participants did not engage in any interventions or experiments. Participants may feel some anxiety when answering some of the survey questions; however, participants were encouraged to answer all questions and to contact me directly if they have questions. Participants who wished to receive additional help for their burnout symptoms were referred to the Employee Assistance Program (EAP).

Data Analysis

Data for this study was analyzed utilizing SPSS Version 24. All response data was exported to SPSS Version 24 for analysis. I conducted multiple linear regressions in SPSS. I had one predictor or independent variable, which was stress. I had one mediator variable, which was burnout. I wanted to determine their contribution to three outcome or response variables, which were empathy, engagement, and turnover. Data screening was done to assess the quality of data and missing values. Data was screened to

determine if any data was entered incorrectly. Surveys were collected electronically and required that participants answer all questions. A scatter plot was used to identify outliers.

Estimated sample size was obtained using the Sample Size Calculators by Qualtrics and the National Statistical Service (NSS). In the sample size calculator, the Confidence Level was set to 95%. The Margin of Error will be set to 10%. Results indicate that a recommended sample size of 96 would be sufficient for the study.

Processing the Data: Cleaning and Recoding

All items in the survey were formatted as multiple-choice to align with the Likert Scale format of the original question design. When all survey data was collected, the value of each of the interval variables was re-coded with 1 as the lowest value.

Researchers conduct data cleaning and recording to find and eliminate errors and outliers in the data. In this research study, the survey was administered electronically which minimized the potential errors/outliers in the data (Statistics Solutions, 2013).

An outlier is a responder with survey values that are substantially different (larger or smaller) from the values obtained from other individuals in the data set. The data of an outlier can have a dramatic influence on the value obtained for the correlation. When an outlier is included in the analysis, a strong, positive (or negative) correlation emerges. A single outlier drastically alters the value for the correlation and thereby affects my interpretation of the relationship between variables (Gravetter & Wallnau, 2014).

The problem of outliers is why researchers look at scatter plots instead of simply basing the interpretation of the data on the numerical value of the correlation. If you only

go by the numbers, you might overlook the fact that one extreme data point inflated the size of the correlation (Gravetter & Wallnau, 2014).

Outliers occur when 1 or 2 scores fall significantly above or below most scores in the data set. In the data analysis for this research, outlier scores were deleted to eliminate any potential outrageous impact of outlier scores on the distribution of the data. Cook's distance test was used to determine if a score was an outlier. Cook's distance test was used to identify influential data points that are particularly worth checking for validity. Outlier scores were removed from the data set.

Assumptions

The assumption that was made in this research is multivariate normality. The data should be normal. Most of the parametric tests require that the assumption of normality be met. Normality means that the distribution of the test is normally distributed (or bell-shaped) with 0 mean, with 1 standard deviation and a symmetric bell-shaped curve. To test the assumption of normality, the following measures and tests were applied: 1) skewness and kurtosis; 2) Shapiro-Wilk's W test; 3) Kolmogorov-Smirnov test; and 4) Q-Q plot. The Shapiro-Wilk test was used to check for a normal distribution. The Kolmogorov-Smirnov test was used to check for a normal distribution.

Confounding Variables

Researchers must account for confounding variables when conducting research. Confounding variables increase variance and introduce bias into the study. When confounding variables are not accounted for, the research results may be useless, or the results may product false correlations. To prevent confounding variables, researches use

control variables or randomization. One potential confounding variable for this research study is tenure or years of experience, which may positively influence an employee's ability to demonstrate empathy, remain engaged, and stay with the organization (Statistics Solutions, 2013). In this research study, tenure data was collected in the demographic questions of the survey.

Data Analysis Plan

The traditional Baron and Kenny model for mediation analysis (Baron & Kenny, 1986) could be conducted to assess if burnout mediates the relationship between stress and empathy, engagement or turnover. In this model, mediation for each of the three outcome variables is tested separately through a series of three regression analyses. The first regression is conducted to predict the outcome from the predictor variable out of which the regression coefficient for the predictor will produce the value of c. The second regression is conducted to predict the mediator from the predictor variable out of which the regression coefficient for the predictor will produce the value of a. The third regression is conducted to predict the outcome from both the predictor variable and the mediator out of which the regression coefficient for the predictor will produce the value of c and the regression coefficient for the mediator will produce the value of b (Field, 2016).

Baron and Kenny (1986) also describe the four conditions of mediation that the above regression models test for. The following are the four conditions of mediation for each of the three outcome variables in this research study. For the outcome variable empathy, stress must significantly predict empathy, stress must significantly

predict burnout, burnout must significantly predict empathy, and stress must predict empathy less strongly in regression #3 than in #1. For the outcome variable engagement, stress must significantly predict engagement, stress must significantly predict burnout, burnout must significantly predict engagement, and stress must predict engagement less strongly in regression #3 than in #1. For the outcome variable turnover, stress must significantly predict turnover, stress must significantly predict burnout, burnout must significantly predict turnover, and stress must predict turnover less strongly in regression #3 than in #1 (Field, 2016).

Instead of using Baron and Kenny's traditional model, this research study used a new model to estimate the indirect effects and its significance. To analyze the data, I used the PROCESS tool, or custom dialog box, with SPSS. This tool more efficiently estimated the indirect effect and its significance. The indirect effect is the combined effects of paths a and b (Field, 2016). For each research question and hypothesis, I will test for total effect, direct effect, and indirect effect, analyze the p-values for significance, and analyze the confidence intervals for significance.

Reporting the Results of the Mediation Analysis

To report the results of this mediational analysis, I used the PROCESS module and commands with SPSS. I fit the regression model with variables specified for this research study (predictor – stress; mediator – burnout; outcome – empathy, engagement, and turnover). I reported the path values and display the values on a path diagram. I reported the value of the indirect effect and its significance.

Ethical Considerations

There was minimal risk in ethical considerations for this study. The research was fully voluntary and anonymous, and participant responses to questionnaires were considered to be consent. A flyer distributed to participants contained my identification, an explanation of the purpose of the research, an explanation of the involvement required by participants, a commitment to confidentiality and anonymity, and my contact information.

Summary

This chapter described the research methodology of this study. The research questions and hypotheses were presented as well as the research design, survey instruments, data collection, analysis, and ethical considerations. This research explores the predictor variable of stress, mediated by burnout, and the impact on empathy, engagement, and turnover among support staff working in an FQHC. Results and corresponding tables are presented in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this study was to examine stress as a predictor variable and burnout as a mediating variable on the criterion variables of empathy, engagement, and turnover among healthcare support staff working in an FQHC. The study design was a quantitative non-experimental analysis that used a self-administered survey to collect data on stress, burnout, empathy, engagement, and turnover among healthcare support staff. The data were collected and analyzed to evaluate the effect of stress and the mediating effects of burnout (defined as exhaustion, cynicism, and inefficacy) on staff person's empathy, engagement, and turnover intentions.

There were three research questions in the study, and responses from participants were analyzed. The research questions for the study are as follows:

RQ1: Does burnout mediate the relationship between stress and empathy in healthcare support staff working in an FQHC?

$H_0 1$*:* Burnout is a mediator in the relationship between stress and empathy.

Ha1: Burnout is not a mediator in the relationship between stress and empathy.

RQ2: Does burnout mediate the relationship between stress and engagement in healthcare support staff working in an FQHC?

$H_0 2$*:* Burnout is a mediator in the relationship between stress and engagement.

$H_a 2$*:* Burnout is not a mediator in the relationship between stress and engagement.

RQ3: Does burnout mediate the relationship between stress and *turnover* in healthcare support staff working in an FQHC?

H_03: Burnout is a mediator in the relationship between stress and turnover.

H_a3: Burnout is not a mediator in the relationship between stress and turnover.

