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Correlating Coworker Relations, Employee Involvement, and Leadership with Associate Commitment in Select Healthcare Companies Using a Mixed Sequential Explanatory Design

Kimberly Ann Lee
University of the Incarnate Word, kim.lee@txstate.edu

CORRELATING COWORKER RELATIONS, EMPLOYEE INVOLVEMENT, AND LEADERSHIP WITH ASSOCIATE COMMITMENT IN SELECT HEALTH CARE COMPANIES USING A MIXED SEQUENTIAL EXPLANATORY DESIGN

by

KIMBERLY ANN LEE-LAYTON

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Grace and modeling of the Holy Spirit represented my experience, learning, and journey at the University of the Incarnate Word. I found myself in a number of life challenges during my education here and with each challenge, Dr. Ettling, Dr. Henderson, Dr. Özturgut, my committee of Dr. Rauschhuber, Dr. Singh, and Dr. Antelo, and Mr. Duncan Hayse, among others, encouraged me and helped me continue my journey of transformation. You never gave up on me as a student. For that, I am forever indebted. I have evolved and am closer to God as a result of my experience and learning here.

As I neared completing Chapter 5, I received word that Dr. Ettling became ill. I visited her in hospice and was struck by the beautiful artwork and peace there. A beautiful metal art display filled one wall. It was a trunk of a tree with many butterflies of different colors fluttering about. The butterflies were of many different colors, shapes, and sizes. Some of the butterflies were embedded over the trunk and great limbs and others were dispersed away from the tree. I wondered which butterfly represented Dr. Ettling, which one represented Dr. Henderson, and even which one represented my grandmother. Certainly, the pink one at a distance was my grandmother. The bright orange one was Dr. Henderson as he always had a remark that was poignant, edgy, and made you think. And then there was a big beautiful one on the midst of the tree, spread among the branches and trunk with hues of pink and purple. That one surely represented Dr. Ettling as she had a grace, spirit, and peace about her that allowed her to make a

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wise statement among the many that guided and settled me. She had a way of influencing the trunk and the branches, as established as they were. I will always be thankful of Dr. Ettling and Dr. Henderson and the gifts they gave. I am appreciative. They taught me to be a better person.

When I learned of Dr. Ettling's strokes and that she was on hospice, I heard Aaron Neville sing one of my favorite songs, Schubert's (1826) "Ave Maria." As Dr. Ettling brought peace and grace to many of us here on Earth, blessed be peace with her now as she returns to our maker. She and her teaching have blessed me. I thank her and God now for her time and her gifts. She gave me so much of which I am forever grateful, and I will not forget.

As a teacher, I learned that students most need encouragement and coaching to see things differently, to learn, and to take on the challenge of education concurrently with whatever personal challenges may be occurring. I also found myself learning how to be a better and more accepting teacher in my own work environment. I cherish and honor everyone's story, as this is how I have been treated here at UIW. Gifts that Dr. Ettling and Dr. Henderson have given me will have a lasting impact on my life, my family, and also the students and adults of which I am honored to serve.

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Kimberly Ann Lee-Layton

CORRELATING COWORKER RELATIONS, EMPLOYEE INVOLVEMENT, AND LEADERSHIP WITH ASSOCIATE COMMITMENT IN SELECT HEALTH CARE COMPANIES USING A MIXED SEQUENTIAL EXPLANATORY DESIGN

Kimberly Ann Lee-Layton, PhD

University of the Incarnate Word, 2014

Increasing patient demands and decreasing reimbursement require better efficiency and effectiveness in health care systems and, subsequently, in health care teams. These environmental and societal factors are further complicated by the complex initiatives set forth by the Affordable Care Act (2010). In this study, the researcher sought to examine and identify the strongest variables of health care teaming and to explore resulting themes through the perception of groups of health care associates.

This mixed sequential explanatory design first examined the relationships between coworker relations, employee involvement, and leadership with associate commitment and with each other. An existing database of associate satisfaction survey data from a 4-year period for a health care organization of 7 different operating companies was utilized in the study. Pearson product correlation, multiple regression, and one-way ANOVA were included in the quantitative design. In the second phase of the study, the relationships between contributing variables were further explored through qualitative semistructured interviews with 9 groups of 75 associates from across the organization representing 4 commitment-level tiers.

Very strong to strong relationships existed between coworker relations, employee involvement, leadership, and associate commitment for all 4 years (*r* values of

$r = 0.80$ to $r = 0.53$) at a 99% certainty level. Leadership had the strongest relationship with and was the biggest driver ($\beta = 0.48–0.52$) of associate commitment for all 4 years. Leadership also exhibited a very strong relationship with coworker relations ($r = 0.75$) in the first year and strong relationships with both coworker relations and employee involvement in subsequent years. Coworker relations, employee involvement, and leadership accounted for 69.5% of the variance with associate commitment. Having friends on the team, trust in team members, making a difference, liking their patients and their jobs, flexibility with work schedules, feeling valued, and earning better pay and benefits emerged as qualitative themes relative to associate commitment. In addition, helping each other, spending time with each other, having mutual commitments, trust, and being dedicated to patients emerged as themes of effective teaming. Supplementary files provide coding detail for 16 focus group questions and responses.

Groups of associates spoke, first and foremost, about the "work family" and acknowledged the leader as the person who sets the environment and expectations and models the work family. This study suggests that leadership is a potential skill in every associate and that the leader serves to set the environment to support everyday leadership from the team collectively and from the team's individual members. The researcher hopes this study's findings may be a topic in future leadership and associate development, ultimately creating a more effective health care delivery team and system.

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Chapter 1: Introduction

Context of Research

Multiple sources have stated that a gray tsunami is upon us because a wave of aging Americans over the age of 65 will require increased care (American Physical Therapy Association [APTA], 2010; Barbarotta, 2010; Hobbs & Stoops, 2002; Lloyd, 2009). The problem is that while Americans are graying and requiring more services, the number of health care professionals is declining. Sources cite significant shortages of family care, general care, and oncology physicians, surgeons, nurses, therapists, and care attendants by 2016 and beyond (American Association of Colleges of Nursing [AACN], n.d.; APTA, 2010; Halsey III, 2009; Hobbs & Stoops, 2002; Lloyd, 2009). A smaller number of older Americans will be caring for a larger aging population with medical needs.

At the same time that this trend is occurring, reimbursement is declining at the federal and state levels. Medicare reimbursement for home care is predicted to decrease by 3% (Medicare Payment Advisory Commission [MedPAC], 2014 p. 219). Medicare reimbursement for long-term care is to decrease by 11.3%. The aging population heavily uses both home and long-term care, and declining reimbursement in these environments will emphasize the need for more effective use of resources translating to more effective teaming. Texas ranks second to last in the nation with Medicaid reimbursement to care for the aging and disabled population. Declining reimbursement challenges health care providers to be more efficient with resources. Equally important, health care teams must use efficient communication to prevent errors.

In addition to environmental, societal, and reimbursement demands, the implications of the Affordable Care Act (2010) require improved quality, efficiency, transparency, and integrity from health care providers and teams. Professionals, specialists, and providers are realizing the

opportunities and necessities of more coordinated and effective teaming to achieve the quality and efficiency targets set forth in the Affordable Care Act (Kocher & Adashi, 2011; Kocher, Emanuel, & DeParle, 2010).

Statement of Problem

Results from poor health care teaming include drug errors due to the miscommunicating and misprescribing of medications by multiple physicians, delayed decisions to do procedures because physicians and specialists do not communicate and physicians talking in complex terms and alienating the most important team members, patients and family members. Poor teaming causing ineffective and inefficient health care. This ineffective and inefficient health care comes when fewer health care team members exist to provide care and when teaming is most critical to care for an increasing number of patients. Identifying the environmental characteristics, the best practices and behaviors of a leader to facilitate teams and teaming, and how to alter environmental characteristics will assist in better health care provision through an improved teaming approach. This was my motivation to conduct this study.

Personal Background

The researcher has worked in the health care industry for 26 years, first as a physical therapist and caregiver and then as a teacher, consultant, health care administrator, and leader for 21 years. During these 26 years of practice, teaching, and leadership, the researcher has participated in the delivery of coordinated care through an intraprofessional team. The researcher has observed when teams work well together resulting in a positive outcome on patient care. The researcher has also observed environments in which teams do not work well, resulting in a negative outcome on the patient. Experience as a health care practitioner provides the observation that the need to work in teams is important and the observation that teams and

groups working well together promote outstanding outcomes. In the pursuit of knowledge and research related to what promotes a good teaming relationship in a health care organization, the researcher was motivated by wanting to obtain more concrete data to support targeted leadership and associate training and development in the skills and behaviors needed to promote quality intraprofessional teaming.

Purpose of Research

The primary purpose of this two-phase, sequential explanatory mixed design was to first examine the relationship between coworker relations, employee involvement, and leadership with associate satisfaction as perceived by health care associate work units in seven health care companies. These seven health care companies were part of a parent health care organization operating in 13 states. The rating on the three independent variables and the one dependent variable were included in a database gathered in a 4-year period from an established associate satisfaction survey (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010). The relationship between the independent variables and the dependent variable represented the primary purpose of this study's two-phase design. The secondary purpose was to examine the relationship between the independent variables. Information from this first phase was further explored in a second qualitative phase.

In the second phase, qualitative semi-structured interviews were conducted to explore what makes an environment conducive to teaming and team leadership as perceived by groups of associates in nine work units. Two work units from each of three tiers were selected to obtain aggregate data. Work units were selected to be representative of the seven different health care companies. The rationale for including a second phase of qualitative semi-structured interviews

was to better explain the relationships resulting from the quantitative survey results. The second qualitative phase assisted in better understanding possible unexplained quantitative relationships.

Qualitative group aggregate data were compared to and built upon characteristics of effective teams and team leaders as identified by Homans' group theory (Homans, 1950), Adair's leadership model (as cited in Thomas, 2008), and more contemporary work by Ancona (1992), Ancona and Bresman (2007), and Kouzes and Posner (2002). Studies show that health care teams have special characteristics and that group or team members expect team leaders to possess special attributes (Ancona, 1992; Cameron, 2005; Carpenter (2005); Clevenger, 2007; DeLoach, 2003; Hassan, Turner-Stokes, Pierce, & Clegg, 2002; Homans, 1950; Karsh, Booske, & Sainfort, 2005; Kirkman-Liff, 2004; Mulcahy & Betts, 2005; Robbins, 2001; Ryan-Woolley, Wilson, & Caress, 2004; Tempest & McIntyre, 2006; Thomas, 2008; Toofany, 2007; Van Norman, 1998; Whatmore, 1999).

Hypotheses

Coworker relations, employee involvement, and leadership have been identified by known authorities in the field of leadership and team theory to be similar to characteristics of effective teams (Ancona, 1992; Homans, 1950; Thomas, 2008; Robbins, 2001; Robbins & Judge, 2012). These same sources have identified that special qualities are required by team leaders to promote a conducive environment for their teams. Therefore, these particular variables were selected because they were identified as characteristics of effective teams and because of the researcher's hypothesis that a high correlation existed between these variables and associate satisfaction, also known as commitment to the organization for which associates work.

Thus, hypothesis 1 was that a strong relationship existed between the three independent variables of coworker relations, employee involvement, and leadership and the dependent

variable of associate satisfaction also known as commitment. Hypothesis 2 was that a strong relationship existed between each of the independent variables with each other. The hypotheses were based on characteristics of effective teams, characteristics of work environments leading to teaming, and the necessary qualities of a team leader as emergent of the function of teams (Ancona, 1992; Cameron, 2005; Carpenter, 2005; Clevenger, 2007; DeLoach, 2003; Hassan et al., 2002; Homans, 1950; Karsh et al., 2005; Kirkman-Liff, 2004; Mulcahy & Betts, 2005; Robbins, 2001; Ryan-Woolley et al., 2004; Solomon et al., 2004; Tempest & McIntyre, 2006; Thomas, 2008; Toofany, 2007; Van Norman, 1998; Whatmore, 1999).

Research Questions

Through observation of various teams, the researcher asked the following questions:

1. Is there a relationship between teaming and associate satisfaction in health care companies?
2. With different factors associated with teaming, does the associate satisfaction change?
3. What aspects of teaming most relate to associate satisfaction?
4. How does the style of the team leader impact associate satisfaction?
5. What are the perceptions of associates working on various teams representing different levels of commitment and from representative companies within the organization?

This study addressed possible answers to these questions through the collection of both quantitative and qualitative data from teams. If answers could be determined to these questions, future health care leadership education may more effectively be tailored for improved leadership

development. Furthermore, contemporary and future leaders must more quickly and flexibly adjust their styles of leadership to facilitate intracompany work teams as well as extracompany and intercompany work teams to better deliver to an increasing number of patients with complicated medical conditions.

Significance of Research

The study sought to better understand the relationships between health care group or team members and their perceptions of each other, of their environment, and of their leader. It was also of interest to identify the best suited behaviors and qualities of team leaders within the health care environment. By better understanding the perceptions and valued qualities of associates, health care organizations can better prepare and develop leaders to engage and support teams in the future. With the increasing need for health care efficiency, team supported delivery will be critical. Having prepared leaders to better provide the valued qualities as team leaders by associates, the more effective and efficient health care teams will be able to better deliver outcomes to a growing population requiring services.

Conceptual Framework

The investigation of variables and perceptions of environment fertile for teaming was best supported by a worldview of pragmatism. Creswell (2009) defined worldview as a general orientation about the world and the nature of research as held by the researcher (p. 6). Pragmatism is a philosophy or worldview that considers the research problem being best supported through assumptions of both quantitative and qualitative methodologies (Creswell, 2009, pp. 10–11; Creswell & Plano Clark, 2007, pp. 13–15). The pluralistic mechanisms of data collection in quantitative research, through the use of closed-ended surveys and then further explained through qualitative open-ended questions within the population, most provided

meaning and answers to the research problem on environment conducive to teaming. Using one or the other of quantitative or qualitative assumptions in isolation of the other omitted a rich and rigorous process and thus a full answer to the research problem. Pragmatism professes a mixed methods approach to draw upon the strengths of both the postpositivist and the constructivist assumptions to most thoroughly address the research problem in this study. Measurement of trends and objective data in the first phase were then further explored through focus group interviews conducted in the second phase in order to examine further the meaning and context of the survey responses (Creswell & Plano Clark, 2007, p. 175). Creswell and Plano Clark (2007) advocated the use of mixed methods research design as the best way to examine complex research questions as is represented in this study (p. 175).

The researcher first used empirical evidence in the form of survey research to draw from a postpositivist perspective. Closed-ended questions in the survey correlated the three independent variables of coworker relations, employee involvement, and leadership with the dependent variable of associate satisfaction. After data analysis in the first phase, a constructivist approach was used to explain the relationships between each of the variables as well as obtain further perspective from participants related to each of the variables. Obtaining a better understanding from groups of associates in their own words represented a constructivist assumption and worldview. The strengths of both the positivist and constructivist assumptions resulted in a more robust and thorough examination of the research problem. This was the essence of a pragmatic approach as the research problem is what is most important and not the assumption or grounding (Creswell, 2009, pp. 5–7, 10–11, 19; Creswell & Plano Clark, 2007, pp. 23–24, 26–27, 175).

Theoretical Framework

Homans' theory of human group behavior together with Kouzes and Posner's findings of team leadership were used to relate to teaming within the context of health care as well as the quality of associate satisfaction (as cited in Williams, 1998, pp. 43–44). Therefore, the approach integrated a macrofunctional social theory, an emergent social theory, and an exchange theory, as identified by Homans and other functionalists, together with team leadership theories developed by Adair, Ancona, and Kouzes and Posner (Ancona, 1992; Homans, 1950; Robbins, 2001; Thomas, 2008). The researcher applied and integrated the named theories to analyze and interpret data about health care companies and the perception of associates in health care companies together with associates' levels of satisfaction. Furthermore, the current study attempted to validate in current teams whether the perceptions by team members of activity, interaction, sentiment, and norms remained valid and consistent with previous functionalistic findings. This was accomplished through focus group interviews with various teams or work units throughout the organization in the second phase of the study.

Conceptual Definitions

Associate. Associate and employee were used synonymously. An associate or employee is compensated through a formal relationship with one of the six health care companies in the health care organization. When the researcher discussed the individuals who worked for one of the health care companies, she used the word *associate*. The word associate was the word of choice in the health care organization being studied. One of the independent variables and survey items was labeled "employee involvement." So when this variable was being discussed, the researcher used the word *employee*.

Health care companies and a health care organization. Seven health care companies or lines of business were contained within a parent organization. Two of the health care companies provided home care: one provided skilled home care delivery and met the reimbursement requirement of the federal Medicare program and the other provided nonskilled supportive care and met the reimbursement requirements of state Medicaid funding. One of the companies was a hospice program providing end-of-life care. One of the companies provided skilled residential assisted living and long-term care. Two of the companies provided ancillary services: one provided skilled rehabilitation care (i.e., physical therapy, occupational therapy, and speech language pathology) and the other provided pharmacy services. The organization also contained a service company that provided accounting, finance, payroll, information technology, human resources, and executive support to all the other companies. All the companies were housed within the parent organization and were connected through a united corporate mission, values, and culture. Services representing the seven companies were provided in 13 states during the last year of the associate survey.

Team(s). The health care teams in the selected organization most represented cross-functional teams. The team members represented various departments and work units coming together to accomplish a common goal (Borkowski, 2009, p. 324; Robbins, 2001, p. 261; Robbins & Judge, 2012, p. 309). The teams generally were interprofessional or interdisciplinary in nature. Robbins (2001) compared a team to a group through the presence of four criteria. Work teams have collective performance in goals, positive synergy between team members, individual and team accountability for results, and come together with complementary skills. He also identified work design, composition, context, and process as the four characteristics of effective teams (Robbins, 2001, pp. 263–269; Robbins & Judge, 2012, pp. 312–319).

The researcher composed a list of representative questions to extrapolate a more rich perspective from each subject in regards to the definition and the characteristics of successful teams. Contemporary investigators have substantiated the questions along with the comparison of the characteristics (Avlund, Jepsen, Vass, & Lundemark, 2002; Cameron, 2005; Cohrs, Abele, & Dette, 2006; Hassan et al., 2002; Tempest & McIntyre, 2006).

Interprofessional. In the past, there has been a delineation between *interprofessional* and *interdisciplinary*. Yet if the delineation and the selection of literature only on interprofessional teams were made, the literature review would be limited (Interprofessional team, n.d.; Van Norman, 1998). For the purposes of this research, the literature review encompassed literature including *teams* in the broad sense of the word (Team, n.d.). Through this research, the researcher attempted to delineate how the use of an interdisciplinary or interprofessional approach has facilitated improved associate satisfaction. Therefore, the terms interdisciplinary and interprofessional were used synonymously within the study as they have been used interchangeably in the literature. Herein represented the opportunity and significance of this research. There is little research that truly relates the difference between an interdisciplinary or interprofessional approach versus a multidisciplinary approach and that relates team leadership style to enhanced associate satisfaction.

Satisfaction and commitment. Associate satisfaction was also known as associate engagement or employee satisfaction or employee engagement (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010). The calculation of results in an online survey of all items represented associate satisfaction. Each of the 68 survey items represented one aspect of associate satisfaction. Seven of the survey items were most powerfully related to associate satisfaction or

engagement and these items are known as *commitment* items or indicators (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010).