The survey, used to answer the research questions for this study involved the JSS, OLBI, IRI-Brief Form, the Behavioral Intention to Withdraw Measure, and a set of demographic questions from healthcare support staff.

Chapter 4 presents the data collection process, any discrepancies in the collection of data compared to what was planned, as well as actual recruitment and response rates. The chapter includes descriptive characteristics of the sample and statistical tests used for the quantitative analysis along with tabulated results. Chapter 4 presents a summary of the findings that emerged from the analysis. Chapter 5 provides a discussion of the quantitative analysis, overall findings, implications for future research, and the implications of research to social change.

Data Collection and Analysis

This study was conducted with a diverse population of healthcare support staff with different titles and duties, all with responsibility for interacting with and providing quality, timely, and professional care and service to patients, clients, and families in an FQHC. This population was selected because healthcare professionals are susceptible to burnout due to high-stress work environments, as well as the challenges of complex patients in the community health environment. Most of the employees working in the FQHC were African American females, but the study represented a diverse group of workers. Participants were invited to participate in the study if they performed healthcare support staff job duties. Healthcare providers (physicians and nurses) were excluded

from the study. There were 10 (9.9%) male participants, 83 (82.2%) female participants, and eight (7.9%) non-specified gender participants. Table 2 illustrates the gender demographics for the participants.

Table 2

Distribution of Gender

Gender	Frequency	Percent
Male	10	9.9%
Female	83	82.2%
Other	8	7.9%

Participants were recruited by direct invitation. The initial design of the study called for use of email to distribute the survey to participants. However, the CEO of the organization requested that the corporate email server not be used for personal research purposes. As a result, upon being identified for the study population, a printed flyer with instructions for accessing the survey web site was handed out to participants. The flyer introduced the website where the survey was located as well as the name and contact information for employees to reach me.

For an unknown population size, based on a margin of error of 10% and a confidence level of 95%, the recommended sample size for survey research was 96 (Raosoft, 2004). The goal for the research was a group of 100 volunteers. The data collection process started in October 2018 and ended on November 30, 2018. A total of 101 volunteers were recruited before the recruitment period ended. The final number of qualified participants was 101.

Table 3 is a description of the frequency of job titles provided by the survey participants and Table 4 presents the analysis of the demographic tenure for the participants in the study.

Table 3

Frequency of Job Titles

Job Title	Frequency	%
Business Office Coordinator	1	1.0
Customer Care Specialist	2	2.0
Client Services	2	2.0
Counselor	9	8.9
Communication Specialist	1	1.0
Customer Service Rep (CSR)	17	16.8
Dental Assistant	7	6.9
Dental Hygienist	6	5.9
Family Services	6	5.9
Health Center Administrator	4	4.0
Lead CSR	2	2.0
Lead Medical Assistant	3	3.0
Medical Assistant	25	24.8
Manager	4	4.0
Medical Case Manager	2	2.0
Safety Security Officer	4	4.0
Unknown	4	4.0
Total	101	100.0

Table 4

Descriptive Statistics – Years of Tenure

Variable	N	Min.	Max.	Mean	SD
Years of Tenure	101	0	24	4.22	4.837

Upon receipt of approval by the Walden IRB (Approval # 09-24-18-0154435) and the organization's CEO, instructions for accessing the survey were distributed to healthcare support staff through an invitation flyer. The invitation flyer provided interested participants with the web site for accessing the survey. During the entire recruitment period, participants were invited to access the web site to complete the survey online. Once in the online survey, participants were first instructed to read the consent form and indicate their agreement to participate in the study. After providing consent, participants completed the Likert scale questions on stress, burnout, empathy engagement, and turnover intentions.

Survey Monkey was the primary method of collecting survey data. However, during the recruitment period, I received several requests for a paper-pencil survey that interested participants could complete and submit. This was not a part of the original plan, but to make the survey easily accessible for all interested participants, an identical paper-pencil survey was created and distributed to site managers who requested it.

Originally, I planned to request each participant's personal email so that a copy of the study findings could be emailed at the conclusion of the research. Instead, to avoid the collection of personal email addresses, some of which allow a reader to identify the person, I decided to post the research results on the same web site where participants

found the survey. As a result, participants were not asked to provide their personal email on either the online or paper survey as originally planned.

I continued to hand out invitation flyers and paper-pencil survey instruments until the target number of participants was achieved. At the close of the survey period, I had received a total of 35 responses through the electronic Survey Monkey instrument. I have received a total of 66 paper-pencil survey responses.

Preliminary Data Management

Upon closing the survey recruitment period, I entered the paper-pencil responses into the data set manually. A total of 97 respondents with complete data for all scales. On the stress survey, 3 respondents had surveys with missing data items. On the burnout survey, 4 respondents had surveys with missing data items. On the empathy survey, 2 respondents had surveys with missing data items. On the engagement survey, 2 respondents had surveys with missing data items. On the turnover intentions survey, 2 respondents had surveys with missing data items.

The data was screened for missing values. The most common method used to deal with missing values is complete data analysis, where subjects with missing values are excluded from the analysis (Guan & Yusoff, 2011). Missing values were identified, and the missing values were re-coded to indicate that the response for that item was missing. Missing data may or may not be a problem. However, if the number of missing values is small, sound conclusions are still possible (Laered, 2018). Listwise and pairwise deletion are the most common techniques to handling missing data (Peugh &

Enders, 2004). I selected listwise deletion (complete-case analysis) which instructs SPSS to remove all data for a case that has one or more missing values.

Given that I collected more than enough data samples to conduct the analysis and applying a listwise deletion to the data would not affect the statistical power of analyses conducted, I decided to use the SPSS listwise deletion tool to handle the missing data.

I ran a frequency analysis to identify any outlier scores. From the pencil-paper survey, two outlier scores were identified and attributed to data entry errors. The scores were corrected to reflect the response provided in the original survey. I also ran Cook's Distance. Cook's Distance is a measure of how much influence a predictor variable (X) has on the predicted value of the outcome variable (Y). Cook's Distance indicates how far an average predicted Y value will change if the record is dropped from the data set. Cook's Distance results of <1 are acceptable. I ran an analysis using Cook's Distance and found no outlier values.

Descriptive Analysis

For each variable, I calculated the mean score across the items. For the IV (stress), the mediator variable (burnout) and dependent variables (empathy, engagement, and turnover intentions), I tabulated the mean score for the participants.

Cronbach's alpha is a test of internal consistency or reliability. Reliability is how well a test measures what it should. Cronbach's alpha is used to see if multiple-questions surveys are reliable. These surveys, which often use a Likert scale, are designed to measure hidden or unobservable variables that are very difficult to measure in real life. Cronbach's alpha tells me if the survey or test is consistently measuring the variable of

interest. Table 5 lists the mean, standard deviation, and Cronbach's alpha for each variable.

Table 5

Descriptive Statistics – Mean Scores for all Variables

	N	Mean				
	Statistic	Statistic	Std. Error	SD	# of Items	Cronbach alpha
Stress	101	4.58	.155	1.56	58	.970
Engage	100	2.34	.047	.476	8	.655
Empathy	100	2.24	.035	.351	16	.696
Burnout	100	2.56	.052	.529	8	.767
Turnover	99	2.54	.120	1.20	2	.881
Valid N (listwise)	99					

I produced a correlations matrix and evaluated the significance of the correlations between all pairs of variables (see Table 6). The matrix shows that the correlation between stress and engagement, stress and burnout, engagement and burnout, stress and turnover, engagement and turnover, and burnout and turnover were all significant positive correlations ($p < 0.05$). These significant positive correlations indicate that higher scores on one of the variables is associated with higher scores on the second variable.