Operational Definitions

Independent variables. Coworker relations, employee involvement, and leadership, terms coined by Morehead Associates (2007a, 2007b, 2008, 2009, 2010), comprised the antecedent or independent constructs in this correlational research. The three independent variables included the characteristics of effective teams as identified by Robbins (2001), Robbins and Judge (2012), and Borkowski (2009, pp. 332–333). Specific behaviors were defined and rated by associates on a 1 to 5 Likert scale. Employee involvement was identified through six survey items (No. 12, 19, 24, 28, 30, and 58). Coworker relations were identified through three survey items (No. 14, 17, and 26). Leadership was identified through seven items (No. 9, 16, 21, 48, 51, 56, and 63). Appendix A includes survey items and coding to independent variables: Independent Variable 1 (IV1) for coworker relations, Independent Variable 2 (IV2) for employee involvement, and Independent Variable 3 (IV3) for leadership. The column labeled "Rationale for Inclusion" identifies the team definition most associated with the particular survey items (Robbins, 2001; Robbins & Judge, 2012). Morehead's theme and the associated magnet recognition model component (American Nurses Credentialing Center [ANCC], n.d.) for each survey item are also included in Appendix A.

Dependent variable. Associate satisfaction or commitment, where "satisfaction" was specifically stated in the survey statement, was operationally defined as a dependent variable in the 5-point survey tool (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010) through 6 items (No. 6, 7, 10, 11, 13, and 49). Associate commitment, engagement, or satisfaction has represented an appropriate and relative outcome in health care as it has been shown to correlate

with more effective patient outcomes and patient satisfaction (Press Ganey, 2013). The survey items included to represent associate commitment are labeled as DV representing the dependent variable in Appendix A.

Overview of Methodology

The current research incorporated a sequential explanatory design, a type of mixed research design (Creswell, 2009, pp. 14, 19, 206–211; Creswell & Plano Clark, 2007, pp. 51, 72–73, 87, 106, 122, 143). A mixed methods sequential explanatory design contains two phases of research. Quantitative data were collected and then analyzed in the first phase of research. After quantitative data analysis, a qualitative data collection phase occurred and represented the second phase of data collection. The qualitative data built upon the first quantitative phase of data collection. Qualitative data were used to further give context and meaning to the relationships discovered from the quantitative phase. Also, any outliers or surprises in the quantitative phase were investigated using a constructivist approach in the second qualitative phase. Heavier emphasis was placed on the quantitative outcomes and data collection in a sequential explanatory design. The qualitative data were connected to the quantitative study and this was used to emphasize and explain trends in the quantitative results. The results from the qualitative data collection served to support or explain the quantitative results.

Application of sequential explanatory design to current study. In the first phase of this study, quantitative data were analyzed using a database of survey data collected over a 4-year period using a standardized survey tool. Data were analyzed relative to three independent variables, coworker relations, employee involvement, and leadership, along with a dependent variable, associate satisfaction. Correlation analysis was performed between the independent

variables and the dependent variable and also between each of the independent variables with each other.

Once quantitative data analysis was complete, the researcher used open-ended qualitative interviews in nine separate focus groups with six to 10 interviewees. The focus groups were volunteer groups and representative of each of the seven different operating companies within the health care organization. The focus groups represented one of three different quantitative tiers. The three tiers were designated according to level of commitment. The focus group interviews provided context and meaning to significant and insignificant quantitative findings, to outlier data and trends, and to demographic trends (Creswell, 2009, p. 181; Creswell & Plano Clark, 2007, p. 143). The researcher did not know the specific outlier or significant findings until the data analysis occurred at the end of the first phase. Creswell (2009) explained how the open-ended nonstructured interview provides additional perspective to the quantitative results thus explicitly addressing the research problem (p. 211).

The mixed methods research design, specifically the sequential explanatory design, was used because the design provided a more detailed explanation of the quantitative results in health care environments related to teaming than the quantitative results alone (Creswell & Plano Clark, 2007).

Research Assumptions

The first key bias was in the researcher's connection to the topic from her years of experience in the health care industry by serving on health care teams and observing them. The researcher has maintained an opinion that teams are good and lead to better patient outcomes. The researcher continued to acknowledge and guard against bias interfering with results.

In addition, the researcher had a long-term connection with the organization in which data was collected on associate satisfaction results. Certain companies and teams were known to be more conducive and supportive of teaming than others within the organization. The researcher guarded against projecting past experiences and observations onto the group interview data.

Limitations and Delimitations

The implications from the results of this study were limited to the health care industry. One cannot extrapolate results beyond the industry of health care. The data and results have limited external validity or generalizability to other populations because they were collected at one point in time in uncontrolled conditions. Because data were collected in a dynamic and changing environment, the environment and conditions in which data were collected could not be controlled, limiting internal validity (McMillan & Schumacher, 2001, pp. 167–170).

Extraneous variables not measured or studied may have interfered with the results involving the dependent variable. The target and sampling populations were fully described through the use of demographic variables. This thorough description served as a delimiting factor. Length of service, shift work, gender, age, job classification, racial origin, and employment status were included to more specifically delineate the sampling populations (Creswell, 2008; McMillan & Schumacher, 2001).

Several limitations occurred through the use of focus group interviews in the second phase of the study. Creswell (2009) highlighted some common limitations of group interviews, which were considered in this study (p. 179). The data and interview responses were the perceptions of the groups of associates and were influenced by their personalities and previous experiences. The interview setting was not a natural team setting and was dependent and influenced by the participants' moods and potentially influenced by other experiences on the day

of the interview within the work setting. The researcher's presence in the interview may have also influenced the participants' answers and openness. Because the participants were volunteers and not known for their level of articulation coming into the interview, some participants were more extroverted in their participation than others.

The interviews were recorded and transcribed at a later time. In this way, key trending, including overall observations and coding of words, occurred more objectively than recording the more extroverted comments only. Trended and most frequently cited phrases and words were combined and considered from all the focus group interviews. In this way, moods and other influences were attenuated. The informed consent explanation and process decreased participants' angst with the researcher and their impulse to fabricate answers that they thought the researcher may have wanted to hear. The researcher also used an outside source in the field of survey and interview research to engage in a more reflective dialogue throughout the study.

Chapter 2: Review of Literature

Introduction and General Literature Characteristics

The literature review included a theoretical perspective with further support of theory through the discussion and analysis of peer-reviewed articles from the health care industry on the elements of teams. The researcher selected literature from a variety of sources for purposes of research into teaming, team leadership, and associate satisfaction. Significant works have been referenced as resources on theory (Ancona, 1992; Homans, 1950), on group dynamics and leadership (Williams, 1998), and on methodology and procedure (McMillan & Schumacher, 2001). A variety of non-peer reviewed electronic resources and reference materials have helped delineate interprofessional and multidisciplinary teaming as well as the definition of groups (Group, n.d.; Interprofessional team, n.d.; Multidisciplinary team, n.d.; Van Norman, 1998). Moreover, the researcher utilized presentations and privately published materials on the survey tool instrumentation (Corrigan & Douthitt, 2007; Morehead Associates, 2007a, 2007b, 2007c, 2008, 2009, 2010).

Theoretical Evolution of Research on Teaming and Teams: George Homans

A study in teaming and relationships on health care teams must be grounded in historical theory. In early group behavior literature, teaming was not differentiated from groups. Theorists in sociology provided grounds for discussion of group behavior, and group behavior was discussed as an organic phenomenon. Evolution of group behavior and leadership behavior within groups then evolved into more contemporary studies in team leadership functions. In this chapter, the researcher includes an introduction to group behavior and dynamics based on sociological theory and then incorporates more contemporary leadership theory.

Functionalism evolved in the 1940s and 1950s and has been a dominant theory in sociology. Two veins of functionalism, macrofunctionalism and microfunctionalism, have existed with precursor theoretical origins. Macrofunctionalism has focused on society as a large unit, whereas microfunctionalism has focused on small-scale systems and then group dynamics, the relationship within groups and societies (Martindale, 1960, pp. 464–466). Macrofunctionalism originated from sociological organicism, which was founded at the turn of the 19th century, and also from functionalistic anthropology. Microfunctionalism, on the other hand, originated from Gestalt psychology.

Sociological organicism, a positivist perspective, presented society as a system made up of integrated and interdependent parts forming a unique whole. Society as a whole has been compared to an organism, with a life of its own. Some theorists described the social system as constantly striving for equilibrium with the environment, creating an ebb and flow of internal and external components (Martindale, 1960, pp. 446–450). The scientific method was also applied to describing society in objective terms and as a process. The application of the scientific method to theoretical conclusions represented a positivist perspective in grounding the field of sociology. Society was described in terms of "structure," "social organization," "social order," and "function" by the positivist organicists (Martindale, 1960, p. 466). Vilfredo Pareto was a well-known sociological organicist who presented society as a system of equilibrium and dynamic interaction from internal and external components.

The study of past societies or extinguished tribes and how their societies functioned as systems and processes occurred within anthropology, occurring simultaneously as the social organismic movement. Ethnology was focused on the common elements and evolutionary search

for origins of societies. It has been written that sociological functionalists have identified anthropological functionalism as their origin for functionalism (Martindale, 1960, p. 454).

Macrofunctional theorists have tended to start with large-scale systems and then break down group dynamics, thus converging with microfunctionalism. And microfunctional theorists have tended to start with small-scale units and expand their theory to the larger society as a whole. Thus in the 1960s and 1970s, functionalism merged in the literature.

Functionalism, in terms of sociological theory, has been defined as an "interpretation of social interaction from a standpoint of functioning as an activity that is system produced" (Martindale, 1960, p. 520). The definition has three key elements:
(a) function is a useful activity fulfilling a need or serving a purpose, (b) function is an appropriate activity, and (c) function is system-produced and system-maintained. Functions have been described as parts, elements, aspects, or phases of an organism-like unit of people or society. And functionalists have described and related the various aspects of societies or smaller groups as making up a whole of the society and characterizing the society (Martindale, 1960, pp. 520–521).

One of the noted macrofunctionalist theorists was George Homans, a Harvard generated sociologist and professor. Homans wrote in the 1950s through the 1970s. He was one of the original Harvard Business School researchers who first identified the Hawthorne effect in the Hawthorne Studies from 1924 through 1933 at the Hawthorne plant of the Western Electric Company (as cited in Dunn, 2010, p. 30). His peers, as was evident through some of their quotations, respected him. Martindale (1960) noted, "because of its thoroughness, if for no other reason, Homans' work undoubtedly remains as one of the most effective statements of the functionalist theory" (p. 477). Martindale was referencing Homans' book, *The Human Group*

(1950). Robert Merton, a noted fellow macrofunctionalist, also wrote about Homans' work in the following manner: "not since Simmel's pioneering analysis of almost half a century ago has any single work contributed so much to a sociological theory of the structure, processes, and functions of small groups as George Homans' *The Human Group* (as cited in Martindale, 1960, pp. 478-479).

In *The Human Group* (1950), Homans developed general functionalistic theory through the careful and scientific analysis of five groups within society. He specifically induced theory and general principles of group and leader behavior through the analysis of these five different groups. The first sentence of Homans' (1950) book reads, "In this book we shall study the most familiar of the most familiar thing in the world—the human group" (p. 1). He defined the human group as a small group of individuals who communicate with each other over a span of time through face-to-face interaction. Homans asserted that small groups have provided the very backbone of society and human civilization (Homans, 1950; Martindale, 1960) and have been overlooked in the formation of sociological theory and foundation. Homans related to his readers as a teacher in that he posed the reflective thought that all individuals first know how to function in society and communities through their first interactions in small groups.

As previously mentioned, Homans (1950) studied five small groups: a team of workmen in a manufacturing environment, a metropolitan street gang, a tribe of Pacific Islanders, a small New England town, and a group of employees in an electrical equipment manufacturing plant. All of these groups formed with specific purposes and possessed certain similar characteristics, even though they were all different. Homans speculated that small groups have always survived when larger organizations have not withstood drastic change. He also speculated that

characteristics of small groups could be extrapolated to larger groups, with small groups representing basic social units.

Homans looked at group behavior in terms of activity, interaction, sentiment, and norms. Activity represented the primary focus of the group. Interaction represented the relationships between the members of the group. Sentiment represented the feelings of members within the group to the group's output and activity. And norms represented the code of behavior within the group. The group was defined to function as a social system. (Homans, 1950; Martindale, 1960).

In addition, Homans (1950) elaborated how individuals in groups form relationships and affinities for each other through common tasks, commitment, and frequency of interaction. The more frequent interaction for a longer period, the more affinity formed and with more affinity and purpose, the more production occurred. Homans found that there was a mutual dependence between activity, interaction, sentiment, and norms of the group. In this way, Homans addressed motivation theory in why group members stay together and like working in teams (as cited in Ancona, 1992).

Homans (1950) also studied how the internal group function impacted the external environment and vice versa. Homans identified physical, technical, and social aspects of the external environment. He made the premise that the internal system of the group and the external system of the environment are mutually interdependent and in an ebb and flow. Thus Homans concluded this interdependency to be a dynamic system in equilibrium (as cited in Martindale, 1960).

Homans (1950) further established that group behavior and products "emerge" as unique byproducts of a whole organic being, a collection of individual contributions, yet with a unique outcome all to its own (pp. 271–272, 447–448). Homans described this organic emergent

behavior of the group as arising involuntarily to serve as a function to propel the group's output further. The emergent group behavior serves to provide a means for survival for the group within the environment (Homans, 1950, p. 271). The emergent group behavior helps the group not only adapt but to further its effectiveness and impact on the environment. Morale, leadership, control, and extension of control have been described to emerge from the group as group behavior to help the group or society further develop and thrive (Homans, 1950, p. 272). The degree in how these byproducts or behaviors emerge is dependent by the forces of the external system or environment (Homans, 1950, p. 447).

Furthermore, others noted Homans was unique for his development of the exchange theory, which is related to groups and group behavior (Ancona, 1992; Gouldner, 1970). Gouldner (1970) described that Homans highlighted how humans in groups or teams receive "gratification" through social exchange and that social values emerged as norms of group behavior and societal behavior (pp. 140, 395–396). Gouldner (1970) also emphasized that through social exchange theory, group or team members not only seek gratification, but they also thrive on it and use it to build societal norms, values, and systems.

In his observation and study of group behavior, Homans (1950) described how groups are dynamic, interacting with the external environment, and ever changing and evolving. Thus Homans (1950) acknowledged how groups need special qualities in leaders (pp. 423–430). He described in his writing that group leaders need to be flexible to serve the changing dynamics of the external environment and facilitate, in essence, the individual characteristics of the group to help the group produce productive outcomes.

Homans (1950) wrote and connected with his audience through "intellectual passion" in the topic of group behavior (p. 2). He said, "Either you are so interested in a subject that you

cannot let it alone, or you are not" (p. 2). It is this same intrigue that the current research study is founded.

Importance of Team Leadership: George Homans

Leadership was a natural evolution in group dynamics. In fact, leadership sustained and helped form group behavior. Homans (1950) laid the groundwork in his delineation of 11 guidelines for group leaders to maintain stability within the environment and with changes (pp. 423–430). Homans (1950) coined the term *moving equilibrium*. He also clarified that the rules did not apply in all situations; rather, he was specifying guidelines. In this way, Homans' disclaimer supported later work by Hersey and Blanchard on situational leadership.

According to Homans (1950), first, the leader should maintain his or her position as leader of the group. Without maintenance of credibility as a leader, group members do not take the orders or directions of the leader seriously. The leader maintains his or her authority through established credibility. And members follow the leader without a benefit of doubt dependent on the amount of credibility. The distance within which the team members will follow orders without question is noted as the *zone of indifference*. More credibility of the leader increases the zone of indifference. Leaders new to a group may do best to delay in delivering orders until credibility is established with the group (Homans, 1950, pp. 425–426).

Second, the leader should live up to the standards of behavior of the group, as he is foremost a member of the group. The leader must set an example and model what he or she orders as described in rule one. In his description of the second rule, Homans (1950) emphasized the "Golden Rule" in that the leader must treat his group members the way in which he or she would want to be treated. Homans established the foundation for a later leadership theorist, Robert Greenleaf in the 1970s, by emphasizing that the leader must take care of his members and

watch out for them, a key concept of servant leadership. The leader is also expected to be fair and just in his leadership behavior (Homans, 1950, pp. 426–428).

The third, fourth, and fifth rules pertain to the group leader acting and giving direction to the group. The third rule emphasized that the leader must originate and act to maintain his or her position as group leader. He or she must be the person in the group to act first and decide. Next, the leader should not give orders if he or she does not expect the group to follow them. Homans (1950) pointed out that if a leader provides direction that is not followed, his or her position as leader is lowered. And in giving orders, the leader is to use a chain of command to implement direction. Homans emphasized that the leader must support and provide access to his or her direct reports in the group. The leader must allow the direct reports to enact the orders he or she provided to them. And if new to the group, the leader is to take time to determine the best individuals in the group to deliver his or her message as opposed to acting prematurely (Homans, 1950, pp. 428–431).

Sixth, the leader is to not "thrust himself or herself" upon his followers on social occasions (Homans, 1950, pp. 431-433). Homans (1950) explained that the group members immediately resort to looking to the leader in social contexts and if the leader does take the lead socially, this will destroy the natural spontaneity and relationship between group peer members. Also, the boundary of separation between work and personal life deteriorates when the leader attends social events with followers. The leader that imposes him or herself on others at social gatherings might also risk embarrassing him or herself and/or group members (Homans, 1950, pp. 431–433).

Seventh, Homans (1950) outlined that the group leader is not to publically blame or excessively praise a group or team member in front of the other group members.

Homans explained that publically blaming a group member defeats the individual's esteem and also lowers his or her own reputation and credibility in the minds of the other group members. Homans further explained that private praise is recommended over excessive public praise. He described that occasional public praise is acceptable, but if taken to the extreme or used too frequently, it can embarrass the team member (Homans, 1950, p. 433).

Eighth, Homans (1950) outlined how a group leader considers all the aspects of a situation in helping the cause of the group; the leader must consider the total situation. The group leader builds on success to build further authority, credibility, and group effectiveness. The group leader must consider the dynamic equilibrium of the internal system of the group and all the contained aspects along with the external environment because a change in one of the elements within the group or a change in the external environment can affect all the other internal system components. Homans discussed how leaders have made fatal errors because they did not consider all aspects of the situation, both internal and external. He also made the point that Americans more customarily have been taught to look externally much more so than being astute to the internal system dynamics (Homans, 1950, pp. 433–435).

Ninth, Homans (1950) discussed the preference of the group leader creating a culture of group discipline as opposed to the leader punishing group members. When mistakes occur, the leader is to focus primarily on identifying system breakdowns and on problem solving in concert with the group member(s) on how to prevent future mistakes. In this way, the leader fosters group and self-discipline as opposed to imposed punishment or humiliation. The leader fosters self-discipline as a norm in this way. Homans (1950) ended this section with the statement, "leave the group alone!" (p. 437).

Tenth, the leader is to listen to his or her group. He or she is to recognize both formal and informal communication mechanisms and use these mechanisms. He or she is to create an environment of openness to receive feedback from group members. He or she is to not assume that communication will naturally happen and must seek it out with his or her followers. And Homans (1950) acknowledged that when communicating with the group, the hardest thing for a leader to do is to listen and not talk, and yet this is most necessary. Listening indicates to the team that the leader cares and is interested. However, the leader must also accept the feedback and communication provided by the group members. By listening and accepting, the leader will see problems and processes more clearly, a key step in providing guidance for an effective direction to the group (Homans, 1950, pp. 437–440).

And finally, Homans (1950) directed that the leader is to know him or herself. This was delineated from the perspective that the leader is the greatest threat to the positive moving equilibrium of the group. The leader has a tendency to dominate, so he or she must work to be silent and attend to the norms of the group. He or she is to be a servant leader to the group and group's purpose. Homans (1950) ended the section on this final guideline by stating, "Self-knowledge is the first step in self-control" (p. 440).

Homans' (1950) 11 guidelines for a group leader provided a basis for more contemporary theorists and researchers to further provide models and guidelines. Homans also specified that even though similar characteristics existed of all groups, he reinforced throughout his writing how generalizations about groups in all situations could not be concluded. He thus delineated how group behavior was situational in nature, setting the stage for Hersey and Blanchard's work on situational leadership.

John Adair's Model of Leadership

Adair's three-circle model, which has been the core of all of his work, is consistent with Homans' work and guidelines (as cited in Thomas, 2008). Three overlapping circles represent Adair's model of leadership (see Figure 1). The leader's role is to achieve a task or give purpose to the team, build and maintain the team, and develop the individual. Each of these roles focuses on needs. Each of the roles or functions overlaps and impacts the other functions. As the team achieves the task, the team is further established and also meets individual needs. Team performance impacts the purpose of the team and also impairs individual satisfaction. A decrease in meeting the individual needs impairs the team and will also likely impact the performance and productivity of the team (as cited in Thomas, 2008, pp. 136–137).

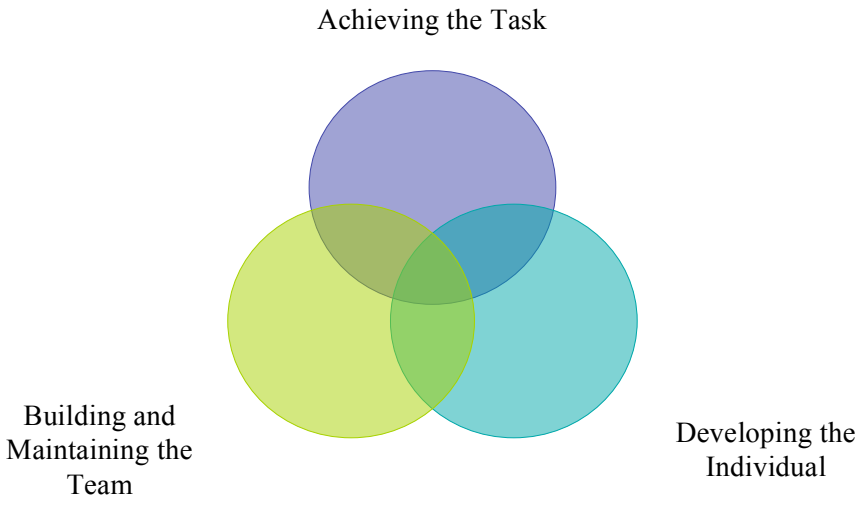

Figure 1. Three primary roles of a leader.

Contemporary Theorists

Ancona has spent her academic and research career researching teams and team leadership behavior. She has written favorably of Homans and has used some of his basic theories to further launch her work (Ancona, 1992).

Kouzes and Posner have emphasized that progressive leaders must facilitate groups and teams to obtain results in an ever- and rapidly-changing world (as cited in Williams, 1998, pp. 43–44).

Efficacy of Interprofessional Teaming in Health Care

Literature regarding teaming, team leadership, and associate satisfaction have clustered into three broad categories. Nine qualitative studies, four qualitative studies, and one meta-analysis of literature comprised the peer-reviewed articles in the three broad categories. Significant results have been presented in each of the three broad categories.

Efficacy of the interprofessional team approach in the treatment of specific diagnoses. Much of the health care literature pertaining to the team approach has addressed how this approach has improved the care of patients with certain specific diagnoses. Many of these diagnoses have been in the realm of neurological rehabilitation, possibly due to the complexity of the diagnoses involved. The complexity involved has required a teaming of skilled experts to join intellect to best care for these patients. The efficacy of the team approach in the treatment of patients with strokes (Tempest & McIntyre, 2006), with hip fractures (Cameron, 2005), and with brain injuries (Hassan et al., 2002) has been demonstrated in the literature. Avlund et al. (2002) presented how the team approach has been beneficial with outcomes with the elderly population.

The team approach served to improve outcomes, benchmarks, and service according to various authors. The team approach improved communication, assisted to clarify team roles, and enhanced service provision according to Tempest and McIntyre (2006). Cameron (2005) associated the interprofessional approach to decreased rehabilitation time and length of stay, both critical in showing efficacy and efficiency of rehabilitation. Carpenter (2005) presented how interdisciplinary communication serves to bridge the competencies and responsibilities between

healthcare team members. Avlund et al. (2002) further reinforced the efficacy and efficiency through improved functional levels at discharge for patients. Hassan et al. (2002) showed how the interprofessional approach improved standards of documentation due to all disciplines reading other disciplines' documentation about a patient and his or her care. The interprofessional team approach has long been associated with better care in the rehabilitation environment as has been evident through this recent literature review.

Factors related to associate satisfaction. The following three studies investigated which determining factors were related to associate satisfaction. DeLoach (2003) studied job satisfaction with hospice interprofessional team members. Karsh et al. (2005) studied job satisfaction with nursing home team members. And Cohrs et al. (2006) studied graduate mathematics students. All the studies were quantitative and one included a mixed methodology design.

All studies showed how supervisory support related to associate satisfaction levels. In the same leadership vein, Cohrs et al. (2006) showed that a participatory leadership style was one of the most important determining factors of associate satisfaction. DeLoach (2003) found teaming was also directly related to associate satisfaction. Surprisingly, teaming was considered to be an indicator of culture in two studies: Mulcahy and Betts (2005) and Ellis and Gates (2005). Thus, indirectly, culture was implied to be related to associate satisfaction as well. In addition, DeLoach (2003) and Cohrs et al. (2006) related affinity with other team members to associate satisfaction. All of these studies and their findings have coincided with the human group theory as posed by Homans (1950).

Consistency occurred in the literature relating role and tasks to associate satisfaction. DeLoach (2003) found that role ambiguity, role conflict, task significance, and degree of routine

repetition related to associate satisfaction. Autonomy and ability to function independently was found to be one of the most important in determining satisfaction (Cohrs et al., 2006; DeLoach, 2003).

Teaming was considered to be an indicator of culture in two articles (Mulcahy & Betts, 2005 and Ellis & Gates, 2005). Thus indirectly, culture was implied to be related to associate satisfaction.

Value of team building on associate satisfaction. A group of qualitative articles related team building to associate satisfaction. Clevenger (2007) presented material to support team-building retreats as a means of enhancing team relationships and communication. Clevenger also found that team building paired with professional education in the health care arena was determined to be more beneficial. Toofany (2007) found with nurses that a team-building leadership style increased associate satisfaction. Solomon, Ohman, and Miller (2004) provided evidence that relationships with coworkers reinforced physiotherapists' satisfaction with career choice.

In reviewing the literature, neither comprehensive nor conclusive results nor conclusions have been evident relating to interprofessional teaming, team leadership, and associate satisfaction in an organization with such diversity and volume. A lack of research in the topic area has been evident in the United States.

The researcher found a void within the current body of research studies including mixed methodology as proposed in this paper. Thus a rich opportunity existed to further the body of knowledge with this study. This study specifically shows that both team interactions within their internal and external environment and team leader facilitation skills do relate to associate satisfaction within various work units and companies within a diverse health care organization.

Additional literature relative to the results and implications of the study is referenced in Chapter 5.

Chapter 3: Methodology

Introduction

The purpose of this two-phase, sequential explanatory mixed design was to first examine the relationship between coworker relations, employee involvement, and leadership with associate satisfaction (also known as commitment) as perceived by health care associate work units in seven health care companies. Information from this first phase was then explored further in a second qualitative phase. In the second phase, qualitative semistructured interviews were conducted to explore what makes an environment conducive to teaming and team leadership as perceived by groups of associates in nine work units. The sequential mixed design was selected because, according to Creswell (2008, 2009), the design helps the researcher fully explore the possible relationships between variables as identified in the first phase of the study. The sequential mixed design is also used to study complex relationships (Creswell, 2009). The perception of teaming (Robbins, 2001) is related to certain identified elements of employee involvement, coworker relations, and leadership, but the full extent of specific attributes has not been fully identified. This was the rationale for first exploring the relationships between the three independent variables with the dependent variable of associate commitment and then more fully exploring the perceptions of staff from three different tiers of data on the qualities of teaming.

This chapter provides more rationale on the use of the sequential mixed design and more details of the components of the quantitative phase and the qualitative phase. The setting, population, instrumentation, data collection, and data analysis are first described for the quantitative phase. Then the setting and rigor for the qualitative phase is provided in detail. The selection of participants follows the description of each phase.

Research Design

The researcher applied the positivist or quantitative research approach in the first phase of the study, which examined the relationship between coworker relations, employee involvement, leadership, and associate commitment. A qualitative component employing the constructivist paradigm was applied following the quantitative analysis through the use of open-ended interviews with groups of associates to explore associates' perceptions of teaming and team leadership (Creswell & Plano Clark, 2007, pp. 71–74). The qualitative component of the study provided additional insight and explanation to the quantitative results, representing an explanatory sequential design.

Rationale for use of sequential explanatory mixed design. The single study design was primarily quantitative with a qualitative component. An explanatory sequential design was utilized to explore the research questions. Creswell and Plano Clark (2007) promoted the use of such a design to provide a more clear understanding of quantitative research through a qualitative clarification of problems. As is the case with this study, using an explanatory sequential design versus a quantitative component alone provided more clarity (Creswell & Plano Clark, 2007, pp. 5–7).

By employing the qualitative component in this study, it was possible to fully explore empirical data and relationships as well as the reality of the individuals most closely related to the team and the team's dynamics, processes, and output. A more holistic and well-rounded view of the research questions and problems was understood with the addition of the qualitative component. The attributes of qualitative insight was employed to further explore the relationships resulting from the quantitative analysis, which led to more comprehensive results as described by Creswell and Plano Clark (2007, pp. 9, 11, 71–74).

Flow diagram of research design. Figure 2 shows the two-phase, sequential explanatory mixed design. The flow diagram shows the phases of data collection and production.

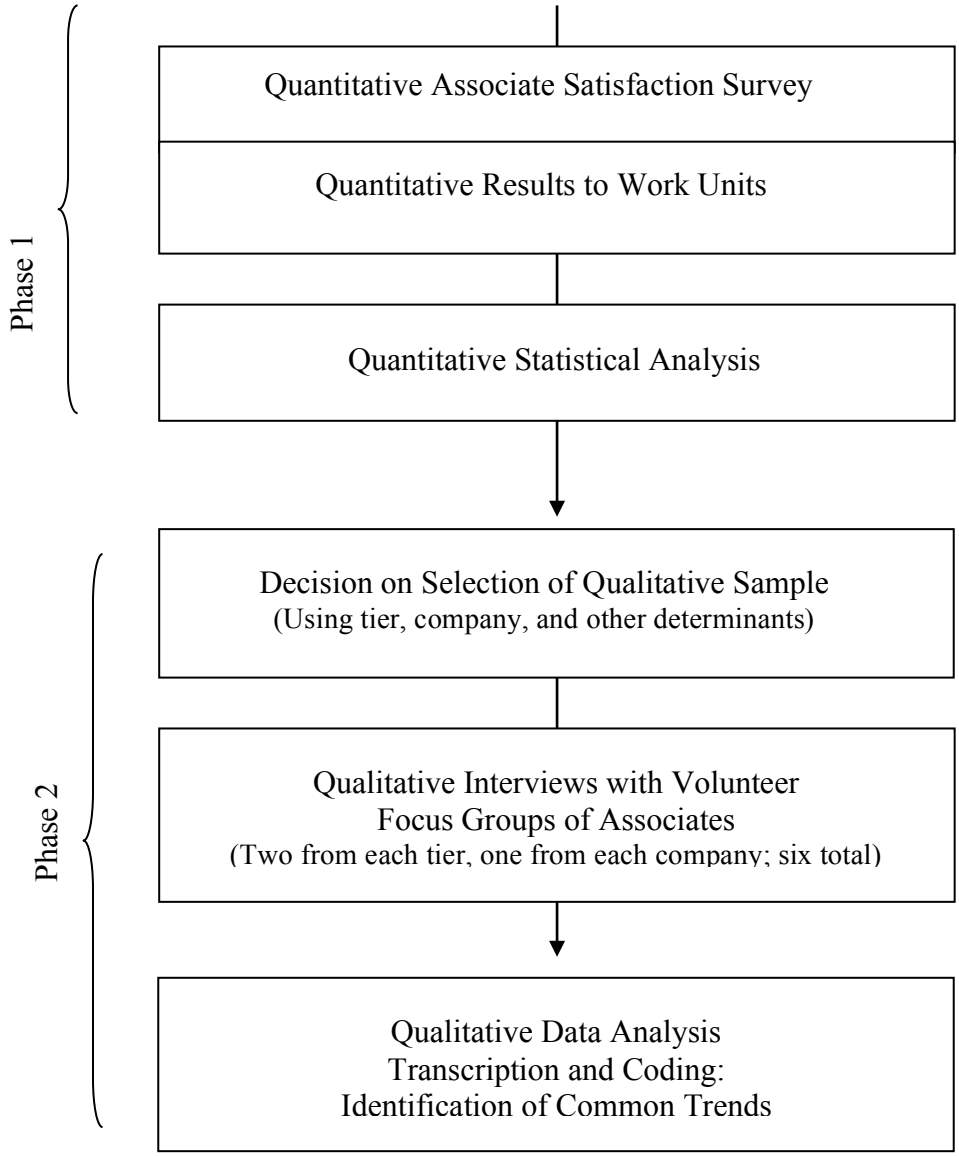

Figure 2. Flow diagram of the research process: Sequential explanatory design.

Quantitative Study: Phase 1

Setting. The health care organization comprised the following: (a) two divisions of home health: one skilled home care in delivery and one nonskilled supportive in delivery; (b) one hospice company; (c) one contract-rehabilitation company; (d) one pharmacy company; (e) one

long-term company, including nursing home and assisted living sites; (f) one nurse practitioner company; and (g) one support services company within a health care organization. The long-term care and nurse practitioner companies were only represented 1 year, 2010, in the database. Participants represented 13 states within the United States.

Population and sample. The population included full-time and part-time health care workers or associates from the seven different health care companies within a health care organization. The participation in the associate satisfaction survey was voluntary and informed consent was included in the survey. Table 1 shows the sample size of associate satisfaction surveys for each year within the database. The population and data in the survey database were conveniently selected from a preexisting organization (Creswell, 2008, p. 155).

A sample size striving for a 99% confidence level with a margin of error of .01 was used for each year of data within the database. Having an abundant sample size for all years of the data collection increased the confidence level, exceeding the recommended 95% confidence level. This was done to increase not only the validity of the study but also the likelihood that the interval of sample data truly represented the parameter being studied and the population (Creative Research Systems, n.d.; Kitchens, 1998, pp. 426–431; McMillan & Schumacher, 2001, pp. 177–180). A sample size of 6,018 survey responses was used from 2007; 2,226 survey responses were used from 2008; 2,151 survey responses were used from 2009; and 3,243 survey responses were used from 2010. One survey existed for all full-time and part-time associates in 2007 and all survey questions were included, accounting for 6,018 data points for that year. In 2008 through 2010, per the request of company presidents, a shortened survey lacking the items on coworker relations was administered to part-time associates. As a result of the shortened

survey to part-time associates, the valid *N* or number of data points for 2008 through 2010 for coworker relations was reduced, although still adequate for 99% confidence level.

Table 1

Sample Size From 4-Year Database of Associate Satisfaction Surveys

Year	Valid *N* in database for EI, L, and Comm	Valid *N* for CR variable [a]	Companies included	No. of work units
2007	6018	6018	Community care, Home health, Hospice, Rehab, Pharmacy, Services (6)	151
2008	6789–7138	2226	Community care, Home health, Hospice, Rehab, Pharmacy, Services (6)	129
2009	6187–6451	2151	Community care, Home health, Hospice, Rehab, Pharmacy, Services (6)	166
2010	7995–8215	3243	Community care, Home health, Hospice, Long-Term care, Nurse practitioner, Rehab, Pharmacy, Services (8)	249

Note. EI = employee involvement; L = leadership; Comm = commitment; CR = coworker relations. One survey version existed in 2007, so the valid *N* is the same for all variables. Two survey formats existed in the years 2008–2010: one longer survey format for full-time staff and a shorter condensed version for part-time team members.
[a]The survey items on coworker relations were not included on the shorter condensed version; thus, the valid *N* is smaller for that variable in the years 2008–2010.

Return rate. The return rate was tracked for full-time and part-time associates and for all versions of the survey (see Table 2). The return rate ranged from 60% to 86% for full-time associates and the combined return rate for all associates, including full-time and part-time associates, ranged from 27% to 31% from 2007 to 2010. The return rate for part-time associates ranged from 9% to 11% for the 4-year period.

Criteria for selection. The health care organization's database, containing associate satisfaction data, was used for the study from 2007 to 2010. The researcher obtained permission

from the organization's CEO to access and use the proprietary, collective, and anonymous database (see Appendix B). The research sample was represented in proportion to the size of the population and companies represented. The sample size for each year of data exceeded 95% confidence level. A sample size of 1,067 for each year of data was required to assure a 95% confidence level with a margin of error of .5. The confidence interval indicated for this confidence level was ± 3. The sample sizes in the database for each year met a 99% confidence level with a margin of error of .1. The confidence interval was ± 2.78 (Creative Research Systems, n.d.; Custom Insight, n.d.; Kitchens, 1998; McMillan & Schumacher, 2001).

The sample included data from all companies, all states, all tiers, and all demographic segments including position, length of service, employment status, gender, shift work, ethnic background, age, job classification, and work history. The researcher used nonprobability, purposive sampling as delineated by Babbie (1990, 2s014). All completed data were utilized, proportional to the company size, and fully representative of demographic differences. Because each of the companies varied in size, in number of associates, and in demographic and

Table 2

Return Rates for 4-Year Database of Associate Satisfaction Surveys

Year	Full-Time associate return rate	Combined full-time and part-time associate return rate
2007	64%	27%
2008	60%	31%
2009	99%	30%
2010	86%	27%

Note. Return rate was recorded and tracked for associates with full-time and part-time work status. The combined return rate was inclusive of all associates with full-time and part-time work status.

geographical differences, it was important that the sample sizes be proportional and fully representative of the companies for which they represented. In addition, the researcher desired to fully explore the perceptions of all segments of the sample population. (Babbie, 1990, p. 97; Babbie, 2014, p. 194; Creswell, 2008; Creswell, 2009; Creswell and Plano Clark, 2007, pp. 111, 119–120; Custom Insight, n.d.; McMillan & Schumacher, 2001, pp. 173–179).