Table 6

Correlational Matrix

		Stress	Engage	Empathy	Burnout	Turnover
Stress	Pearson Correlation	1	.345**	.048	.505**	.411**
	Sig. (2-tailed)		.000	.639	.000	.000
	Sum of Squares and Cross-products	239.374	25.326	2.578	41.156	75.596
	Covariance	2.443	.258	.026	.420	.771
Engage	Pearson Correlation	.345**	1	-.106	.618**	.626**
	Sig. (2-tailed)	.000		.298	.000	.000
	Sum of Squares and Cross-products	25.326	22.509	-1.750	15.446	35.294
	Covariance	.258	.230	-.018	.158	.360
Empathy	Pearson Correlation	.048	-.106	1	.076	-.116
	Sig. (2-tailed)	.639	.298		.456	.251
	Sum of Squares and Cross-products	2.578	-1.750	12.201	1.396	-4.837
	Covariance	.026	-.018	.124	.014	-.049
Burnout	Pearson Correlation	.505**	.618**	.076	1	.494**
	Sig. (2-tailed)	.000	.000	.456		.000
	Sum of Squares and Cross-products	41.156	15.446	1.396	27.742	30.907
	Covariance	.420	.158	.014	.283	.315
Turnover	Pearson Correlation	.411**	.626**	-.116	.494**	1
	Sig. (2-tailed)	.000	.000	.251	.000	
	Sum of Squares and Cross-products	75.596	35.294	-4.837	30.907	141.338
	Covariance	.771	.360	-.049	.315	1.442

**. Correlation is significant at the 0.01 level (2-tailed).

b. Listwise N=99

The assumption made in this research is multivariate normality, meaning that the data should be normally distributed. To test the assumption of normality, I conducted the skewness and kurtosis analysis (see Table 7).

Skewness and kurtosis are two analyses that researchers use to test the normality of the data. Skewness refers to lack of symmetry in the data, which indicates that the normal distribution curve is off-center. Kurtosis refers to the pointedness of the curve in the peak of the distribution curve. A negative value of less than -1.0 (-1.5 or -2) means the data is skewed. A positive value of 1.0 (1.5 or 2) means the data is skewed. These rules apply to both the skewness and kurtosis analysis. Results between -1.0 and 1.0 suggest that the data reflects a normal distribution. Table 7 presents the results of the skewness and kurtosis analysis for each variable in the study and confirms a normal distribution.

Table 7

Skewness and Kurtosis Analysis

	N	Skewness		Kurtosis	
	Statistic	Statistic	Std. Error	Statistic	Std. Error
Stress	101	-.383	.240	-.450	.476
Engage	100	.043	.241	.025	.478
Empathy	100	.256	.241	.452	.478
Turnover	99	.593	.243	-.657	.481
Burnout	100	-.341	.241	.383	.478
Valid N (listwise)	99				

To test the assumption of normality, I conducted the Shapiro-Wilk's W and the Kolmogorov-Smirnov tests (Table 6). The Shapiro-Wilk's test is a test of normality. The significance value of the Shapiro-Wilk's test indicates whether the values in the data are statistically significantly different from a normal distribution. If the significance value is statistically significant, it indicates that the distribution is normal should be rejected.

Based on the findings from the Shapiro-Wilk test of normality, and a significance level of .05, the normality test for the variable Stress produced a result of .03, which is less than .05 and statistically significant. This finding means that I reject the null hypothesis and there is a statistically significant difference between the values and a normal distribution. The stress data is not normally distributed. The normality test for the variable burnout produced a result of .29, which is more than .05 and not significant. This finding means that I fail to reject (or accept) the null hypothesis and there is not a statistically significant difference between the values and a normal distribution. The burnout data is normally distributed. The normality test for the variable empathy produced a result of .24, which is more than .05 and not significant. This finding means that I fail to reject (or accept) the null hypothesis and there is not a statistically significant difference between the values and a normal distribution. The empathy data is normally distributed. The normality test for the variable engagement produced a result of .29, which is more than .05 and not significant. This finding means that I fail to reject (accept) the null hypothesis and there is not a statistically significant difference between the values and a normal distribution. The engagement data is normally distributed. The normality test for the variable turnover produced a result of .00, which is less than .05 and statistically significant. This finding means that I reject the null hypothesis and there is a statistically significant difference between the turnover values and a normal distribution. The turnover data is not normally distributed.

The Kolmogorov-Smirnov (K-S) test compares the distribution generated by my data with a known hypothetical probability distribution and indicates if they have the

same distribution. Small p-values in the output indicate that the data is not from a normal distribution.

The K-S analysis shows that the result of the K-S test for the variable stress is .107, with a significance of p = .01, which is statistically significant. The K-S test result for the variable burnout if .078, with a significance of *p* = .149, which is not significant. The K-S test result for the variable empathy is .084, with a significance of *p* = .080, which is not significant. The K-S test result for the variable engagement is .093, with a significance of *p* = .034. The K-S test result for the variable turnover is .179, with a significance of *p* = .000.

The variables mean stress, mean engagement and mean turnover produced significance, indicating that the distribution is significantly different from a normal distribution (it is not normal). For the variables of mean burnout and mean empathy, the analysis did not produce significance, as the p-values were greater than .05, indicating that the data is not statistically significant from a normal distribution (it is normal).

Table 8

Tests of Normality: Kolmogorov-Smirnova and Shapiro-Wilk

	Kolmogorov-Smirnova			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Stress	.107	99	.01	.972	99	.03
Burnout	.078	99	.15	.984	99	.29
Empathy	.084	99	.08	.983	99	.24
Engagement	.093	99	.03	.984	99	.29
Turnover	.179	99	.00	.913	99	.00

The Q-Q plot is a graphical tool to help researchers assess if a set of data came from a normal distribution. It is a visual check, which allows researchers to see at-a-glance if the assumption of normality is realistic and what data points in the data set (if any) may be contributing to a violation of the assumption of normality. I conducted Q-Q Plot analyses which are presented in Figures 4 – 8 and support an assumption of normality. The Q-Q plots support the findings that the research is not violating assumptions of normality.

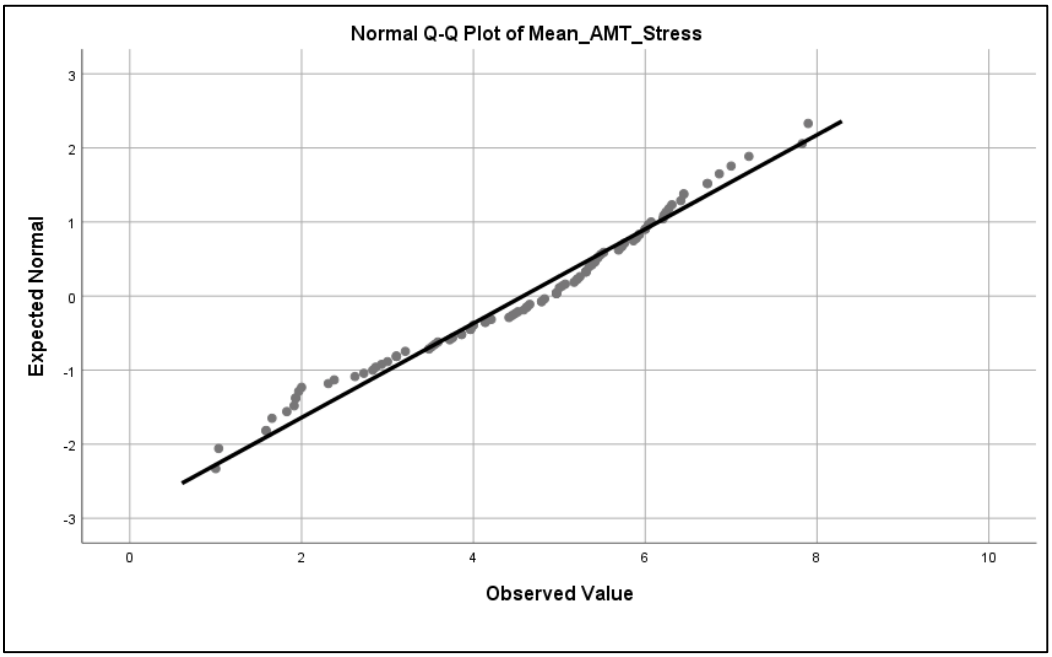

Figure 4. Mean stress Q-Q plot

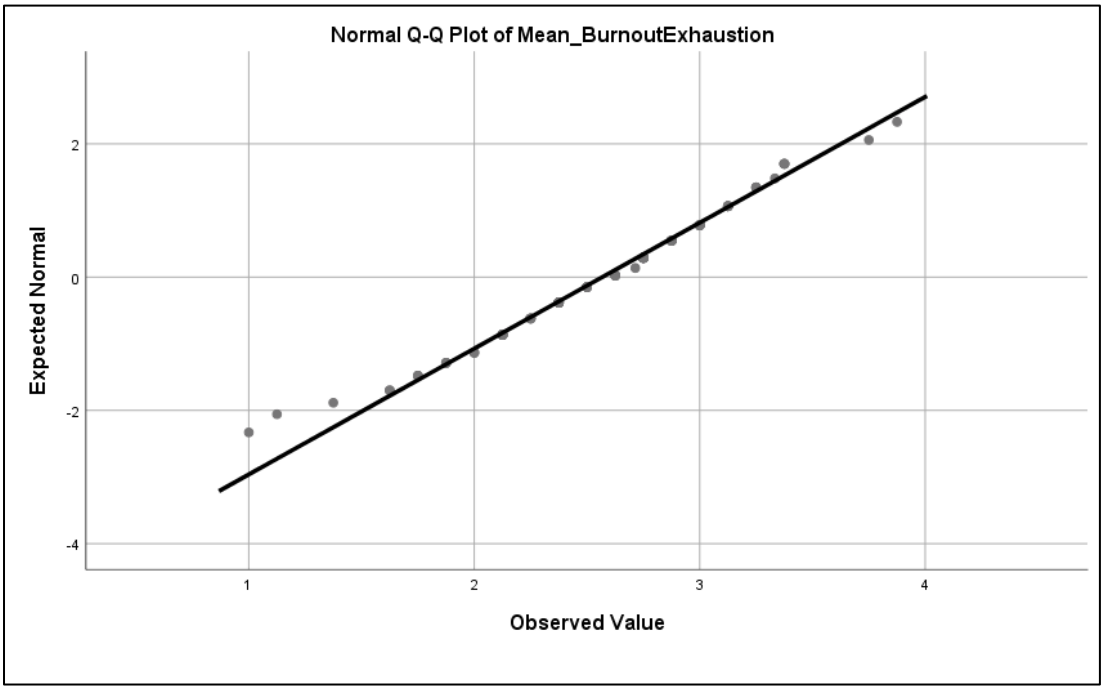

Figure 5. Mean burnout Q-Q plot.

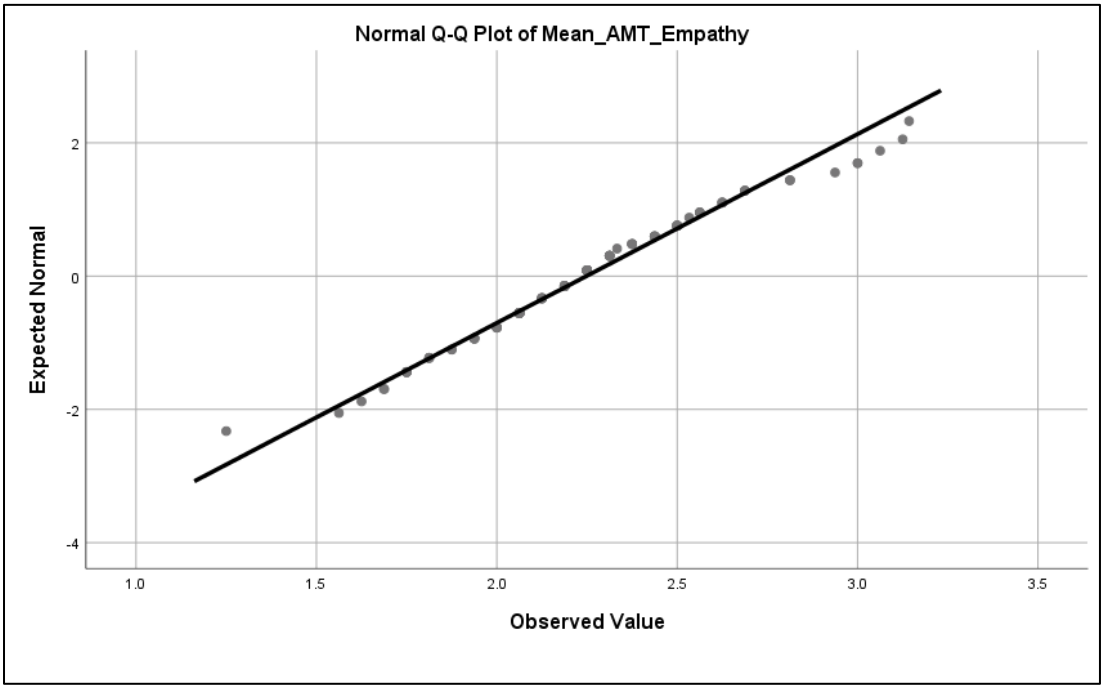

Figure 6. Mean empathy Q-Q plot.

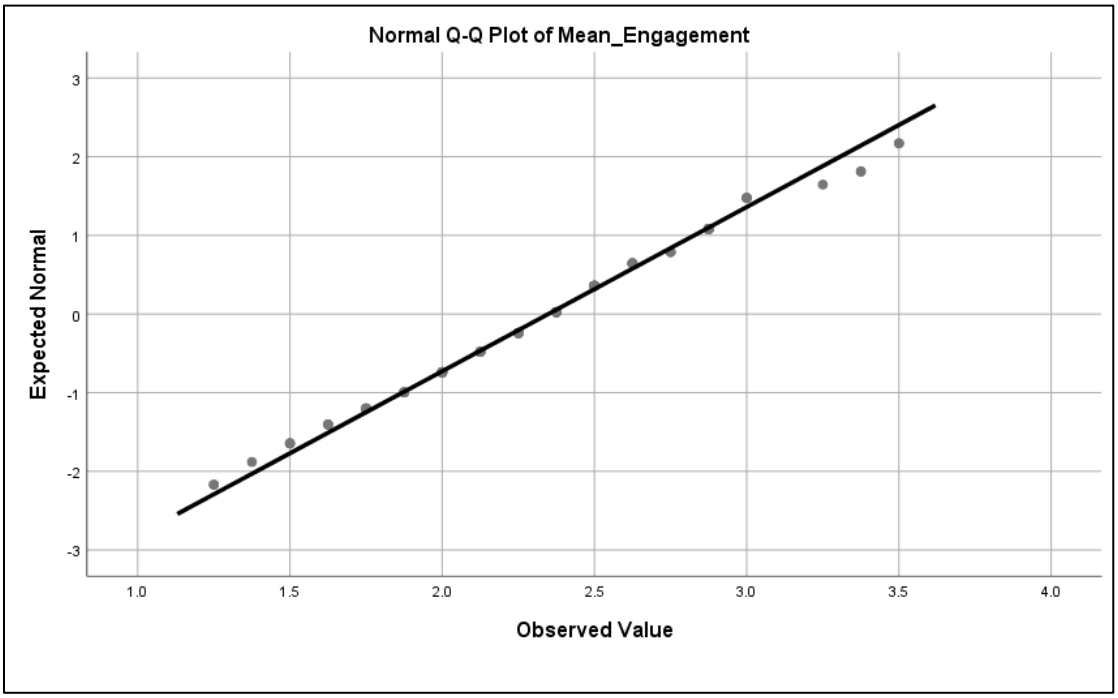

Figure 7. Mean engagement Q-Q plot.