Instrumentation. The survey tool as designed by Morehead Associates (2010) was used in generating the 4-year database. The tool has been used for over 27 years with over five million responses across various industries. Screen prints from the online survey tool are shown in Appendix C. Content validity was assured by a panel of experts and pretested on associates from various companies to assure accuracy of test.

Regression analysis was applied throughout the history of the tool to indicate a grouping of related survey items and these highly correlated survey items were grouped into three domains. Regression analysis resulted with the organizational domain to have shown the greatest impact on associates' satisfaction, having a regression coefficient of 0.64. Regard for associates, work-personal life balance, fair compensation, growth and development, citizenship, unity, and quality or customer focus represented survey items in the organizational domain. Manager domain and employee domain resulted, according to Corrigan and Douthitt (2007), in showing less influence on associate satisfaction with regression coefficients of .10 and .14, respectively. Thus one could conclude from these statistics that organizational culture has the most influence on associate satisfaction. This study more specifically looked at the manager and employee domain items related to teaming and the perception of teaming and team leadership by the supervisor or manager and correlating those items with associate satisfaction.

Pertaining to reliability, the alpha coefficient for standard items was 0.93, which indicated a high degree of internal consistency between survey items. Items grouped according to themes displayed an alpha coefficient level of 0.85 to 0.97, indicating a high degree of reliability according to themes. The current study further explored, both quantitatively and qualitatively, the influence that the organizational domain and the manager domain have on associate satisfaction. The tool served as a sound tool with a long-standing presence serving to reinforce valid and reliable construct. Since the use of the tool with a solid 27-year history of credibility, Press Ganey acquired Morehead, and the tool has been integrated into another gold standard in the associate survey market space.

The data resulting from the administration of the associate satisfaction survey provided by Morehead Associates (2007a, 2008, 2009, a2010) was utilized. Data had been collected for 4 years for the purposes of improving the organizational, managerial, and local work unit environments. The survey was selected in comparison to five other associate satisfaction survey companies through a consistent process of comparison on
21 different criteria. These criteria for survey tool selection included:

- reputation
- robust health care database
- validity and reliability statistics
- measurable scale
- available web version
- available voice version
- available hard copy version
- available bilingual version
- number of questions
- time to take survey
- recommended frequency
- available training and resources
- available action-planning tool
- assistance with work-group organization

- familiarity with Quint Studer's "Hardwiring Excellence" leadership principles
- concurrent and user-friendly reporting of results
- turnaround of reports
- number of on-site days
- customer service
- pricing
- set-up time

An abbreviated matrix showing the comparison of the six associate satisfaction survey vendors is included in Appendix D.

At the beginning of each associate satisfaction survey, a pledge of confidentiality, survey instructions, informed consent, an example for marking, and a definition of key terms in the survey prefaced the survey items. Data were organized by work unit and company through the use of specific coding and questions on the survey. No personal identifiable information was obtained at the time of the survey, thus the data collection was anonymous. Participation in the associate satisfaction survey for all 4 years was voluntary, and participants had the opportunity to withdraw at any time.

The survey tool had 68 closed-ended items all randomly ordered in 2007. The survey was composed of 65 closed-ended items in 2008 through 2010, again randomly ordered. Fifty-five of the items were standardized from Morehead's database of over 300 organizations and one million subjects. Nine demographic items were included in the survey. Thirteen items were customized in 2007 including three items on perception about a recent acquisition. Ten items were customized in 2008 through 2010, and the three items on acquisition were eliminated in those respective years.

Items to survey with regard to associates, work-personal life balance, fair compensation, growth and development, quality or customer focus, citizenship, unity, leadership skills,

associate involvement, job-person match, coworker relations, and commitment indicator were randomly presented on the survey. Three items for perception of the organization's position with acquisition, two additional items on benefits, two items on orientation and education development, two items on climate within organization, one item on performance evaluations, one item on assistance with job stress, one item on support services, and one item on a perception of making a difference in people's lives were included. Participants rated each of the survey statements using a 5-point ordinal scale: first in the level of agreement and then according to the level of importance of that item in being satisfaction (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010). The researcher chose to study and analyze relationships between teaming items, perceptions on management style, and satisfaction, since that perspective had not been conducted within the scope of the organization or within health care. Thus, this study represented valuable research that may be beneficial in helping managers to better structure their delivery to facilitate teaming and more optimal patient care.

Associate satisfaction database. Data collection occurred over a 4-year period for purposes of improving the associate work environment and satisfaction in the selected diverse health care organization. Quantifiable data from 2007 to 2010 was used for comparison and historical purposes. The 4-year database was owned by the organization and maintained by a third-party national associate satisfaction survey company. The survey was administered for a 4-week period and was available in an abbreviated version via hard copy and online as well as via a full, web-based online version. Each company publicized the survey in advance using consistent tools, provided reminder communication during the survey period, provided information on confidentiality and anonymity, provided work unit leaders and associates with results, and communicated follow-up actions to be taken as a consequence of survey results.

Data analysis.

Descriptive statistical analysis. Descriptive statistics including central tendency, variability, confidence intervals, and relationship was performed for each of the respective years of the database and for the three independent variables (coworker relations, employee involvement, and leadership) and the dependent variable (commitment) at a level of $p < .01$ using the 65 survey items (McMillan & Schumacher, 2001, pp. 210–236).

Quantitative correlational statistical analysis. A two-tailed Pearson product correlation was used for producing results for both Hypotheses 1 and 2 using SPSS/PASW. A Pearson product correlation was used because the data were quantifiable, discrete in nature, of normal distribution, and because the strength in a linear relationship between multiple variables was desired in this particular study (Hauke & Kossowski, 2011; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore, Douthitt, & Carson, 2011). Thus, according to multiple sources, a Pearson product correlation was the appropriate analytic test. Correlational tests were run between the three independent variables of coworker relations, employee involvement, and leadership with the dependent variable, commitment, in order to test Hypothesis 1. Correlational tests were also run between each of the three independent variables with each other in order to test Hypothesis 2. Pearson correlation analytics were performed by year for the entire organization and also by company. Tests were run on individual companies due to the range in the size of the companies. Conducting Pearson correlation by year and also by company allowed a more thorough study on the contextual factors associated with organizational changes and company differences. The researcher did not want to bias the smaller company results with the vastly large companies.

Multiple regression was utilized to predict the strength and combination of the independent variables together and individually with the outcome on commitment (McMillan & Schumacher, 2001). In this way, the researcher was able to more fully show predictive relationships between the independent variables and groups of variables. Statistical analysis was conducted using an SPSS statistical program. The data records and analyses were maintained securely by the researcher, and she will continue to do so for the next 5 years to protect the integrity of records.

A one-way analysis of variance (ANOVA) was performed for Hypothesis 1 for each of the 4 years of data and was used to further analyze the impact of the combined effect of all three independent variables of coworker relations, employee involvement, and leadership on the dependent variable of commitment. A one-way ANOVA was performed to further provide credibility to the Pearson correlation and multilinear regression results (Babbie, 1990; Hauke & Kossowski, 2011; Khan Academy, 2014; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011; Yale University, n.d.). A one-way ANOVA was run on all organizational data by year.

Protection of human subjects. The research design and practice attended to respecting, demonstrating beneficence to, and practicing justice with human subjects. Attending to these three key principles was in keeping with the *Belmont Report* (Collaborative Institutional Training Initiative [CITI] Program, 2010; National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). The researcher attended two 2-hour courses in the "Protection of Human Subjects." The first course was completed with a 100% competency score in 2009 and a refresher course was completed with 93% competency in 2012 (see Appendices E and F for proof of completion). The University of the Incarnate Word's Institutional Review

Board (IRB) approved both courses. By having participated in the course, the researcher attended to any potential risks with human subjects (CITI Program, 2005, 2010). The IRB also reviewed the researcher's study proposal and critiqued the research process assuring the protection of human subjects. The approval letter from the university's IRB to conduct this study can be found in Appendix G.

The database that was used for the study was associate satisfaction data from a 4-year period. The data were collected through the use of a survey. The survey procedures adhered to informing participants of their confidentiality, anonymity, and voluntary participation. Researchers invited associates to participate in the quantitative phase of the study on a voluntary basis to honor their autonomy and free will, thus demonstrating respect. A third party collected survey information to further assure anonymity and confidentiality of information. The participants' anonymity was protected, demonstrating respect of human subjects. The existing, previously collected data were analyzed from a collective perspective and the participants' identity could not and cannot be identified. Because of the nature of the first quantitative phase of the research design, this phase met the criteria for "exemption" as described by the CITI Program (2010, Module 2).

The researcher explored the risks of harm to the participants and designed mechanisms to minimize the likelihood of such risks. The risk most present in this study was the violation of confidentiality and anonymity of participants. If a manager were to access data and survey results and were to use the responses against an associate or associates, this could constitute harassment of the associate(s), with risk of psychological, social, and economic harm. A third-party administrator collected the survey responses from the database in the quantitative phase preventing the risk of exposure of associates' data and thus harassment. The research was

conducted on an existing database collected over a 4-year period, thus the risk of exposure of human subjects individually was much minimized according to the CITI Program (2010). All data were kept in a locked and secured location and will be destroyed upon completion of the study not to exceed 5 years.

Data were available from a 4-year period for the purposes of improving the work environment for staff and with the ultimate goal of improving patient care. The organization's beneficent intentions were to do well and not to influence the outcome of any applied research. The benefits from receiving feedback from associates helped ultimately improve the workplace environment for associates who directly impacted the patient care experience, which was a desirable benefit in the study. Furthermore, participants could also benefit from organizational and management changes made as a result of the study. Possible examples may include improvements in medical benefits, improvements in break rooms, provision of additional associate support processes, and improvement in management communication and leadership style.

Qualitative Study: Phase 2

Purpose. The purpose of the qualitative component was to fully explore the perceptions of groups pertaining to coworker relations, employee involvement, and leadership relative to associate commitment through the use of nine focus groups. Seventy-five associates were interviewed in nine focus groups, and the groups ranged in size from five to 12 associates. The qualitative purpose evolved throughout the course of the study and specifically emerged after results from the first phase were quantified. The researcher wanted to hear the direct words and thoughts from groups of associates on their beliefs and perceptions related to teaming and team leadership. Therefore, the questions were asked relative to the attributes necessary for effective

teams according to Robbins (2001) and others. The qualitative design included four primary questions supported by 12 possible secondary questions. The researcher modified the secondary questions in the qualitative phase of the study based upon the group interview responses. This is often the case with a qualitative design (Creswell, 2008; Creswell & Plano Clark, 2007).

Research questions. The key question that was addressed in this phase of the study was, what are the perceptions of associates working on various teams representing different levels of commitment and from representative companies within the organization? In addition, the researcher explored (a) the perceptions of associates on the aspects of teaming that most relate to associate satisfaction or commitment according to teams of associates and (b) the perceptions of associates as to how the style of the team leader impacts associate satisfaction and their perception of teaming.

This study addressed possible answers to these questions by collecting qualitative data from teams. Additional questions emerged after the quantitative phase and during the focus groups, and they were deemed as critical in the reflective and attentive nature of qualitative interviewing.

Setting. Work unit teams were interviewed from across the health care organization, representative of the seven different companies within the organization. All the work unit teams originated from the state of Texas as each of the seven companies had branch offices in Texas. Branch offices were located in small rural towns as well as in large cities. The company and geographic origin of the nine focus groups is shown in Table 3. A work unit focus group consisted of an entire work unit team in a smaller rural town branch office. A work unit focus group in some cases was a portion of a larger work unit team in a bigger metropolitan branch office.

Each branch office had a conference or meeting room, which served as an interview site for the open-ended interviews. The researcher arranged a meeting room through a branch office gatekeeper and insured the meeting room was scheduled in advance with the appropriate person. Each of the meeting rooms had a door to insure privacy.

Table 3

Delineation of Company and Geographical Area for Qualitative Focus Groups

Group	Company	Town/City
1	Services	Austin
2	Pharmacy	Round Rock
3	Hospice	Georgetown
4	Community care	Dallas
5	Community care	Dallas
6	Long-Term care	Georgetown
7	Home health	Burnet
8	Rehabilitation	Georgetown and Killeen
9	Long-Term care	Corpus Christi

Note. Focus groups represented seven different companies and were located in both rural and metropolitan communities in the state of Texas.

The researcher provided light refreshments to show respect to the associates who volunteered to assist with the study. The gatekeeper's job title, interview location, number of group members, and gender identification for each of the focus groups is shown in Table 4.

Participants and method of selecting participants. Nine groups of associates were included in the qualitative data phase. The researcher utilized senior managers to help identify groups from each company willing to also participate in the study. The sample of groups was purposeful and voluntary in nature, thus representative of a purposeful sample of convenience.

Senior managers helped to identify informal gatekeepers who, in turn, helped communicate to team members, reserve meeting rooms, and set up site logistics for the focus groups.

Table 4

Description of Focus Groups

Group	Gatekeeper's job title	Interview location	No. of members	♀	♂
1	Controller	7th Floor conference room	5	5	0
2	President	Break room at pharmacy	7	7	0
3	Branch manager	Team member's office	5	5	0
4	Branch manager	Branch office conference room	9	9	0
5	Branch manager	Branch office conference room	9	9	0
6	Facility administrator	Facility morning meeting room	9	9	0
7	Branch manager	Branch office meeting area	8	7	1
8	Regional manager	Rehab gym	11	10	1
9	Facility administrator	Facility morning meeting room	12	10	2

Note. A total of 75 associates were included in the qualitative phase.

Nine volunteer groups of five to 12 associates were selected from across the organization with a total of 75 associates included in the study. A group represented a full or portion of a work unit team.

Groups were selected from each of three tiers as ranked from level of associate commitment on the associate satisfaction survey in the first quantitative phase of the study. The highest tier (Tier 1) groups were those groups with the highest level of work unit commitment as

calculated by their average scores on the survey items most related to organizational commitment, having achieved the highest level of scoring on the commitment indicator items or the dependent variables (Corrigan & Douthitt, 2007).

The average scores on the commitment items were compared to a national benchmark average. The middle tier (Tier 2) groups represented those groups with a midrange level of commitment indicator scores or average scores at or close to the national benchmark average. The low tier (Tier 3) groups were those groups with low levels of associate commitment as compared to the national benchmark average. Two groups were from Tier 1, five groups were from Tier 2, and two groups were from Tier 3. In this way, the researcher was able to compare similarities and differences in the associates' perceptions on coworker relations, employee involvement, leadership, associate commitment, and teaming behaviors on the basis of not only company origin but also on tier ranking levels as compared to the national benchmark using the Morehead tool (Morehead Associates, 2007a, 2007, b, 2008, 2009, 2010). The tier delineation is shown in Table 5.

The 2011 tier rankings (Mondore & Douthitt, 2011) were used to identify potential focus groups as opposed to the 2010 tier rankings. This was done due to the lapse in time between the survey date and the timing of the qualitative focus groups. The 2011 tier rankings were more characteristic of the work groups at the time of the qualitative focus groups. The commitment score range for each Tier 1, 2, and 3 classifications is indicated in Table 6 (Mondore & Douthitt, 2011). The specific commitment scores for each of the focus groups are shown in Table 7 (Mondore & Douthitt, 2011).

Study instrument: Open-ended focus groups. Qualitative open-ended focus groups occurred in the summer and fall of 2012 with various work unit associates to provide a more in-depth view

Table 5

2011 Delineation of Tiers for Qualitative Focus Groups

Tier	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7	Group 8	Group 9
1	X								X
2		X	X	X	X		X		
3						X		X	

Note. Tier designation was based upon the 2011 commitment indicator score representing the average of the items most connected with associate engagement. Adapted from *Commitment Tier Report*, by S. P. Mondore and S. S. Douthitt, 2011, Charlotte, NC: Strategic Management Decisions. Copyright 2011 by Strategic Management Decisions. Adapted with permission.

Table 6

2011 Tier Commitment Indicator Score Range

Tier	CI score range	Necessary action planning
1	≥ 4.22	Minimal
2	3.96 – 4.21	Some
3	≤3.95	Significant and critical

Note. CI = commitment indicator. Adapted from *Commitment Tier Report*, by S. P. Mondore and S. S. Douthitt, 2011, Charlotte, NC: Strategic Management Decisions. Copyright 2011 by Strategic Management Decisions. Adapted with permission.

of their perceptions of employee involvement, coworker relations, leadership, teaming, and associate satisfaction. The researcher served as an instrument within this phase of the research and thus switched from an impartial observer to an involved participant within the scope of research.

The researcher provided a letter to potential participants explaining the research study, the design and process, the voluntary nature of participation, contact information for questions, and advisement of informed consent (see Appendix H). A hard copy of the letter was provided in advance to each participant in each group.

Table 7

2011 Commitment Indicator Scores for Qualitative Focus Groups

Focus group	CI score
1	4.38
2	4.15
3	4.07
4	4.18
5	4.18
6	3.90
7	4.02
8	3.95
9	4.80

Note. CI = commitment indicator. Adapted from *Commitment Tier Report*, by S. P. Mondore and S. S. Douthitt, 2011, Charlotte, NC: Strategic Management Decisions. Copyright 2011 by Strategic Management Decisions. Adapted with permission.

For each of the focus groups, the researcher provided refreshments for group participants as a symbol of respect and appreciation. Work unit managers did not attend the focus group interviews. In some cases, the work unit leader or manager socialized and greeted the participants and then exited for the focus group questioning. The researcher also posted and followed an agenda. The agenda was posted on a white flip chart, and this same flip chart was used in every focus group (see Figure 3).

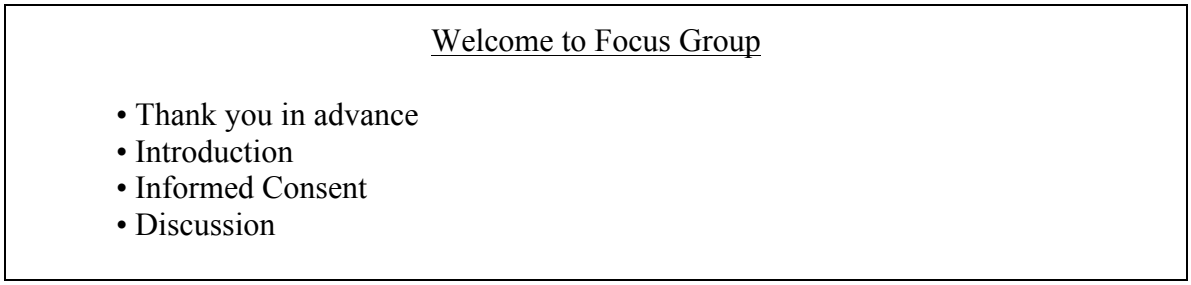

Figure 3. Focus group agenda on a flip chart.

The researcher started the focus group by thanking participants and explaining the voluntary nature of the study process. The researcher also explained that responses would be recorded as group responses and no individual identities would be known. After an explanation of the study and prior to conducting the group interviews in a discussion format, the researcher explained the Informed Consent form and paused to answer any questions (see Appendix I). Participants read and signed the Informed Consent form prior to the researcher proceeding with questions. Signed Informed Consent forms for each focus group were maintained in a labeled folder by focus group number in a secured and locked location along with other group interview transcripts, researcher's notes, and data.

Data collection. The descriptive identifiers for each qualitative interview were recorded on a form (see Table 8). The descriptive identifiers along with the notes, interview logs, and transcriptions were then organized in a folder by group number and secured in a locked location.

Focus group questions were posed in an open discussion format. The four primary questions that the researcher asked were the following: (a) How does the work unit work together to accomplish their goals?, (b) What enhances workplace satisfaction?, (c) What enhances the teaming experience?, and (d) What facilitates teaming? Secondary questions were asked as follow-up to the primary research questions.

Sixteen questions existed in totality, but not all secondary questions were asked in every interview (see Appendix J). Secondary questions were customized based on responses to the first four primary questions. The researcher explored the perceptions of associates that may be helpful in tailoring and administering actions to assist in improving work environment and associate satisfaction in the future.

Table 8

Descriptive Identifiers for Each Focus Group

Description of study
Explanation of confidentiality and anonymity of responses and data
Informed consent to participate in interview
Location of interview: _____
Start time of interview: _____
Company: _____
Tier 1, 2, or 3 from Associate Satisfaction Survey: _____
Number of work unit members in group interview: _____
Date of interview: _____
End time of interview: _____

Group interviews were audio recorded. The researcher also took notes during the session and made notes of her observations and of the inflections of participants' voices as they responded. Audio recordings were then transcribed and reviewed for accuracy of content and transcription by the researcher three times. Any names or identifiable information was eliminated from the transcripts so as not to distract from the research analytic process or expose identities.

Pilot focus group. The researcher conducted the first focus group as a pilot and made adjustments to the qualitative interview process. This process included distributing the participant letter in advance, arranging the meeting room through the informal gatekeeper, explaining the informed consent, conducting the open-ended focus group interview, audio recording the interview, providing refreshments, and then transcribing the data.

Means of establishing credibility, trustworthiness, and rigor. A field journal, use of a peer debriefer, and critical reflexivity were incorporated to enhance reflexivity and soundness of the interview phase of the research. Disciplined subjectivity was used to enhance the authenticity of participants' responses during the qualitative phase. Interviews were conducted using a

semistructured format and then recorded, transcribed, coded for trends, and checked periodically for accuracy. Transcripts, notes, and coding documents were checked and rechecked several times at different times to insure accuracy and completeness of data. Techniques, such as triangulation, to insure accuracy and soundness of data and of research results were attempted for both the quantitative and qualitative phases of this research.

Protection of human subjects. During the second phase of research, attention and practices were implemented to minimize risk of harm to the subjects participating in the focus group interviews. Privacy and confidentiality were preserved through the interview design and protocol. The researcher managed risk of harm through the interview design, setting, and process. (CITI Program, 2010, Module 3).

Groups included a collection of five to 12 work unit associates. Focus group interviews were conducted in a room with a closed door so as to minimize invasion of privacy. No personal identifiable information was collected or recorded, thus minimizing the risk of a breach of confidentiality. Any proper names were erased from the transcripts so as to insure anonymity. Because a 1-year period elapsed from the data collection in the quantitative phase and the administration of the group interviews in the qualitative phase, the risk of exposure was much reduced. Group interviews were recorded and transcribed without any specific identifiable information recorded. Data were analyzed as being obtained from a group within the organization. The exact work unit location was not recorded, thus further protecting against a breach of confidentiality.

Participation in the focus group interviews was voluntary and participants were able to withdraw at any time during the process (Creswell, 2008, pp. 238–240). The researcher disclosed the purpose of the study and explained the process. The study was explained to the participants

in advance through a letter sent to the focus group participants and again verbally directly before the study (see Appendix H). Two copies of the consent form were signed (see Appendix I). One copy of the consent form was returned to the participants, and the second copy was and will be maintained in a locked and secured location for a period of 5 years as per the university's IRB guidelines (University of the Incarnate Word, 2011). At any time during the group interviews, a participant had the freedom to drop out without repercussion. The researcher explained this in advance of their participation.

The collection of group data through the group interviews and the audiotaped interview discussions posed a minimal risk of exposure and breach of privacy and confidentiality. Because the data collected in this second phase of the study was minimally invasive and posed minimal risk, the study was eligible for an expedited review by the university's IRB (CITI Program, 2010, Modules 2–3; University of the Incarnate Word, 2011, pp. 11–14). The design protocol as has been described provided utmost care in minimizing exposure or risk.

Health care associates in general have potential for benefitting from organizational and management changes to be made in the industry as a result of the study. Possible examples may include improvements in benefits, improvements in physical environments to support teaming, provision of additional associate support processes, enhancement in leader and associate education, increase in resources to support teaming, and improvement in management communication and leadership style.

The IRB at the University of the Incarnate Word, through the process of a thorough review of the proposal and their involvement in the study, assured respect, beneficence, and the protection of human subjects. The proposal and study were also monitored through an

organizational review by a corporate institutional review board. The two boards, peer reviewers, and the researcher critiqued the research process and assured subject protection.

Chapter 4: Results

Quantitative Research Results

Purpose. The purpose of this two-phase, sequential explanatory mixed design was to first examine the relationship between coworker relations, employee involvement, and leadership with associate satisfaction as perceived by health care associate work units. A quantitative study was conducted using a 4-year database of associate satisfaction survey results (Morehead Associates, 2010) from seven health care companies operating in 13 states. The relationship between the independent variables with the dependent variable was first analyzed, and then the relationship between the independent variables with each other was analyzed. The quantitative results were further explored in the second phase of research, which was using qualitative focus groups and analysis. The qualitative results and analysis are presented after the quantitative results as the qualitative results were used to provide richer meaning to the quantitative results in this particular design.

Variables. Coworker relations, employee involvement, and leadership represented the independent variables in the quantitative analysis. These variables were selected because they have been most cited by known authorities to be defining characteristics of strong teams (Ancona, 1992; Acona & Bresman, 2007; Homans, 1950; Robbins, 2001; Thomas, 2008). Associate satisfaction, also known as associate engagement or associate commitment, represented the dependent variable.

Each of the independent variables was operationally defined through specific survey items on the associate satisfaction survey (Morehead Associates, 2007a, 2008, 2009, 2010). The survey used a 5-point Likert scale where 1 represented the least agreement with the statements and 5 represented the greatest agreement with the statements. Coworker relations were defined

through three survey items (No. 14, 17, and 26). The statements that operationally defined coworker relations were (a) “My work unit works well together,” (b) “I enjoy working with my coworkers,” and (c) “There is a climate of trust within my work unit.” Employee involvement was defined through six survey items (No. 12, 19, 24, 28, 30, and 58). The statements that operationally defined employee involvement were the following: (a) “My work allows me to make a difference in people’s lives;” (b) “My ideas and suggestions are seriously considered;” (c) “I am satisfied with the recognition I receive for doing a good job;” (d) “I am involved in decisions that affect my work;” (e) “When appropriate, I can act on my own without asking for approval;” and (f) “My job responsibilities are clear.” Leadership was defined through seven survey items (No. 9, 16, 21, 48, 51, 56, and 63). The statements on the survey that operationally defined leadership were the following: (a) “The person to whom I report is a good communicator,” (b) “The person to whom I report treats me with respect,” (c) “The person to whom I report cares about my job satisfaction,” (d) “The person to whom I report encourages teamwork,” (e) “My performance evaluations have been conducted fairly,” (f) “I respect the abilities of the person to whom I report,” and (g) “The person to whom I report gives me useful feedback.”

The dependent variable was measured using six survey items (No. 6, 7, 10, 11, 13, and 49). The statements that operationally defined associate satisfaction, commitment, or engagement using a 5-point Likert scale rating on the associate satisfaction survey (Morehead Associates, 2007a, 2008, 2009, 2010) were the following: (a) “I would recommend this company to family and friends who need care;” (b) “I would like to be working at this company three years from now;” (c) “I would stay with this company even if offered a similar job elsewhere for slightly higher pay;” (d) “I would recommend this company as a good place to work;” (e)

"Overall, I am a satisfied employee;" and (f) "I am proud to tell people I work for this company." The survey-coding tool, including all the survey items, can be found in Appendix A.

Hypotheses. Hypothesis 1 was that a strong relationship existed between the three independent variables of coworker relations, employee involvement, and leadership with the dependent variable of associate satisfaction, also known as associate commitment. Hypothesis 2 was that a strong relationship existed between each of the independent variables with each other. The hypotheses were formulated based on characteristics of effective teams, characteristics of work environments leading to teaming, and the necessary qualities of a team leader as emergent of the function of teams (Ancona, 1992; Cameron, 2005; Clevenger, 2007; DeLoach, 2003; Hassan et al., 2002; Homans, 1950; Karsh et al., 2005; Kirkman-Liff, 2004; Mulcahy & Betts, 2005; Robbins, 2001; Ryan-Woolley et al., 2004; Tempest & McIntyre, 2006; Thomas, 2008; Toofany, 2007; Van Norman, 1998; Whatmore, 1999). The researcher wanted to explore both the elements of effective teams and the characteristics of a good team leader, in conjunction with associate satisfaction in health care companies. The researcher had not found a study combining all of these perspectives as applied to health care in one study.

Mixed sequential explanatory design. This study incorporated a mixed sequential explanatory design. The first phase of the study included the quantitative study using the existing 4-year database of associate satisfaction survey data from six health care companies from 2007 to 2009 and from seven companies in 2010. The analysis of the relationship of the independent variables with the dependent variable and the independent variables with each other was conducted first. The qualitative phase followed with the purpose of providing more context and meaning to the quantitative results (Creswell, 2009; Creswell & Plano Clark, 2007). The qualitative component of the study chronologically followed the quantitative component and

provided additional insight and explanation to the quantitative results. The study itself and the analysis of results followed the mixed sequential explanatory design as depicted in a flow diagram in Figure 2, Chapter 3. In this chapter, the results are presented in the same sequence with the quantitative results presented first and the qualitative findings presented second. The quantitative and qualitative results are then merged with quantitative variables and hypotheses related to qualitative themes.

Setting, population, and sample size. A health care organization comprising a variety of post-acute health care companies with locations in 13 different states provided the setting for the research. Between 2007 and 2009, associates from six health care companies contributed to the associate satisfaction survey database. The companies included two divisions of home health, which were community care and home health. Community care represented a state Medicaid-reimbursed home health program. A skilled home care that was reimbursed by Medicare represented the second home health company. A hospice, a rehabilitation company, which provided physical therapy, occupational therapy, and speech language pathology services, and a pharmacy company also contributed to the database. And the sixth company, Services, included associates from accounting, finance, human resources, informational technology, public affairs, and other corporate team members that supported all of the operating companies in the health care organization. In 2010, the survey database included responses from a long-term care company, which included skilled nursing facility and assisted living facility staff, as well as a nurse practitioner company that provided long-term care. Database responses represented seven different companies in the organization in 2010. Data volume for the nurse practitioner company was insufficient for a valid analysis and was dropped from the study; therefore, seven companies were represented in the study results.

The population included health care associates from a variety of direct care and administrative roles from all representative companies. The sample was a sample of purpose and convenience. Participation was voluntary, and all data included were from associates who provided informed consent at the time of the associate satisfaction survey (Morehead Associates, 2007a, 2008, 2009, 2010) during the 4-year period of 2007 to 2010. The data was collected in the past, and the identity of individuals was not included in the database. Permission was obtained from the health care organization's CEO to use the collective and anonymous data (see Appendix B). The return rate for the associate satisfaction survey for each year for full-time employees within the database was shown in Table 2, Chapter 3. The combined return rate for full-time and part-time employees using responses from all versions of the survey yielded a 27% combined response rate in 2007, 31% combined response rate in 2008, 30% combined response rate in 2009, and 27% combined response rate in 2010.

The research sample was represented in proportion to the size of the population and companies represented. The sample size for each year of data exceeded 95% confidence level. A sample size of 1,067 for each year of data was required to assure a 95% confidence level with a margin of error of .5. The confidence interval indicated for this confidence level was ± 3. The sample sizes in the database for each year met a 99% confidence level with a margin of error of .1. The confidence interval was ± 2.78 (Creative Research Systems, n.d.; Custom Insight, n.d.; Kitchens, 1998; McMillan & Schumacher, 2001).

The sample included data from all companies, all states, all tiers, and all demographic segments including position, length of service, employment status, gender, shift work, ethnic background, age, job classification, and work history. The sample size for each year was indicated in Table 1, Chapter 3. The valid *N* was higher for the variables of employee

involvement, leadership, and commitment because two versions of the survey form were administered, and items for these variables were included on both forms of the survey. One of the survey forms was condensed, per request, for field staff of specific home health company leaders. The shorter, condensed version did not include the survey items for coworker relations; thus, the *N* value for this variable is lower. The *N* value for coworker relations (CR) still met the requirements for 95% and 99% confidence interval.

Sample population demographics. Demographic characteristics were collected on the population of health care associates participating in the associate satisfaction survey (Morehead Associates, 2007a, 2008, 2009, 2010) over a 4-year period from 2007 to 2010. Nine demographic items were included: position, length of service, employment status, gender, shift work, ethnic background, age, job classification, and work history for the last 3 years.

Position. Certified nurse assistants, technicians, registered nurses (RNs), licensed vocational nurses (LVNs), licensed practicing nurses (LPNs), and other health workers represented the majority, 76.3%, of the associates participating in the associate satisfaction survey (Morehead Associates, 2007a, 2008, 2009, 2010) over the 4-year period from 2007 to 2010. Figure 4 shows the distribution of position in the sample population. The researcher worked with the Morehead Associates survey company and human resources to identify the major potential positions within the population. Associates that did not fall in one of the major identified position categories were categorized as "Other."

Length of service. Length of service described how long associates had worked for the companies. Figure 5 shows the distribution of the length of service for the sample population. The categories included less than 1 year, 1 to 2 years, 3 to 5 years, 6 to 10 years, 11 to 20 years, and greater than 20 years. Seventy-eight percent of the population worked for the family of

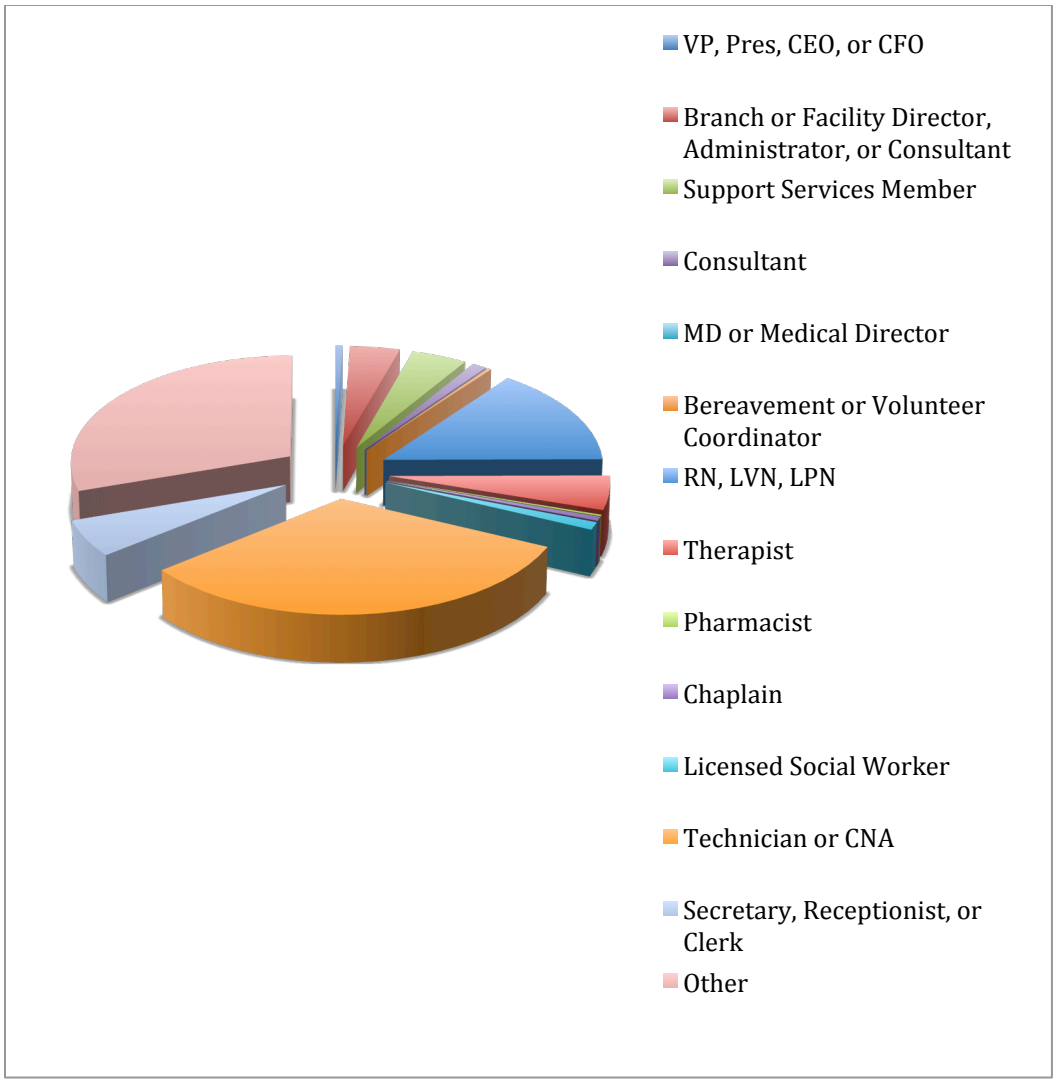

Figure 4. Distribution of position in the sample population for the associate satisfaction survey from 2007 to 2010.

companies for less than 5 years and 54% worked for the family of companies less than 2 years. The largest segment of the population being surveyed worked for the family of companies between 1 and 2 years. One and one-half percent of the sample had worked for the family of companies for over 20 years.

Employment status. Employment status described whether associates worked full-time or part-time. Figure 6 shows the distribution of employment status in the sample population.

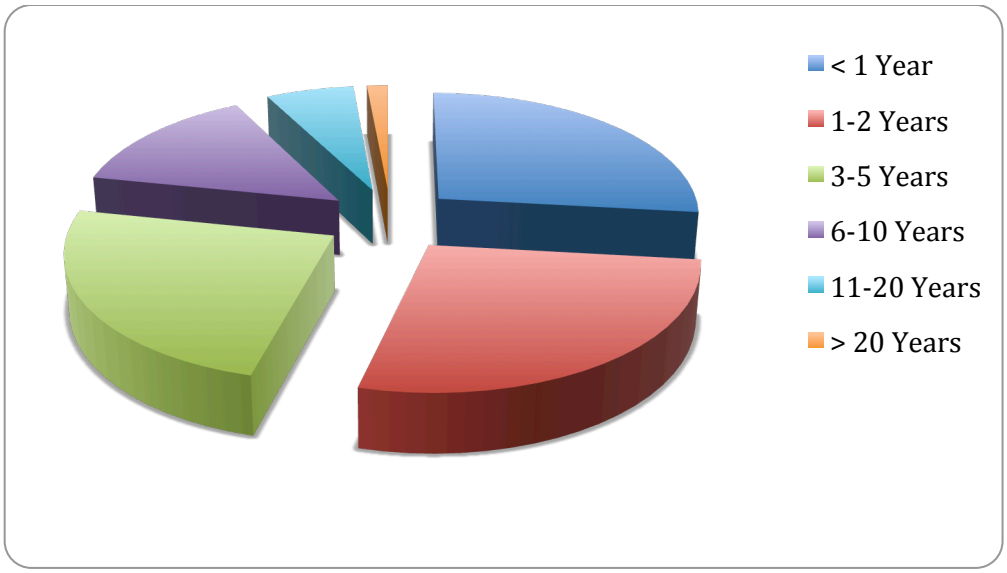

Figure 5. Distribution of length of service in the sample population for the associate satisfaction survey from 2007 to 2010.