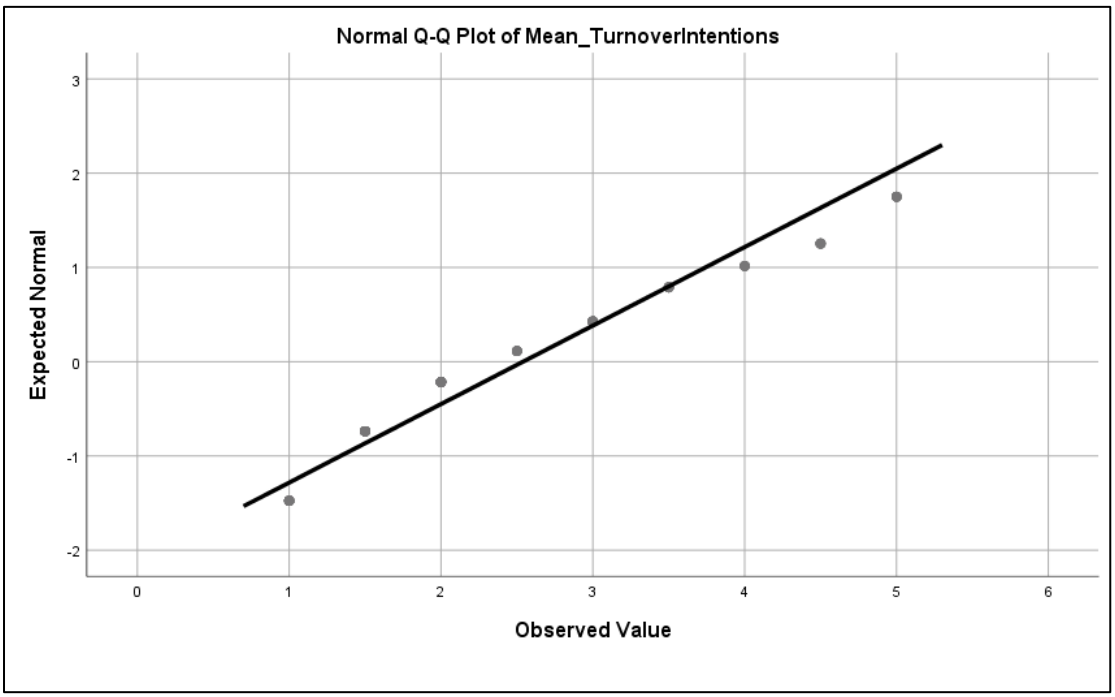

Figure 8. Mean turnover intentions Q-Q plot.

Detailed Results

A mediation analysis to evaluate the relationship between stress, burnout, and the outcome variables (empathy, engagement, and burnout) was performed using SPSS and the PROCESS analysis tool by Hayes. First, I performed a simple regression of burnout predicted from stress. The results showed that stress significantly predicts burnout, b = .1689, t = 5.7382, p = .000. The R^2 value tells us that stress explains 25% of the variance in Burnout (R^2 = .2515). Because b is positive, we understand that the relationship is positive also, meaning that as stress increases, burnout increases and vice versa.

RQ1

RQ1: Does burnout mediate the relationship between stress and *empathy* in healthcare support staff working in an FQHC?

I performed a regression of empathy predicted from both stress and burnout. The results show that Burnout does not significantly predicts empathy with stress in the model, b = .0482, t = .6202, p = .5366. Stress also does not significantly predict empathy, b = .0012, t = .0470, p = .9626. The R^2 value tells us that stress and burnout explain <1% of the variance in empathy (R^2 = .0057). The b for stress is positive (.0012), indicating that the relationship is positive. The b for burnout is also positive (.0482), indicating that the relationship is also positive (See Figure 9).

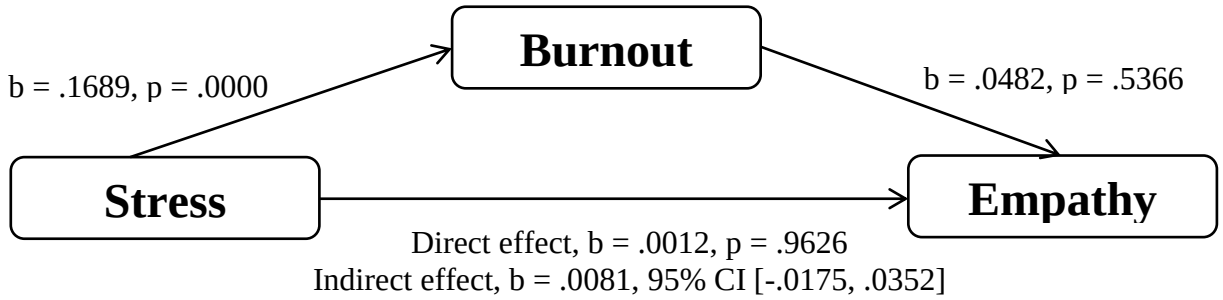

Figure 9. Direct and indirect effect of Stress and Burnout on Empathy

The results of the analysis of total effect of stress on empathy (when the mediator burnout is not present in the model) showed that stress does not significantly predicts empathy, b = .0094, t = .4151, p = .6790. The R^2 value tells us that stress explains .0018 or <1% of the variance in empathy (R^2 = .0018). The b for stress is positive (.0094), indicating that the relationship is positive.

I analyzed the total, direct and indirect effect of stress (X) on empathy (Y). The total effect of X (stress) on Y (empathy) without burnout in the model is not significant as follows: b = .0094, t = .4151, p = .6790. The direct effect of stress on empathy when burnout is included as a predictor in the model is not significant as follows: b = .0012, t = .0470, p = .9626. The indirect effect of stress on empathy is estimated at b = .0081. The effect size measures have a confidence interval range that includes zero (bias-corrected with acceleration (BCa) CI [-.0175, .0352]), so it is not likely that there is a genuine indirect effect.

The fact that the observed p-values do not fall below the established alpha level of .05 indicates that the association between the independent variable (stress) and the dependent variable (empathy) is not reduced significantly by the inclusion of the mediator (burnout) in the model. There is no evidence of mediation.

RQ2

RQ2: Does burnout mediate the relationship between stress and engagement in healthcare support staff working in an FQHC?

I performed a regression of engagement predicted from both stress and burnout. The results show that Burnout significantly predicts engagement with stress in the model, b = .5362, t = 6.4609, p = .0000. Stress did not significantly predict engagement, b = .0139, t = .4969, p = .6204. The R^2 value tells us that stress and burnout explain 38% of the variance in engagement (R^2 = .3837). The b for stress is positive (.0139), indicating that the relationship is positive. The b for burnout is also positive (.5362), indicating that the relationship is positive (see Figure 10).

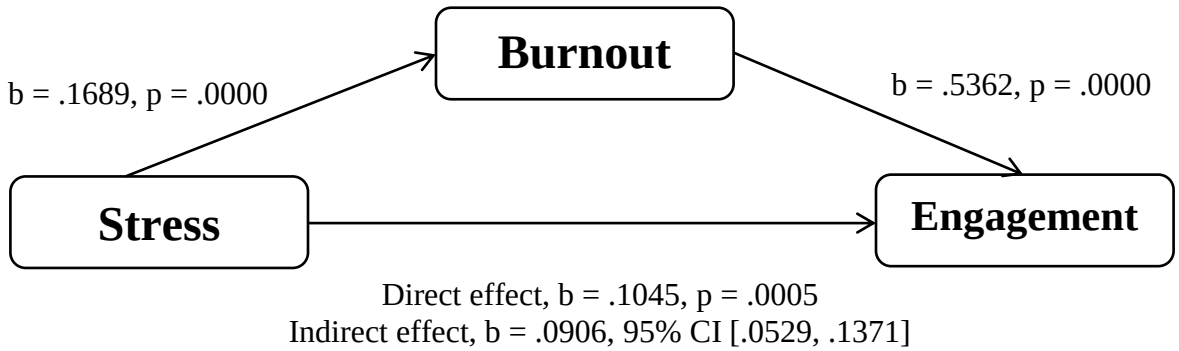

Figure 10. Direct and indirect effects of stress and burnout on engagement

I analyzed the total effect of stress on engagement. This result tells me that the total effect of the predictor (stress) on the outcome (engagement) when the mediator (burnout) is not present in the model. When burnout is not in the model, stress significantly predicts engagement, b = .1045, t = 3.6302, p = .0005. The R^2 value tells

me that stress explains 12% of the variance in engagement (R^2 = .1185). The *b* for stress is positive (.1045), indicating that the relationship is positive.

I analyzed the total, direct, and indirect effect of stress (X) on engagement (Y). The total effect of X (stress) on Y (engagement) without burnout in the model is significant as follows: b = .1045, t = 3.6302, p = .0005. The direct effect of stress on engagement when burnout is included as a predictor in the model is not significant as follows: b = .0139, t = .4969, p = .6204. The indirect effect of stress on engagement is estimated at b = .0906. The effect size measures have a confidence interval range that does not include zero, so I can be confident that the indirect effect is greater than no effect. There was a significant indirect effect of stress on engagement through burnout, b = .0906, BCa CI [.0529, .1371].

The fact that the observed p-value, for the total effect of engagement predicted by stress, falls below the established alpha level of .05 indicates that the association between the independent variable (stress) and the dependent variable (engagement) is reduced significantly by the inclusion of the mediator (burnout) in the model. There is evidence of mediation.

RQ3

RQ3: Does burnout mediate the relationship between stress and turnover in healthcare support staff working in an FQHC?

I analyzed regression of turnover intentions predicted for both stress and burnout. The results show that Burnout significantly predicts turnover intentions with stress in the model, b = .8666, t = 3.8230, p = .0002. Stress also significantly predicts turnover

intentions, b = .1668, t = 2.1616, p = .0331. The R^2 value tells me that stress and burnout explain 28% of the variance in turnover intentions (R^2 = .2787). The b for stress is positive (.1668), indicating that the relationship is positive, and as stress increases, turnover intentions increase. The b for burnout is also positive (.8666), indicating that the relationship is positive, and as burnout increases, turnover intentions increase (see Figure 11).

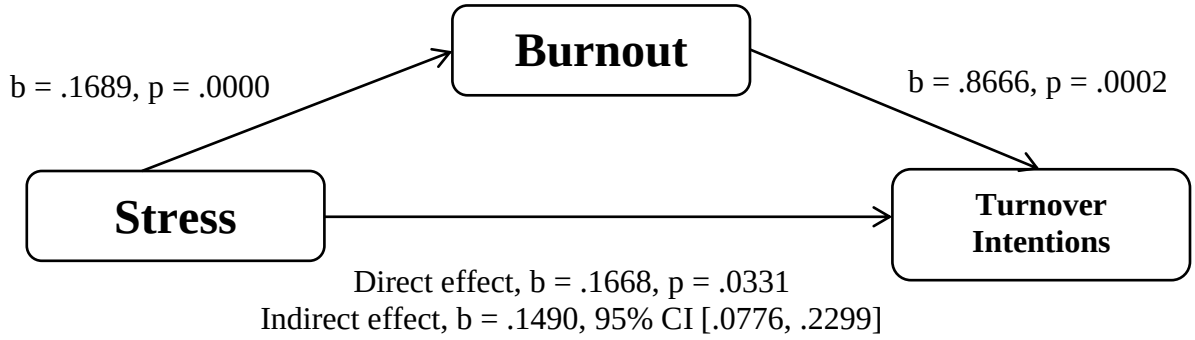

Figure 11. Direct and indirect effect of stress and burnout on turnover intentions

I analyzed the total effect of stress on turnover intentions. This result tells me the total effect of the predictor (stress) on the outcome (turnover intentions) when the mediator (burnout) is not present in the model. When burnout is not in the model, stress significantly predicts turnover intentions, b = .3158, t = 4.4401, p = .0000. The R^2 value tells me that stress explains 17% of the variance in turnover intentions (R^2 = .1689). The b for stress is positive (.3158), indicating that the relationship is positive, and as stress increases, turnover intentions increases.

I analyzed the total, direct, and indirect effects of stress (X) on turnover intentions (Y). The total effect of X (stress) on Y (turnover intentions) without burnout in the model is significant as follows: b = .3158, t = 4.4401, p = .0000. The direct effect of

stress on turnover intentions when burnout is included as a predictor in the model is significant as follows: $b = .1668$, $t = 201616$, $p = .0331$. The indirect effect of stress on turnover intentions is estimated at $b = .1490$. The effect size measures have a confidence interval range that does not include zero, so I am confident that the indirect effect is greater than no effect. There was a significant indirect effect of stress on turnover intentions through burnout, $b = .1490$, BCa CI [-.0776, .2299].

Summary

This chapter presented the detailed findings of the research. In summary, this research study found that burnout does not mediate the relationship between stress and empathy in healthcare support staff working in an FQHC. The research study found evidence that burnout does mediate the relationship between stress and engagement in healthcare support staff working in an FQHC. Finally, the study found evidence that burnout mediates the relationship between stress and turnover intentions in healthcare support staff working in an FQHC. Chapter 5 summarizes the key findings, describes the potential impact for social change, and discusses recommendations for future research.

Chapter 5: Study Findings

This research study was designed to add to the very limited research literature on the effects of stress and burnout on healthcare support staff. The effects of stress and burnout on empathy, engagement, and turnover among healthcare support staff working in an FQHC, where stress levels are often higher due to patient complexity and limited resources (Hayashi et al., 2009). The purpose of this study was to analyze stress as a predictor variable and burnout as a mediating variable on the criterion variables of empathy, engagement, and turnover.

There were three research questions used for the study:

RQ1: Does burnout mediate the relationship between stress and empathy in healthcare support staff working in an FQHC?

RQ2: Does burnout mediate the relationship between stress and engagement in healthcare support staff working in an FQHC?

RQ3: Does burnout mediate the relationship between stress and turnover in healthcare support staff working in an FQHC?

The theoretical framework for this study was the COR theory, which claims that when people are stressed, emotionally exhausted, and experiencing burnout, they protect and preserve their physical and mental resources from becoming depleted by reducing their effort and withdrawing from work (Hobfall, 1989). When stress and burnout are present, employees deploy coping strategies that will improve their ability to handle the stressful environment (Rees, 1995). Burnout prompts people to distance themselves emotionally and cognitively so they can handle the workload (Maslach & Leiter, 2008).

The findings presented in Chapter 4 support the COR theory as employees experiencing burnout reserve physical and emotional resources by choosing not to fully engage in the work. These employees also are at risk for seeking new employment where there is less perceived stress.

Stress, Burnout, and Empathy

The research results indicate that burnout does not mediate the relationship between stress and empathy in healthcare support staff working in an FQHC. Empathy is the capacity for understanding another person's emotional state (Frankel, 2017), and perhaps cognitive capacity may more significantly influence the relationship between stress and empathy. Frankel (2017) suggested that without the cognitive capacity to experience empathy, a person may be limited in their ability to connect with and respond to another person's distress, even if they themselves are experiencing stress and burnout. Future research should be conducted to explore cognitive capacity for empathy as a mediator between stress and empathy in this population.