A category of "Other" was included for associates who were contract employees, who had inconsistent status, or who did not know their employment status. Fifty-two percent of the sample population was part-time, 23.9% of the sample population was full-time, and 24.8% were "Other."

Gender. The sample population was predominantly female with 91.6% of the sample represented as female. The female to male ratio of associates in the population was 11:1 (see Figure 7).

Shift work. Shift work represented in the survey population included day, evening, night, weekend, and rotating shift workers. Figure 8 shows the distribution of shift work in the sample population. For clarification, the day shift included scheduling from 7 a.m. to 3 p.m. or similar in nature, the evening shift included scheduling from 3 p.m. to 11 p.m. or similar in nature, and the night shift included scheduling from 11 p.m. to 7 a.m. or similar in nature. Ninety-three percent of the sample population represented the day shift. Three percent of the sample was from rotating shifts, and only 1.4% and 1.12% were from the weekend and evening shifts, respectively.

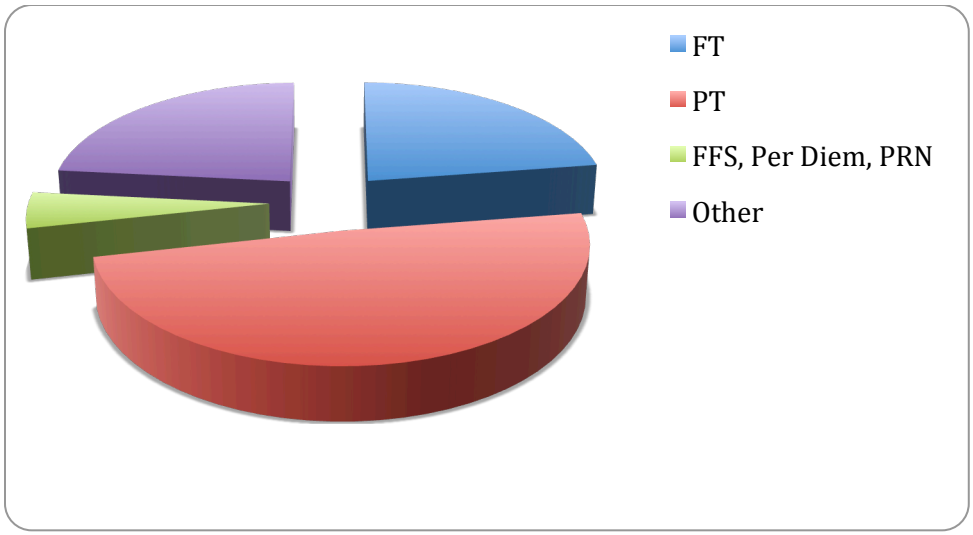

Figure 6. Distribution of employment status in the sample population for the associate satisfaction survey from 2007 to 2010.

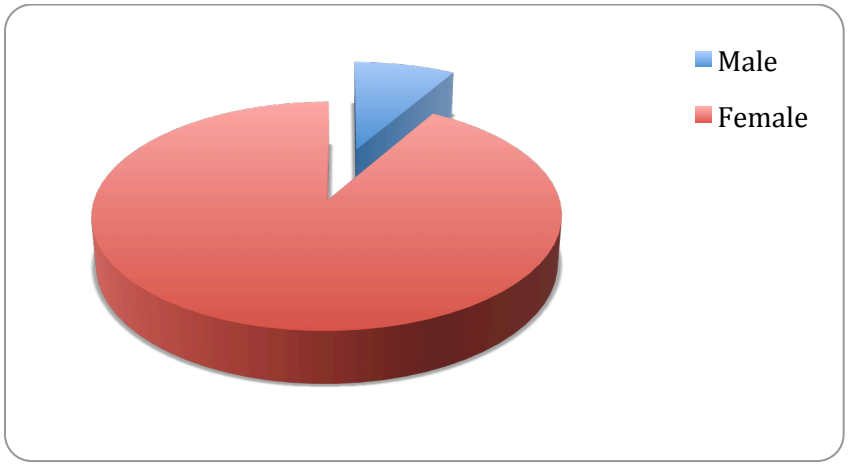

Figure 7. Distribution of gender in the sample population for the associate satisfaction survey from 2007 to 2010.

Ethnic background. Ethnic background included seven predominant categories. Figure 9 shows the distribution of ethnic background in the sample population. Forty-five percent of the population sample was Caucasian, 26.6% was African-American, and 24.6% was Latino. Ninety-six percent of the sample population represented one of these three ethnic background categories.

Age. Age was categorized by ranges of years of age. Figure 10 shows the age distribution in the sample population. Fifty-two percent of the sample population was between 40 and 60

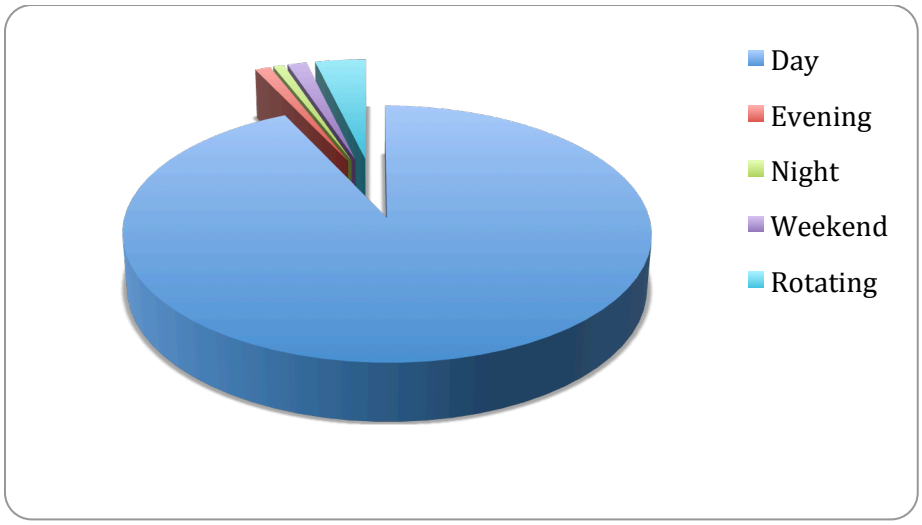

Figure 8. Distribution of shift work in the sample population for the associate satisfaction survey from 2007 to 2010.

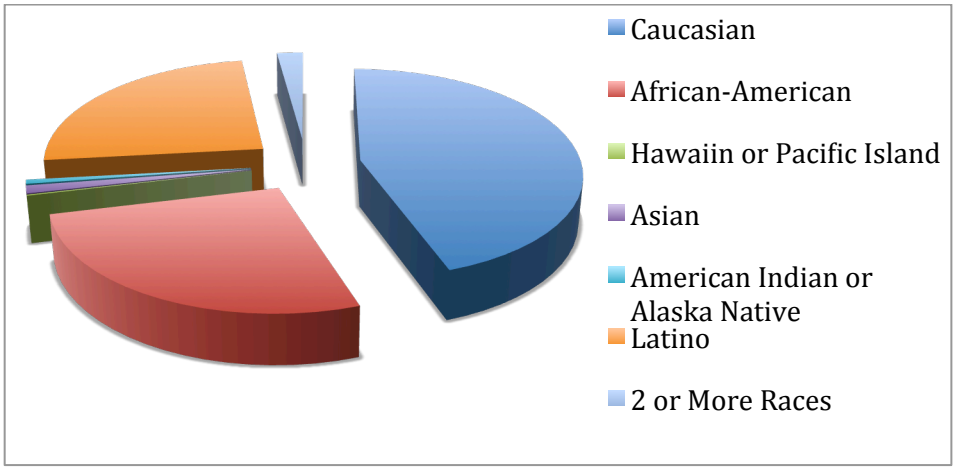

Figure 9. Distribution of ethnic background in the sample population for the associate satisfaction survey from 2007 to 2010.

years of age. Twenty-seven percent of the sample population was between 25 and 39 years of age. Fifteen percent of the sample was over 60 years of age. Only 5.6% of the sample population was between the ages of 18 and 24. None of the sample was under the age of 18 years of age.

Job classification. Job classification for the sample population was indicated in the payment of wages either by hourly payment or salaried payment. Figure 11 shows the distribution of job classification in the sample population. Sixty-one percent of the sample earned

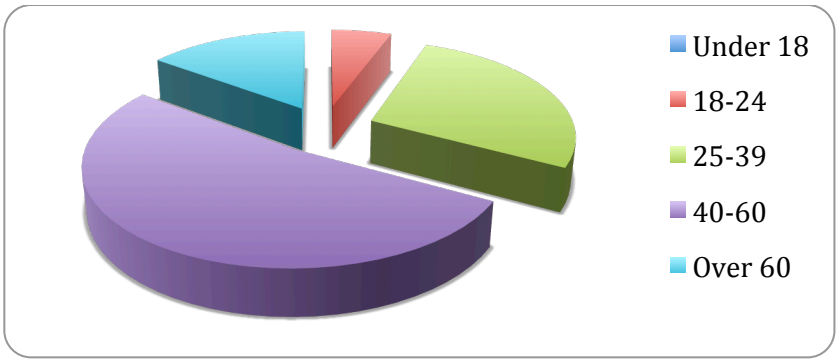

Figure 10. Distribution of age in the sample population for the associate satisfaction survey from 2007 to 2010.

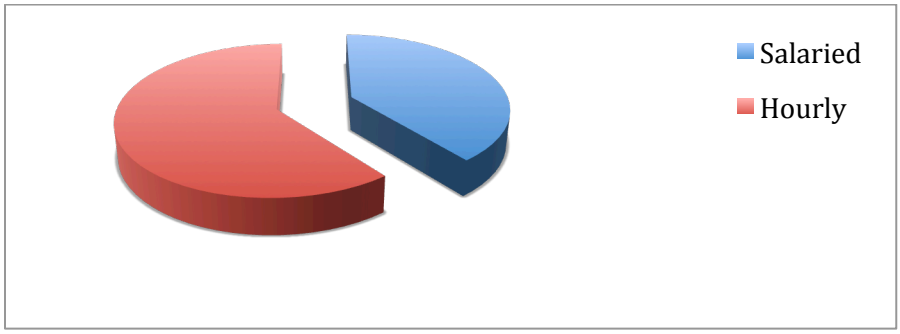

Figure 11. Distribution of job classification in the sample population for the associate satisfaction survey from 2007 to 2010.

hourly wages.

Work history for the last 3 years. Associates in the sample population were asked the number of other companies for which they had worked in the last 3 years. The intent of this question was to identify the reference point of the population in rating the associate satisfaction items in relation to their work history and experience. Figure 12 shows the number of other companies for which the sample population had worked in the last 3 years. Seventy-three percent of the sample population had worked for only the family of companies and did not have any other health care work history. Twenty-six percent of the sample population had worked for two to three other companies in the last 3 years. Only 1.2% of population had worked for four or more companies in the last 3 years.

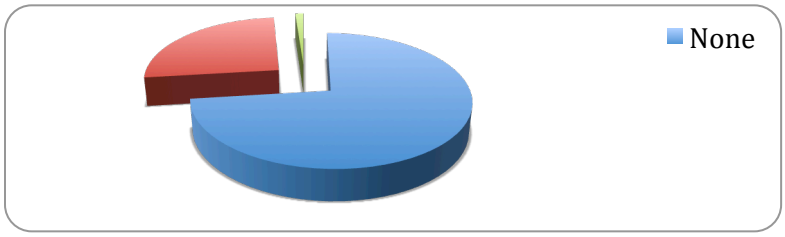

Figure 12. Distribution of associates' work history for the last 3 years in the sample population for the associate satisfaction survey from 2007 to 2010.

Data collection and statistical process.

Definition of key terms, tools, and tests. Coworker relations, employee involvement, and leadership represented the three independent variables in the study. These key terms were selected because they represented both the established theme names within the associate satisfaction survey tool (Morehead Associates, 2007a, 2008, 2009, 2010) and because they were identified as necessary components of effective teams (Robbins, 2001). The same labels for the three independent variables were used throughout the study. The variable of coworker relations was also noted as Independent Variable 1 (IVI). Employee involvement was noted as Independent Variable 2 (IV2), and leadership was noted as Independent Variable 3 (IV3).

Commitment represented the dependent variable (DV) in the study. Morehead Associates (2007a, 2008, 2009, 2010) identified associate commitment as the culmination of six survey items on the associate satisfaction survey. Associate commitment has been synonymous with associate satisfaction and associate engagement. For purposes of simplicity and directness, *commitment* was used to label the dependent variable in tests, tables, and in the discussion.

Other words and terms required clarification for reader understandability. *Associate* was used interchangeably with the word employee. The author utilized associate intentionally because it represented a more inclusive label for the worker or employee. *Company* was used to consistently represent division. One of the entities, Services, was also identified as a company,

although it was not established as a company with binding legal documents. This was intentionally applied so as to be consistent with the other companies or divisions.

Tools and rationale. The associate satisfaction survey tool (Morehead Associates, (2007a, 2008, 2009, 2010) that was utilized for the 4 years of data collection was selected because of its credible 27-year history and its application to many different industries including health care. This survey tool was also selected because of its established content validity and its high reliability ($\alpha = .93$ for individual items and $\alpha = .85$ to .97 for reliability between groups of themed items). In addition, the survey tool was user-friendly for associates, and it provided reports and resources for action planning.

The Statistical Package for the Social Sciences (SPSS), also known as Predictive Analytics Software (PASW), was used for statistical analysis of survey data sets. It was selected due to its long history and reputation as being the most widely used program for statistical analysis in social sciences as well as in health sciences, marketing, survey analysis, education, and research. Descriptive statistics, multifactorial correlation, multilinear regression, and one-way analysis of variance were performed using SPSS/PASW.

Tests and rationale. All sample data were analyzed for each year individually so that more specific characteristics could be analyzed by year and by company and because the organization had continual organizational changes, which potentially could have affected the results. Sample data were also proportionate to the size and population of the company. A descriptive analysis included central tendency, standard deviation, and confidence intervals and was calculated using SPSS/PASW. Data were quantitative and multivariate in nature. Focus group descriptions were shown in Table 4, Chapter 3.

A two-tailed Pearson product correlation was used for producing results for both Hypotheses 1 and 2 using SPSS/PASW. A Pearson product correlation was used because the data were quantifiable, discrete in nature, of normal distribution, and because the strength in a linear relationship between multiple variables was desired in this particular study (Hauke & Kossowski, 2011; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011). According to multiple sources, a Pearson product correlation was, therefore, the appropriate analytic test. Correlational tests were run between the three independent variables of coworker relations, employee involvement, and leadership with the dependent variable, commitment, for testing Hypothesis 1. Correlational tests were also run between the three independent variables with each other for testing Hypothesis 2. Pearson correlation analytics were performed by year for the entire organization and also by company. Tests were run on individual companies due to the range in the size of the companies. Conducting Pearson correlation analytics by year and also by company allowed a more thorough study on the contextual factors associated with organizational changes and company differences. The researcher did not want to bias the smaller company results with the vastly large companies.

A multilinear regression analysis was performed for Hypothesis 1 to provide more predictive power of the three independent variables of coworker relations, employee involvement, and leadership on the dependent variable, commitment. The contribution of each independent variable to the dependent variable was studied. The multilinear regression provided a stronger level of analysis over the Pearson product correlation (Hauke & Kossowski, 2011; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011). Data were studied for the entire organization by year for this particular analysis and were not evaluated by company.

A one-way analysis of variance (ANOVA) was performed for Hypothesis 1 for each of the 4 years of data and was used to further analyze the impact of the combined effect of the three independent variables of coworker relations, employee involvement, and leadership on the dependent variable of commitment. A one-way ANOVA was performed to further provide credibility to the Pearson correlation and multilinear regression results (Hauke & Kossowski, 2011; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011). A one-way ANOVA was run on all organizational data by year, although not run by individual company.

Assumptions of data collection. The researcher assumed that the data samples from each year of collection and from each company truly represented the population of associates from each of the companies within the organization. The size of the samples was proportionate to the size of the company and of the population from which it came. The researcher also assumed that the perceptions provided on the surveys by the sample of associates were diverse in nature and represented all the possibilities present in the opinions of the population.

Protocol adjustments with rationale. Samples for statistical testing and analysis were not stratified because data were tested and analyzed by company and in totality for all companies for each year of data collection. Because data were tested and analyzed to the level of detail by company and the size of the data collection exceeded the necessary 95% confidence level, stratification of the sample was neither necessary nor desirable. Results will be presented in each of the respective years by company. Data were naturally mixed by tier across all company lines.

Errors and correction. With the continual organizational changes in each of the 4 years of survey administration, the mapping document of work unit and company coding was updated and revised. With each year and each revision, multiple organizational changes required mapping

work units to different supervisors and different geographies. Work units were assigned numerical codes for work unit numbers. To decrease error in mislabeling work unit codes, the researcher instructed the use of organization-assigned work unit codes consistent with the organization's accounting and human resource software systems as opposed to the arbitrary work unit number assignment or the assignment of a work unit number by the third-party survey vendor. In this way, potential for error was decreased for allocating work units to the wrong company or geographical division. In addition, the mapping document, which included work unit coding and company coding assignments, was reviewed multiple times by several unrelated reviewer and coders.

After administering the survey and prior to loading the data files in the statistical software (SPSS/PSAW) for analysis, the researcher coded each row of data with a company code. Human error could have occurred where a potential row of data was miscoded and thus allocated to the wrong company. The researcher reviewed the coding document three times for accuracy after going through the company coding process, reviewed the coding document from back to front during review, and took breaks during the company coding process to reduce errors.

Data that were not complete for each variable were eliminated as valid. For example, if an associate did not complete all question items representing one of the independent variables, that associate's responses indicated on a line item in a data file were not used in the correlation analysis. In this way, bias error towards use of only certain question items was prevented.

A potential for associates to select the wrong demographic category on the survey existed. The researcher attempted to prevent associates from selecting the wrong work status by first working with company presidents to designate certain work unit codes to work units solely composed of part-time associates. The researcher coded those work units after survey

administration and before data analysis with a specific code for part-time associates. Particular care was taken with accurate coding of part-time associates as it has been well established that the needs and perceptions of part-time associates varies from full-time associates (Dunn, 2010).

A potential for associates of part-time working status to take the longer survey version or the potential for associates of full-time working status to take the shorter, condensed survey intended for part-time associates existed. Training and communication was provided to company leaders and work unit managers on the appropriate survey to circulate. Demographic questions were posed in both the shorter and longer forms of the survey to allocate data lines appropriately. This was done with the attempt to accurately code the data lines to the appropriate company and appropriate key demographic item.