Other possible explanations are based on the COR theory. The COR theory points to the idea that when stressed, employees conserve the emotionally energy needed to connect with another person's experience. According to Reiss (2017), when employees are emotionally overloaded or overwhelmed, the capacity for empathy declines. Empathy declines because the amount of emotional labor to connect with or empathize with another person's condition is not available because it is being conserved.

Another possible explanation is that the ability of health care support staff to demonstrate and maintain healthy levels of empathy requires one to achieve and maintain

their own emotional self-care (Reiss, 2017). Additional research is needed to determine if cognitive capacity and emotional self-care have a greater influence on the relationship between stress and empathy than burnout.

A third explanation may be found in the possibility that resource loss, characterized in the COR theory, is associated with workplace stress and burnout, but it is not a strong enough influence that it interferes with an employee's ability to demonstrate empathy. This may be attributed to the type of people who are attracted to health care support staff positions. Perhaps this type of employment attracts the type of employee who can continue to demonstrate empathy despite the resource loss associated with workplace stress and/or burnout (Anthony-McMann et al., 2017). Further research is needed.

Stress, Burnout, and Engagement

The findings show evidence that burnout does mediate the relationship between stress and engagement. Burnout significantly predicts engagement in healthcare support staff working in an FQHC when stress is the predictor. The findings from this study confirm that burnout influences the engagement level of healthcare support staff in the work environment. The relationship between burnout and engagement was positive, suggesting that as employees experience burnout, they may actually move toward, not away, from what matters to them at work. Burnout influences the relationship between stress and engagement, causing people to focus, connect, put forth more effort, and apply more energy and effort toward their job tasks. Stress alone does not significantly predict

engagement in this population. However, as prolonged stress becomes burnout, the effect on employee engagement is significant.

Salmela-Aro and Upadyaya (2018) found that during the early stage of an employee's career, economic problems increase the impact of stress and burnout, on engagement. During the late stage of an employee's career, it was caregiving demands that significantly increased the influence of between work stress and burnout on work engagement. Employees with high resilience skills are more effective at balancing the demands of job stress, burnout, and job engagement (Salmela-Aro and Upadyaya, 2018). In essence, economic problems, caregiving demands, and resilience skills are additional variables which exacerbate stress and burnout and may significantly increase the relationship between stress, burnout, and engagement in this healthcare support staff population. More research is needed.

Auh et al., (2016) studied employee engagement extensively and found a decline in employee engagement when burnout was present. Burnout adversely impacts employee engagement and a micromanagement leadership style similarly adversely impacts burnout. Leadership style affects the relationship between stress, burnout, engagement, and employee turnover. A micromanagement leader style can be detrimental to employee engagement because their overbearing and sometimes punitive style leads to feelings of emotional exhaustion and depersonalization for employees. A developmental, participative management style fosters employee engagement. Manager oversight and monitoring is valuable for employee growth and development because effective observation with timely feedback improves employee performance and

engagement. Ineffective oversight and monitoring can increase burnout, which in turn reduces engagement (Auh et al., 2016).

Most of the employees who participated in this study have a significant customer service responsibilities in their position. Customer service feedback is valuable for employee engagement, it should be encouraged, and it has been found to reduce burnout (Auh et al., 2016). When employees receive much-needed feedback on ways to improve customer service, burnout is diminished, despite close monitoring. As the COR theory suggests, this may be due to the idea that customer service feedback and training replenishes necessary resources that employees need to have in order to effectively cope with and manage stress. In order to reverse the trend of declining employee engagement, managers should use monitoring effectively and provide frequent customer service feedback and training, which reduces burnout and increases employee engagement (Auh et al., 2016).

Employee perception of the leader influences the relationship between stress, burnout, and employee engagement (Steffens et al., 2018). Steffens et al. (2018) found that leaders who foster a team environment generate more work engagement among team members and employees show fewer signs of burnout and turnover intentions.

Future studies should include leader behaviors because Steffens et al. found that turnover intentions are mediated by burnout and work engagement increased when a leader used a team-based approach. The implication on improving the engagement and retention of health care support staff highlights the need for a healthcare leaders to practice a leader style and tone that will have a significant impact on reducing

employee burnout and turnover intentions. Leaders benefit when they help to reduce and manage employee stress and burnout in the workplace by creating and developing a shared sense of identity among those they lead. This ultimately reduces employee burnout and turnover intentions (Steffens et al., 2018).

According to Schaufeli (2017), engaging leadership focuses on how to increase employee engagement. Engaging leaders inspire, strengthen, connect their followers by encouraging a team dimension, building enthusiasm for the vision, granting them freedom and responsibility, and encouraging teamwork and collaboration. The engaging leadership style was shown to have an indirect effect on preventing burnout and increasing employee engagement by reducing demands and increasing job resources (Schaufeli, 2017).

Focusing on effective leader behaviors to reduce burnout, increase engagement, and reduce turnover is consistent with the COR Theory. Engaging leaders provide their followers with valued organizational resources they need to be effectively in their work and on their teams. These resources include elements such as trust, job control, task variety, and performance feedback, a good atmosphere, role clarity, and career perspective. These are also resources that employees value in an employment relationship, and resources that reduce job demands, levels of burnout, turnover intentions and enhance levels of employee work engagement (Schaufeli, 2017). Matziari, Montgomery, Georganta, and Goulougeri, (2017) found similar results in their research on burnout and employee engagement, which found that organizational practices and values, have the potential to reduce burnout and increase job engagement. Future

research on the influence of leader style and behavior on employee stress, burnout, engagement and turnover intentions is important to explore.

Stress, Burnout and Turnover Intentions

The current study produced evidence that burnout mediates the relationship between stress and turnover intentions in healthcare support staff working in an FQHC. This is consistent with earlier research which confirms that there is a positive relationship between work exhaustion and employee turnover intentions. If an employee experiences exhaustion at work, there is a greater probability that the employee may be willing to leave the job in order to avoid the exhaustion (Saleem, Ahmad, and Saleem, 2016).

The influence of burnout on the turnover intentions of healthcare support staff is costly for healthcare organizations because it can result in high performing, dedicated employees leaving the job to escape the burnout. Without more leadership attention on burnout among healthcare support staff, engagement and turnover will be adversely affected, and in turn, adversely affect the patient's health care experience.

Healthcare organizations must commit time and resources to uncovering the causes of burnout among healthcare support staff if they ever hope to build employee engagement and increase employee retention. According to Wunder, Dougherty, and Welsh (2016), stress and burnout impact turnover which is crucial for the economic viability of an organization. Organizations that work to identify and alleviate stress and

burnout among staff produce positive benefits for retaining employees (Wunder, Dougherty, and Welsh, 2016).

Study Limitations

The following study limitations were identified. This study was conducted in a specific type of health care delivery system –community health center – so the findings cannot be generalized to all support workers in all types of health care organizations (i. e. hospital, private practice). The study participants were predominantly female workers, so the findings cannot be generalized to male support staff workers in an FQHC. The study population was made up of predominantly African American employees, so the findings cannot be generalized to support staff workers from other racial or ethnic groups. This study, which relied on self-reported data from support staff working in clinical and non-clinical areas of the health facility, was limited by the fact that self-reported data cannot be independently verified but it can be influenced by selective memory, exaggeration, and fear of being identified. The study was also limited due to the organization's restrictions on use of email to communicate with potential participants. These limitations did not prevent the completion of the study with the target number of study participants, but they do point to additional areas of future research on this topic.

The theoretical implications for this study suggest that the COR theory can be attributed to the reason why healthcare support staff become less effective when they are under stress or are experiencing burnout. Employees invest less in the work process because they are conserving their energy, emotions, and physical output due to the stress and burnout they experience in the environment. In these conditions, turnover intentions

also increase as employees conserve their physical and emotion investment so they can redirect it toward finding and achieving success in a new employment arrangement.

Recommendations for Future Research

The following recommendations for further research are provided based on the strengths and limitations of the current study. This research study did not confirm a relationship between burnout and empathy as anticipated. As a result, empathy and the factors that positively or negatively affect health care worker empathy, is a recommended topic for future research. Given the findings from this study, which point to a relationship between burnout and employee engagement, future research on successful burnout prevention and elimination strategies for health care professionals should be studied to help health care leaders engage employees in the important work of caring for others. The study results also show a relationship between burnout and turnover intentions, so future research on burnout reduction and effective retention strategies will benefit health care organizations in their attempt to keep value-added employees on staff.

Implications for Leaders

The results of this research can inform health care leaders and enable them to improve their patients' experience by addressing the toll that stress and burnout take on employee engagement and retention. FQHCs serve the most vulnerable and yet medically complex patients. So, the support staff who provide care and service need to be fully engaged in and committed to the work they do with patients. Creating an environment that engages workers in the process by including them in problem solving and conveying the value they bring to healthcare delivery will result in a more positive

experience with caring support staff for patients and families. The organization benefits because employees who are engaged care about how the organization functions. They identify opportunities for improvement and speak up with processes are not working as designed. They invest their time, energy, ideas, and creativity in helping to improve the way the organization cares for patients. Ultimately, society benefits because patients receive quality care, the build a trusting relationship with their care givers and the support staff, they are more adherent to treatment plans, and they are more likely to return for follow up care to address complex chronic health needs.

Improving the work experience for healthcare support staff is an imperative because they are the frontline experience for patients seeking care. In the community health environment, many of the patients are lost to care, have a distrust of health care organizations, and simply neglect basic, routine health care services. When they present to the community centers for treatment, they frequently have multiple chronic health conditions that have not been treated and are therefore not controlled. They may also have physical and behavioral health needs that make it difficult to complete the necessary treatment plans.

In order to provide safer, higher quality care, for these complex patients, health care organizations must engage staff to identify ways to improving quality and service, engage staff in the development of process and protocols that will best support patient care, and engage staff to find solutions and develop more efficient approaches. When employees participate in determining how the work gets done, they are engaged, they feel their contribution is valued, and turnover intentions are reduced.

Earlier research studies underscore the need for healthcare organization leaders to consider the stage of an employee's career when developing interventions to reduce stress and burnout. Employees in the early career stage may benefit from financial planning and management training as well as the use of employee development tools to guide career planning and progression. Late state employees, on the other hand, may best benefit from options for balancing caregiving and work-life conflicts like flexible work arrangements and telecommuting. Resilience skills training is also an option to help employees with problem solving, decision making, and focusing on issues that are within their scope of control.

Organizations that work to increase patient satisfaction while they simultaneously involve employees input and ideas, have better coordination of frontline work and overall employee outcomes (Avgar, Givan, and Liu, 2011). By improving employee work conditions through engagement and involvement, organizations can affect quality of care. Engagement positions frontline employees with the resources, processes, and opportunities they need to address patient needs and concerns. By focusing employees on patient centered care, organizations can engage employees to affect patient care and remain with the organization.

Investing in creating a work atmosphere where employees are less stressed, are not experiencing burnout at work, are enthusiastically engaged in accomplishing the work goals of the organization, and are committed to remaining with the employer, has enormous long-term benefits for individual employees, healthcare organizations, patients, and the health of our communities. Research has identified a direct correlation between

employee satisfaction and patient satisfaction. Engaged, satisfied employees deliver better care which results in better outcomes and higher patient satisfaction. What matters most in health care are the health outcomes. Working for an organization that values patients and delivers quality care increases employee satisfaction, retention, and loyalty (Stanowski, 2009). Greater use of patient centered care practices was associated with lower employee turnover intentions and improved care quality and delivery. Supportive work environments and highly engaged workforce are linked to improved quality and health care performance (Avgar, Givan, and Liu, 2011). Every aspect of patient care can be improved with improved staffing, engaged employees, and a work environment that contributes to employee retention (Clark, Wolosin, Gavran, 2005). Investing in reducing stress and burnout and increasing employee engagement benefits the entire healthcare delivery system.

This study confirmed what is well documented in the literature. There is a relationship between stress and burnout. In fact, these findings confirmed that stress significantly predicts burnout. So, the first call to action for health care leaders is to invest time and resources into evaluating stress levels among their employees. Because unaddressed stress leads to burnout, and burnout is detrimental to employee performance and retention. Leaders of health care organizations must consider individual interventions like stress management and stress reduction training classes to help employees identify and reduce work stressors. In addition, leaders can benefit by identifying organizational stressors that result in burnout overtime, such as workload,

inefficient processes, inadequate recognition and rewards, and poor management practices.

Recommendations for Practice

These study findings have added to our knowledge of the effects of stress and burnout among health care support workers. Previous research studies have reported that, unfortunately, every part of delivering care to patients can be compromised by burnout (Dyrbye & Shanafelt, 2011). When patients enter a health care center for care, the reception they receive often determines if they stay for treatment. If the front desk staff, are stressed and experiencing burnout, their greeting, reception, and registration service will not be as welcoming and supportive to new and returning patients. If Medical Assistants are stressed and experiencing burnout, patients will experience a triage process that feels rushed, insensitive, and uncaring. Stress and burnout can result in patients feeling unheard, hurried, and dismissed by staff. Stress and burnout can also result in employees disengaging from their important work, and even looking for employment in a less stressful work arrangement.

Intervention programs for alleviating the severity of stress and burnout can be classified into person-oriented, organization-oriented, or a combination of the two. Person-oriented interventions are designed to change the person's behavior, and they do not focus on improving the work environment, so they may not produce desired improvements in work related stress. (Valdut and Kallay)

The following recommendations for practice can benefit health care organizations, employees and patients. Enlist support staff to participate on project teams

or work teams that are responsible for seeing a project through from planning to evaluation. Engage workers on solutions teams that exist for a short period of time for the purpose of designing a solution to an organizational problem. Identify high performing employee delegates who serve as liaisons between senior management and employees for key communication initiatives. Develop a robust employee development strategy that engages workers in crafting a development plan for themselves while they also share learnings with the entire organization. Develop leader effectiveness through coaching clinics for managers, enhancing manager skills which are paramount to staff engagement. Identify employees contemplating turnover by conducting more frequent progress checks and feedback sessions during the course of the year. Engage employees in "stay interviews" to learn why they stay and how managers can help employees achieve better performance in their job role.

To effectively build and maintain employee engagement, employers must improve 2-way communication with employees and include workers in process improvement initiatives. Study findings also point to a relationship between stress and turnover intentions as well as burnout and turnover intentions. So, for employers to effectively manage turnover among this employee population, it would be beneficial for employers to develop and implement strategies and interventions to identify and reduce burnout in the health center environment. Employers need to provide individual and organizational burnout reduction strategies and interventions so that employees remain engaged in the delivery of caring, supportive, safe and quality healthcare.

The results of the study call attention to the need to invest in reducing stress and burnout and increasing employee engagement and retention among health care support staff. Just as stress and burnout cannot be ignored among physicians and nurses, stress and burnout have detrimental effects when they are present in the work environment for support staff. Burnout was shown to influence the relationship between stress and employee engagement, as well as stress and turnover intentions. Reducing burnout in the workplace can increase employee engagement and reduce employee turnover, both of which are vital factors to an organization's growth, success, and sustainability. Engaged workers are energetic and enthusiastic about the work they do and the care they provide to sick patients. Employees who choose to remain employed with the organization are committed to learning and growing with the organization, and save an organization enormous time, money, and effort backfilling vacancies. Patients who come to the health care organization for services encounter support staff who care, are committed, and apply their best effort toward helping patients receive the life-saving treatments they need and helping them achieve the health outcomes they deserve.

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