A potential sampling error existed in that the samples of associates from each company were biased positively or negatively toward the company or organization. A potential sampling error also potentially existed being biased with regard to the demographic make-up of the associates taking the survey. The researcher did not influence or select certain subsets of data. Associates representing all aspects of the company populations were included so as not to bias the sample. In addition, purposeful coding of the sample data by company assisted in providing a means for comparison contextually of companies and companies' attributes, such as subcultures or leadership (Kitchens, 1998; McMillan & Schumacher, 2001).

Descriptive statistics. The descriptive statistics, shown in Table 9, include mean (*M*), standard deviation (*SD*), and confidence interval (CI). The mean for the independent variables of coworker relations, employee involvement, and leadership ranged from 3.57 to 4.40 for the 4-year period between 2007 and 2010. The range of possible scores on each of the variables was 1 to 5. The lowest mean for the independent variables occurred in 2007 with the mean for

employee involvement at 3.57. The highest mean of 4.40 occurred in 2009 for employee involvement. In fact, the highest mean of all the independent variables resulted with employee involvement in 2008 through 2010. It appears that the lowest mean of 3.57 also associated with employee involvement may have been an outlier with unknown cause. The means for coworker relations ranged from 4.12 to 4.35 and for leadership from 4.13 to 4.17. Less variability occurred in the means for leadership than the other two independent variables. The mean for the dependent variable of commitment ranged from 4.06 in 2007 to 4.15 in 2009.

The standard deviation ranged from .62 to .94 for all variables. The highest standard deviation in 2008 through 2010 occurred with leadership. It showed the most variation in 2007 between all the variables and was fairly consistent with coworker relations, employee involvement, and commitment for 2008 through 2010.

The confidence level was reported at 99% with probability of .01 ($\alpha = .01$) error; thus, the results occurred with 99% certainty not due to chance. The confidence interval points are shown in Table 9. The confidence interval ranged from ± .02 to ± .04 from the mean. The confidence interval was the largest (± .04) for coworker relations in 2008 through 2010 due to a smaller number of data points (*N*) for coworker relations in 2008 through 2010 as was shown in Table 1, Chapter 3.

Hypothesis 1: Strong Relationship Between Independent Variables and Dependent Variable

Pearson two-tailed correlation results. The Pearson correlation coefficient for all 4 years of data for the overall organization ranged from 0.53 to 0.80 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the

independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment (see Table 10).

Table 9

Descriptive Statistics for Coworker Relations, Employee Involvement, Leadership, and Commitment in Associate Satisfaction Survey Data From 2007 to 2010 for Health care Organization

Variables by year	*M*	*SD*	99% CI
2007			
Commitment	4.06	0.72	[4.04, 4.08]
Coworker relations	4.35	0.62	[4.33, 4.37]
Employee involvement	3.57	0.80	[3.54, 3.60]
Leadership	4.13	0.69	[4.11, 4.15]
2008			
Commitment	4.11	0.76	[4.09, 4.13]
Coworker relations	4.22	0.76	[4.18, 4.26]
Employee involvement	4.39	0.77	[4.37, 4.41]
Leadership	4.14	0.92	[4.11, 4.17]
2009			
Commitment	4.15	0.78	[4.13, 4.17]
Coworker relations	4.22	0.75	[4.18, 4.26]
Employee involvement	4.40	0.76	[4.38, 4.42]
Leadership	4.17	0.92	[4.14, 4.20]
2010			
Commitment	4.11	0.79	[4.09, 4.13]
Coworker relations	4.12	0.79	[4.08, 4.16]
Employee involvement	4.32	0.77	[4.30, 4.34]
Leadership	4.14	0.94	[4.11, 4.17]

Note. CI = confidence interval. CI ranged between ± 0.02 and ± 0.04 at a 99% confidence level.
$p < .01$.

Leadership as an independent variable showed the strongest correlation with commitment consistently in all 4 years with the highest *r* value of 0.80 in 2007. Coworker relations and employee involvement showed the second strongest correlations with commitment in all 4 years of data collection with the *r* values of 0.72 and 0.68, respectively, both occurring in 2007. The correlations between leadership and coworker relations with commitment were very strong in

2007, which were represented by very high *r* values of 0.80 and 0.72, respectively. The relationship between employee involvement and commitment in 2007 and all other relationships for 2008 through 2010 were strong as represented by *r* values ranging between 0.53 and 0.68.

Variation existed in the strength of the relationship between years and between companies. Each of the variations in correlation with specific companies is addressed with a presentation of each of the 4 years' of data in the following respective sections for each of the companies.

Acceptance of Hypothesis 1. The results supported the first hypothesis that a strong relationship existed between the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment, also known as associate satisfaction or associate engagement. The first hypothesis was accepted on the basis of the very strong to strong relationships that resulted between the independent variables and the dependent variable for the 4 years of data analysis.

Table 10

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Health care Organization

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.72	.61	.54	.57
Employee involvement	.68	.56	.56	.53
Leadership	.80	.63	.63	.61

Note. DV = dependent variable. Very strong relationship occurred in 2007 between coworker relations and commitment and between leadership and commitment. Leadership had the strongest relationship with commitment all 4 years.
$p < .01$.

Pearson two-tailed correlation: Company comparisons to overall organization. Data from each of the companies were analyzed separately for each of the respective years between 2007 and 2010. This was done to further compare trends and results from each of the companies to the overall organizational results. Each of the companies represented a subculture of the overall organization and possessed similar and unique characteristics.

Community care. Community care data, the largest subset of data, were analyzed, and the results were most like the overall organization. Correlation results are shown in Table 11. The Pearson correlation coefficient (r) for all 4 years ranged from 0.50 to 0.80 showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment.

Leadership showed a very strong correlation with commitment in 2007 and a strong correlation in 2008 through 2010. Leadership also showed the strongest correlation with commitment all 4 years of the study. Coworker relations and employee involvement showed strong correlations with commitment with an r value of 0.70 and 0.67 in 2007. The results with community care supported Hypothesis 1.

Home health. The Pearson product correlation coefficient for 2007 to 2010 ranged from 0.55 to 0.82 between the independent variables of coworker relations, employee involvement, and leadership showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. In 2007, two home health companies with separate and individual infrastructures and cultures existed. Both companies were surveyed separately, and associates reported their perceptions on the survey relative to the

Table 11

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Community Care Company

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.70	.57	.52	.61
Employee involvement	.67	.50	.50	.50
Leadership	.80	.61	.62	.62

Note. DV = dependent variable. Very strong relationship occurred in 2007 between coworker relations and commitment and between leadership and commitment. All other relationships were strong for all 4 years. Leadership had the strongest relationship with commitment all 4 years.
$p < .01$.

two separate home health structures. In 2008, the two companies were merged into one organizational structure, and the results were reported as Company 1 in 2008 through 2010. Results for the companies of home health are shown in Table 12.

Very strong correlations resulted between coworker relations, employee involvement, and leadership with commitment in Company 1 in 2007, 0.73, 0.73, and 0.82, respectively. Very strong correlations resulted between coworker relations and leadership in Company 2 in 2007, 0.73 and 0.81, respectively. The correlations between coworker relations and leadership with commitment were very similar between Company 1 and Company 2 in 2007. The correlation trends between independent variables with the dependent variable with home health in 2007 were similar to the overall organization trends with correlation.

Different from the overall organization, in 2008 through 2010, the strongest relationship resulted between employee involvement and commitment in the home health company. The correlation value ($r = 0.73$ and $r = 0.71$) was very strong in 2008 and 2009 between employee involvement and commitment. In short, the strength of all of the correlation relationships (very

strong to strong) between the independent variables with the dependent variable supported Hypothesis 1.

Hospice. The Pearson correlation coefficient for all 4 years of data for the hospice ranged from 0.59 to 0.73 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment (see Table 13). The general results of the hospice data were consistent with the results of the overall organization. Results were most similar to the overall organizational results for 2007.

Coworker relations exhibited the strongest relationship with commitment in 2007 with an *r* value of 0.73, which indicates a very strong relationship. Leadership exhibited a very strong relationship with commitment in 2007 with an *r* value of 0.72. Leadership also exhibited a very strong relationship with commitment in 2009 with an *r* value of 0.71. Employee involvement exhibited the strongest relationship with commitment in 2008 and in 2010 with an *r* value of 0.69 and 0.66, respectively. Therefore, the strength of all of the correlation relationships (very strong to strong) between the independent variables with the dependent variable supported Hypothesis 1.

Rehabilitation. The Pearson correlation coefficient for all 4 years of data for the rehabilitation company ranged from 0.35 to 0.83 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A moderately positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment (see Table 14). The general results with the rehabilitation data were consistent

with the results of the overall organization. Results were most similar to the overall organizational results for 2007.

Table 12

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Home Health Companies

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations				
Company 1	.73	.64	.56	.61
Company 2	.73	NA	NA	NA
Employee involvement				
Company 1	.73	.73	.71	.66
Company 2	.67	NA	NA	NA
Leadership				
Company 1	.82	.65	.55	.63
Company 2	.81	NA	NA	NA

Note. DV = dependent variable. Company 1 and Company 2 were merged together in 2008 and results were reported only for Company 1 for 2008–2010. Very strong relationships occurred in 2007 between coworker relations and commitment, employee involvement and commitment, and leadership and commitment for the home health companies. A very strong relationship occurred in 2008 and 2009 between employee involvement and commitment in the merged home health company. Employee involvement had the strongest relationship with commitment all 4 years.
$p < .01$.

A very strong relationship occurred between all of the independent variables with commitment in 2007 with *r* values of 0.75, 0.72, and 0.83, respectively. Leadership showed the strongest relationship with commitment in 2007 and 2010. Employee involvement showed the strongest relationship with commitment in 2008 and 2009 with *r* values of 0.60 and 0.66. The weakest relationship of a moderately positive level existed between coworker relations and commitment in 2010. Thus, the strength of the correlation relationships (very strong to moderately positive) between the independent variables with the dependent variable supported Hypothesis 1.

Table 13

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Hospice Company

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.73	.57	.60	.59
Employee involvement	.62	.69	.59	.66
Leadership	.72	.59	.71	.59

Note. DV = dependent variable. Very strong relationship occurred in 2007 between coworker relations and commitment and between leadership and commitment. Very strong relationship occurred in 2009 between leadership and commitment. All other relationships were strong.
$p < .01$.

Table 14

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Rehabilitation Company

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.75	.49	.47	.35
Employee involvement	.72	.60	.66	.54
Leadership	.83	.46	.60	.55

Note. DV = dependent variable. Very strong relationship occurred in 2007 between coworker relations and commitment, employee involvement and commitment, and leadership and commitment. Leadership had the strongest relationship with commitment in 2007 and 2010. Employee involvement had the strongest relationship with commitment in 2008 and 2009.
$p < .01$.

Pharmacy. The Pearson correlation coefficient for all 4 years of data for the pharmacy company ranged from 0.50 to 0.71 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the independent variables of coworker relations,

employee involvement, and leadership with the dependent variable of commitment (see Table 15). The general results of the pharmacy data were consistent with the results of the overall organization.

A very strong relationship resulted between leadership and commitment in 2007 with an *r* value of 0.71. This was the strongest correlational relationship in 2007. The strongest relationships between all independent variables and the dependent variable of commitment occurred in 2008 with *r* values of 0.73, 0.75, and 0.77, respectively. Leadership exhibited the strongest relationship with commitment in 2008. Employee involvement demonstrated the strongest relationship (very strong) with commitment in 2009 with an *r* value of 0.70. In short, **t**he strength of the correlation relationships (very strong to strong) between the independent variables with the dependent variable supported Hypothesis 1.

Services. The services company included associates from accounting, information technology, human resources, and other support staff departments. The staff residing in the corporate offices supported the operating companies within the overall organization.

Table 15

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Pharmacy Company

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.61	.73	.55	.50
Employee involvement	.64	.75	.70	.60
Leadership	.71	.77	.63	.60

Note. DV = dependent variable. Very strong relationship occurred in 2007 between leadership and commitment. Very strong relationship occurred between coworker relations and commitment, employee involvement and commitment, and leadership and commitment in 2008. Leadership had the strongest relationship with commitment in 2007 and 2008. Employee involvement had the strongest relationship with commitment in 2009.
$p < .01$.

The Pearson correlation coefficient for all 4 years of data for the services company ranged from 0.36 to 0.73 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A moderately positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment (see Table 16). The general results with the services data were consistent with the results of the overall organization.

A very strong relationship occurred between leadership and commitment in 2007, represented by an *r* value of 0.73. A very strong relationship occurred between employee involvement with commitment in 2008, represented by an *r* value of 0.70. The lowest correlational relationships were between coworker relations and commitment in 2009 ($r = 0.45$) and between leadership and commitment in 2010 ($r = 0.36$). The strength of the relationships were strongly positive and moderately positively, respectively. Therefore, the strength of the correlation relationships (very strong to moderately positive) between the independent variables with the dependent variable supported Hypothesis 1.

Executive team. The executive team included the executive staff and the presidents of each of the operating companies. The number of data points, represented by *N*, was 42 for 2007, 19 for 2008, 22 for 2009, and 15 for 2010. The executive team definition for 2007 was more global and vague and thus included a larger *N*. The number of data points was more representative of the core executive team in 2008 through 2010.

The Pearson correlation coefficient for all 4 years of data for the executive team ranged from 0.17 to 0.81 showing statistical significance at a *p* level of .01 and .05. At a *p* level of .01, 99%

certainty existed that the correlation result was not due to chance. And at a *p* level of .05, 95% certainty existed that the correlation result was not due to chance.

Table 16

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 in Services Company

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.66	.65	.45	.50
Employee involvement	.67	.70	.63	.62
Leadership	.73	.67	.56	.36

Note. DV = dependent variable. Very strong relationship occurred in 2007 between leadership and commitment. Services included accounting, information technology, human resources, and other small support staff departments that supported operating companies within the organization.
$p < .01$.

A wide range of relationship strength existed with this data set, ranging from very strong in 2007 and 2010 between leadership with commitment ($r = 0.81$ and 0.72, respectively) at a *p* level of .01 to negligible in 2009 between leadership ($r = 0.17$) with commitment without significance. A very strong correlation existed between employee involvement and commitment in 2007. A consistently strong positive correlation resulted between employee involvement and commitment from 2008 through 2010, both at the significance level of $p < .01$ and $p < .05$. Coworker relations demonstrated a strongly positive correlation with commitment in 2007 ($r = 0.69$) and in 2008 ($r = 0.64$). Coworker relations did not show a significant positive relationship with commitment in 2009 or 2010.

Generally positive relationships existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment, although inconsistently over the 4 years of data collection (see Table 17). The

general results with the executive team data were consistent with the results of the overall organization and supported Hypothesis 1.

Table 17

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 for Executive Team of Health care Organization

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.69**	.64**	.28	.37
Employee involvement	.75**	.57*	.56**	.64**
Leadership	.81**	.34	.17	.72**

Note. DV = dependent variable. Very strong relationship occurred in 2007 between employee involvement and commitment and between leadership and commitment. A very strong relationship resulted in 2010 between leadership and commitment. The relationships with the executive team were the most inconsistent correlational relationships out of all comparisons.
*$p < .05$. **$p < .01$.

Part-time staff. Part-time staff included clinical care associates who worked hourly schedules on an as needed basis or on a regular part-time hourly basis. The part-time staff participated in the full associate satisfaction survey in 2007, which included 68 items. By request of the company presidents, part-time staff was offered a condensed survey in 2008 through 2010, which included only 13 items. Results from the data analysis of the survey data from part-time staff is shown in Table 18.

The Pearson correlation coefficient for all 4 years of data for the part-time staff ranged from 0.56 to 0.77 showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong positive relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment.

The general results with the part-time staff data were consistent with the results of the overall organization.

Coworker relations very strongly correlated with commitment with an *r* value of 0.70 in 2007. The survey items on coworker relations were not included on the condensed version of the survey in 2008 through 2010. For this reason, no data existed relative to the correlation between coworker relations and commitment between 2008 and 2010. A strong positive relationship resulted between employee involvement and commitment all 4 years in this subset of data with *r* values ranging from 0.56 to 0.63. A very strong positive relationship existed between leadership and commitment in 2007 with an *r* value of 0.77. This was consistent with the results of the overall organization relative to leadership's positive correlation with commitment. Leadership had the strongest positive relationship with commitment all 4 years in this subset of data. Thus, the strength of the correlation relationships (very strong to strong positive) between the independent variables with the dependent variable supported Hypothesis 1.

Long-term care. Long-term care data was only available for the year of 2010 because the company used another associate satisfaction survey tool between 2007 and 2009. The Pearson correlation coefficient for 1 year of data for the long-term care company ranged from 0.36 to 0.62 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A moderate positive to strong positive relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment (see Table 19). The general results with the long-term care company data were consistent with the results of the overall organization.

A strong positive relationship existed between coworker relations and employee

involvement with commitment with *r* values of 0.50 and 0.62, respectively. Again, this result was consistent with the results of the overall organization. The relationship between leadership and commitment was of moderate positive strength with an *r* value of 0.36. Therefore, the results with the long-term care data subset supported Hypothesis 1.

Table 18

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2007 to 2010 for Part-Time Staff in Health Care Organization

	Commitment (DV)			
Independent variables	2007	2008	2009	2010
Coworker relations	.70**	1.00	-	-1.00**
N	656	3	0	2
Employee involvement	.61**	.61**	.63**	.56**
N	663	1797	1752	1031
Leadership	.77**	.64**	.68**	.65**
N	666	1788	1771	1038

Note. DV = dependent variable; *N* = number of data points in data set. Low *N* for coworker relations existed due to part-time staff receiving an alternative, condensed version of the survey in 2008–2010 without coworker relations questions per request of company presidents. Very strong relationship occurred in 2007 between leadership and commitment. Leadership had strongest relationship with commitment all 4 years.
**$p < .01$.

Table 19

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Commitment for 2010 in Long-Term Care Company

	Commitment (DV)
Independent variables	2010
Coworker relations	.50
Employee involvement	.62
Leadership	.36

Note. DV = dependent variable. Strong relationship existed between coworker relations and employee involvement with commitment in 2010. The long-term care company was included in the survey for the first time in 2010.
$p < .01$.

Pearson two-tailed correlation of company results supports Hypothesis 1. In summary, the correlational tests and results for each of the companies' subsets of data and analyses, in general, supported Hypothesis 1. Thus, the results supported the first hypothesis that a strong relationship existed between the independent variables of coworker relations, employee involvement, and leadership with the dependent variable of commitment, also known as associate satisfaction or associate engagement. The first hypothesis was accepted on the basis of the very strong to moderate positive relationships that resulted between the independent variables and the dependent variable for the 4 years of data analysis in the companies' subsets of data.

Multiple linear regression for all 4 years for organization. A multilinear regression analysis was performed for Hypothesis 1 to provide more predictive power of the three independent variables on the dependent variable. Coworker relations, employee involvement, and leadership represented the predictor variables (X1, X2, and X3) in the regression equation. Commitment represented the criterion in the regression equation (Y). The results from the multiple linear regression analysis are shown in Table 20.

The coefficient of multiple correlation (R) was highly positive at a highly significant level ($p \leq .0001$), ranging from 0.83 in 2007 to 0.70 in 2009. The highest correlation coefficient occurred in 2007 with $R = 0.83$. In further analyzing the percentage of variance (R^2), the three independent variables together accounted for the following: (a) 69.5% of the variance with the criterion variable of commitment in 2007, (b) 56.9% of the variance with commitment in 2008, (c) 48.8% of the variance with commitment in 2009, and (d) 55.75% of the variance with commitment in 2010. The adjusted variance values are also included in Table 20.

Individual contributions of each of the independent variables (coworker relations, employee involvement, and leadership) were analyzed (see Table 21). Leadership was the

biggest driver of commitment in 2007 with a β coefficient of 0.49. Employee involvement was the biggest driver of commitment in 2008 through 2010. Coworker relations had the lowest β coefficients ranging from 0.18 to 0.22.

Table 20

Multiple Linear Regression Model for Relationship of Independent Variables of Coworker Relations, Employee Involvement, and Leadership With Dependent Variable of Commitment in 2007 to 2010 Associate Satisfaction Survey Data for Health care Organization

Year	*N*	*R*	R^2	Adjusted R^2	*SE*
2007	6018	.83	.70	.70	.40
2008	2226	.76	.57	.57	.46
2009	2151	.70	.49	.49	.50
2010	3243	.75	.56	.56	.50

Note. The three independent variables accounted for 69.5% of the variance in commitment in 2007, 56.9% of the variance in commitment in 2008, 48.8% in the variance in commitment in 2009, and 55.7% in the variance in commitment in 2010.
$p \leq .0001$.

Multilinear regression provided a stronger level of analysis over the Pearson product correlation (Babbie, 1990, 2014; Hauke & Kossowski, 2011; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011). Data were studied for the entire organization by year for this particular analysis and not evaluated by company. The results of the multiple regression analysis for the organization further supported the acceptance of Hypothesis 1 that a strong relationship

existed between coworker relations, employee involvement, and leadership with commitment.

One-way analysis of variance. A one-way analysis of variance (ANOVA) was performed for Hypothesis 1 for each of the 4 years of data and was used to further analyze the impact of the combined effect of the three independent variables of coworker relations, employee

involvement, and leadership on the dependent variable of commitment. A one-way ANOVA was performed to further provide credibility to the Pearson correlation and multilinear regression results (Babbie, 1990; Hauke & Kossowski, 2011; Khan Academy, 2014; Kitchens, 1998; McMillan & Schumacher, 2001; Mondore & Douthitt, 2009; Mondore et al., 2011; Yale University, n.d.). A one-way ANOVA was run on all organizational data by year, and the results are shown in Table 22.

Table 21

Multiple Regression Coefficients for Coworker Relations, Employee Involvement, and Leadership for 2007 to 2010 Associate Satisfaction Survey Data for Health care Organization

Independent variables		Standardized β coefficients	*t*
Constant		β_0	
	2007	NA	4.67
	2008	NA	13.36
	2009	NA	13.24
	2010	NA	16.00
Coworker relations		β_1	
	2007	.22	20.49
	2008	.20	10.78
	2009	.18	8.92
	2010	.18	11.45
Employee involvement		β_2	
	2007	.22	21.44
	2008	.48	20.78
	2009	.48	21.12
	2010	.52	28.89
Leadership		β_3	
	2007	.49	39.84
	2008	.16	6.91
	2009	.12	5.03
	2010	.13	7.62

Note. Leadership was the biggest driver of commitment in 2007 as evident by $\beta_3 = .49$. Employee involvement was the biggest driver of commitment in 2008 to 2010 as evident by β_2.
$p \leq .0001$.

The square of the sample population as represented by the sum of squares (SS) for the regression model, compared to the sum of squares for the total sum of squares for each of the 4 years, showed a high percentage of variability in the commitment and this was due to the combination of the three independent variables of coworker relations, employee involvement, and leadership. This being known as the fraction of variability for the data resulted in 69.5%, 56.9%, 48.8%, and 55.7% for 2007 through 2010, respectively. Thus, 69.5%, 56.9%, 48.8%, and 55.7% variability in commitment was explained through the combination effect of the independent variables. Data from the sum of squares column in Table 22 was used to calculate the fraction of variability for the regression equation. In addition, the large *F* statistic values, as shown in Table 22, exceeded the critical *F* values for 2007 through 2010 at a statistical significance of $p \leq .0001$ (Soper, 2014). Therefore, the statistically significant *F* values, in addition to the high fractions of variability for all 4 years, supported the acceptance of Hypothesis 1 that a strong relationship existed between the independent variables of coworker relations, employee involvement, and leadership with commitment.

Summary. The Pearson product correlation results for the overall organization and for each of the subsets of company data, in addition to the multiple regression analysis and the one-way ANOVA, supported the acceptance of Hypothesis 1 that a strong relationship existed between coworker relations, employee involvement, and leadership with commitment. The strongest Pearson product correlation values resulted in 2007, the first year of the study. The subset data from the executive team and from the long-term care company had the least significant results, yet supported Hypothesis 1.

The multiple regression analysis and the one-way ANOVA showed that the three independent variables combined accounted for 69.5% of the variance in commitment in 2007,

56.9% of the variance in commitment in 2008, 48.8% of the variance in commitment in 2009, and 55.7% of the variance in commitment in 2010. Leadership was the biggest driver of commitment in 2007, and employee involvement was the biggest drive of commitment in 2008 through 2010 as per the multiple regression analysis results.

Table 22

One-Way ANOVA for 2007 to 2010 Associate Satisfaction Survey Data for Health care Organization

Model	*SS*	*df*	*MS*	*F*	Critical *F* value
2007					
Regression	2150.45	3	716.82	4568.09	7.048
Residual	943.71	6014	.16		
Total	3094.15	6017			
2008					
Regression	635.25	3	211.75	980.69	7.068
Residual	479.77	2222	.22		
Total	1115.02	2225			
2009					
Regression	521.60	3	173.87	683.52	7.069
Residual	546.14	2147	.25		
Total	1067.74	2150			
2010					
Regression	1010.85	3	336.95	1357.56	7.058
Residual	803.93	3239	.25		
Total	1814.78	3242			

Note. Significant regression was supported by high *F* values for 2007–2010. 69.5%, 56.9%, 48.8%, and 55.7% variability in commitment was explained by coworker relations, employee involvement, and leadership combined as independent variables respectively for 2007, 2008, 2009, and 2010.
$p \leq .0001$.

The researcher sought additional insight and reasons for the quantitative results through the second phase of the study, the qualitative group interviews. The researcher wanted to explore the perceptions of groups of associates from a variety of work groups across the organization related to coworker relations, employee involvement, and leadership and how these were related

to their perceptions of teaming, team leadership, and commitment. Discussion as to the explanation for the quantitative results is addressed in Chapter 5.

Hypothesis 2: Strong Relationship Between Each of the Independent Variables With Each Other

Hypothesis 2 was that a strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. Predominant literature on teaming presented the existence of key qualities of effective teams but did not interrelate the various qualities or show strength in the relationships of the qualities with each other. The researcher conducted an analysis using a Pearson two-tailed correlation to quantify the relationships of qualities found to be present in associates' perceptions of teams.

Pearson two-tailed correlation results for organization for all 4 years. The Pearson correlation coefficient for all 4 years of data for the overall organization ranged from 0.45 to 0.75 showing statistical significance at a p level less than .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the independent variables of employee involvement, coworker relations, and leadership with the each other (see Table 23).

Leadership showed the strongest positive correlation with coworker relations in 2007 for the organization with an r value of 0.75. Leadership and coworker relations were strongly positive in strength for 2008 through 2010 with r values ranging from 0.60 to 0.62. Leadership and employee involvement and employee involvement and coworker relations exhibited strong positive correlational values for all 4 years of data collection, from 2007 through 2010. Leadership and employee involvement exhibited the second strongest correlation with each other in 2007 with $r = 0.69$. The strength of the correlation between leadership and employee

involvement dropped to a strong positive level for 2008 through 2010 and remained consistently strong positive (r = 0.45–0.49). The r values ranged from 0.45 to 0.69 for the interrelationship between these independent variables.

Variation existed in the strength of the relationships between years and between companies. Each of the variations in correlation with specific companies is addressed with a presentation of each of the 4 years' of data in the following respective sections for each of the companies.

Acceptance of Hypothesis 2. The results supported the second hypothesis that a strong relationship existed between the independent variables of coworker relations, employee involvement, and leadership with each other. The second hypothesis was accepted on the basis of the very strong to strong relationships that resulted between the independent variables for the 4 years of data analysis.

Pearson two-tailed correlation: Company comparisons to overall organization. Data from each of the companies were analyzed separately for each of the respective years between 2007 and 2010. This was done to further compare trends and results from each of the companies to the overall organizational results. Each of the companies represented a subculture of the overall organization and possessed similar and unique characteristics.

Community care. Community care data, the largest subset of data, were analyzed, and the results were most like the overall organization. Correlation results are shown in Table 24. The Pearson correlation coefficient (r) for all 4 years ranged from 0.37 to 0.72 showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. A moderate positive to very strong relationship existed

between each of the independent variables of coworker relations, employee involvement, and leadership with each other.

Table 23

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Health care Organization

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.59	.75
2008	1	.64	.62
2009	1	.59	.60
2010	1	.61	.60
Employee involvement			
2007	.59	1	.69
2008	.64	1	.45
2009	.59	1	.45
2010	.61	1	.49
Leadership			
2007	.75	.69	1
2008	.62	.45	1
2009	.60	.45	1
2010	.60	.49	1

Note. Very strong relationship occurred in 2007 between leadership and coworker relations. All other relationships were strong for all 4 years between all of the independent variables.
$p < .01$.

Leadership showed a very strong positive correlation with coworker relations in 2007 and a strong positive correlation in 2008 through 2010. Leadership showed a strong positive correlation with employee involvement in 2007 and 2010 and a moderate positive correlation with employee involvement in 2008 and 2009. Coworker relations and employee involvement showed strong positive correlations with each other with an *r* value ranging between 0.56 and 0.61 for the 4 years of data collection. Thus, the results for community care supported Hypothesis 2 and were similar to the trends in the overall organization.

Home health. Correlation results for home health are shown in Table 25. The Pearson correlation coefficient (*r*) for all 4 years ranged from 0.59 to 0.79 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. Home health data were analyzed and demonstrated similarity in trends to the overall organization, but there were higher *r* values in the relationships.

Leadership showed a very strong positive correlation with coworker relations in 2007 ($r = 0.79$), demonstrating the strongest correlation between the independent variables for home health. Leadership and coworker relations showed a strong positive correlation in 2008 through 2010. Leadership showed a very strong positive correlation with employee involvement for 2007 through 2009 (*r* value ranging from 0.70 to 0.73) and a strong positive correlation with employee involvement in 2010 ($r = 0.59$). Coworker relations and employee involvement showed strong positive correlations with each other with an *r* value ranging between 0.62 and 0.64 for the 4 years of data collection. Thus, the results for home health supported Hypothesis 2 and were similar to the trends in the overall organization.

Hospice. Correlation results for hospice are shown in Table 26. The Pearson correlation coefficient (*r*) for all 4 years ranged from 0.52 to 0.78 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. Hospice data were analyzed and demonstrated similarity in trends to the overall organization.

Table 24

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Community Care Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.56	.72
2008	1	.61	.57
2009	1	.52	.58
2010	1	.58	.64
Employee involvement			
2007	.56	1	.69
2008	.61	1	.39
2009	.52	1	.37
2010	.58	1	.41
Leadership			
2007	.72	.69	1
2008	.57	.39	1
2009	.58	.37	1
2010	.64	.41	1

Note. Very strong relationship occurred in 2007 between leadership and coworker relations. All other relationships were strong for all 4 years between all of the independent variables with the exception of moderately positive relationships between leadership and employee involvement in 2008 and 2009.
$p < .01$.

Coworker relations showed a strong positive correlation with both employee involvement and leadership for all 4 years of data collection with *r* values ranging from 0.52 to 0.65. Employee involvement exhibited a strong positive correlation with leadership 3 of the 4 years, from 2007 to 2008 and 2010. Employee involvement and leadership exhibited a very strong positive correlation in 2009 with an *r* value of 0.78, which was the highest positive correlation of all the tests run between the independent variables for the hospice data. Therefore, the results for hospice supported Hypothesis 2 and were similar to the trends in the overall organization.

Table 25

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Home Health Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.62	.79
2008	1	.66	.65
2009	1	.64	.62
2010	1	.63	.64
Employee involvement			
2007	.62	1	.71
2008	.66	1	.73
2009	.64	1	.70
2010	.63	1	.59
Leadership			
2007	.79	.71	1
2008	.65	.73	1
2009	.62	.70	1
2010	.64	.59	1

Note. Very strong relationship occurred in 2007 between leadership and coworker relations and between leadership and employee involvement. Very strong relationship occurred in 2008-2010 between leadership and employee involvement. All other relationships were strong for all 4 years between all of the independent variables. Company 1 was used for the 4-year comparison because Company 2 merged into Company 1 after 2007.
$p < .01$.

Rehabilitation. Correlation results for rehabilitation are shown in Table 27. The Pearson correlation coefficient (r) for all 4 years ranged from 0.49 to 0.76 showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. Rehabilitation data were analyzed and demonstrated similarity in trends to the overall organization.

Coworker relations showed a very strong positive correlation with leadership in 2007 with an *r* value of 0.76, the highest positive correlation in the 4 years of data collection with the rehabilitation data. The remaining 3 years of data correlations between coworker relations and leadership were of the strong positive nature. The correlational relationships between coworker relations and employee involvement were strong positive in nature for all 4 years of data analysis. Employee involvement exhibited a very strong positive correlation with leadership in 2007 and 2009 with *r* values of 0.74 and 0.72, respectively. Employee involvement and leadership exhibited a strong positive correlation in 2008 and 2010 with an *r* value of 0.69 and 0.55, respectively. Therefore, the results for rehabilitation supported Hypothesis 2 and were similar to the trends in the overall organization.

Pharmacy. Correlation results for pharmacy are shown in Table 28. The Pearson correlation coefficient (*r*) for all 4 years ranged from 0.49 to 0.80 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. Pharmacy data were analyzed and demonstrated similarity in trends to the overall organization.

Coworker relations showed a strong positive correlation with both employee involvement and leadership for all 4 years of data collection with *r* values ranging from 0.49 through 0.62. Employee involvement exhibited a very strong positive correlation with leadership 2 of the 4 years, in 2008 and 2009. These were the highest of the positive correlations with the pharmacy results, *r* values of 0.80 and 0.74, respectively. Employee involvement and leadership exhibited a strong positive correlation in 2007 and 2010 with an *r* value of 0.61 and 0.59, respectively. Thus,

the results for pharmacy supported Hypothesis 2 and were similar to the trends in the overall organization.

Table 26

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Hospice Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.55	.61
2008	1	.58	.52
2009	1	.59	.65
2010	1	.60	.58
Employee involvement			
2007	.55	1	.58
2008	.58	1	.65
2009	.59	1	.78
2010	.60	1	.62
Leadership			
2007	.61	.58	1
2008	.52	.65	1
2009	.65	.78	1
2010	.58	.62	1

Note. Very strong relationship occurred in 2009 between leadership and employee involvement. All other relationships were strong for all 4 years between all of the independent variables.
$p < .01$.

Services. Correlation results for services are shown in Table 29. The Pearson correlation coefficient (r) for all 4 years ranged from 0.41 to 0.82 showing statistical significance at a p level of .01. At a p level of .01, 99% certainty existed that the correlation result was not due to chance. The services company showed the greatest range in r values with a spread of 0.41 at the significance level of $p < 0.01$. A strong positive to very strong relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with

each other. The services company data were analyzed and demonstrated similarity in trends to the overall organization.

Table 27

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Rehabilitation Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.68	.76
2008	1	.46	.49
2009	1	.49	.49
2010	1	.40	.52
Employee involvement			
2007	.68	1	.74
2008	.46	1	.69
2009	.49	1	.72
2010	.40	1	.55
Leadership			
2007	.76	.74	1
2008	.49	.69	1
2009	.49	.72	1
2010	.52	.55	1

Note. Very strong relationship occurred in 2007 between leadership and coworker relations and between leadership and employee involvement. Very strong relationship occurred in 2009 between leadership and employee involvement. Most other relationships were strong for all 4 years between all of the independent variables. $p < .01$.

Coworker relations showed a strong positive correlation with both employee involvement and leadership for all 4 years of data collection with *r* values ranging from 0.41 to 0.68. Employee involvement exhibited a very strong positive correlation with leadership 2 of the 4 years, in 2008 and 2009. These were the highest of the positive correlations with the services results, *r* values of 0.82 and 0.74, respectively. Employee involvement and leadership exhibited a strong positive correlation in 2007 and 2010 with an *r* value of 0.60 and 0.66, respectively.

Thus, the results with the services data supported Hypothesis 2 and were similar to the trends in the overall organization.

Table 28

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Pharmacy Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.49	.66
2008	1	.63	.67
2009	1	.60	.60
2010	1	.63	.62
Employee involvement			
2007	.49	1	.61
2008	.63	1	.80
2009	.60	1	.74
2010	.63	1	.59
Leadership			
2007	.66	.61	1
2008	.67	.80	1
2009	.60	.74	1
2010	.62	.59	1

Note. Very strong relationship occurred in 2008 and 2009 between leadership and employee involvement. All other relationships were strong for all 4 years between all of the independent variables.
$p < .01$.

Executive team. The executive team included the executive staff and the presidents of each of the operating companies. The number of data points, represented by *N*, was 42 for 2007, 19 for 2008, 22 for 2009, and 15 for 2010. The executive team definition for 2007 was more global and vague and thus included a larger *N*. The number of data points was more representative of the core executive team in 2008 through 2010.

The Pearson correlation coefficient for all 4 years of data in the executive team ranged from 0.30 to 0.88 showing statistical significance at a *p* level of .01 and .05. At a *p* level of .01,

99% certainty existed that the correlation result was not due to chance. And at a *p* level of .05, 95% certainty existed that the correlation result was not due to chance. The Pearson correlation results for Hypothesis 2 relative to the executive team are shown in Table 30.

A wide range of relationship strength existed with this data set. It ranged from very strong in 2007 and 2010 between leadership and employee involvement ($r = 0.77$ and 0.88, respectively) and between leadership and coworker relations ($r = 0.72$) at a *p* level of .01 to insignificant in 2008 and 2009 between leadership and coworker relations. A strong positive correlation existed between coworker relations and leadership in 2007 and between employee involvement and leadership in 2008 at a *p* level of 0.01 or with 99% confidence. A strong positive correlation also existed ($r = 0.53$) between employee involvement and leadership at a *p* level of 0.05 or with 95% confidence. Therefore, the general results with the executive team data were consistent with the results of the overall organization and supported Hypothesis 2.

Part-time staff. Part-time staff included clinical care associates who worked hourly schedules on an as needed basis or on a regular part-time hourly basis. The part-time staff participated in the full associate engagement survey in 2007, which included 68 items. By request of the company presidents, part-time staff was offered a condensed survey in 2008 through 2010, which included only 13 items. Results from the data analysis on the survey data from part-time staff relative to Hypothesis 2 is shown in Table 31.

The Pearson correlation coefficient for all 4 years of data for the part-time staff ranged from 0.48 to 0.72 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive to very strong positive relationship existed between each of the independent variables of coworker

relations, employee involvement, and leadership with each other. The general results with the part-time staff data were consistent with the results of the overall organization.

Table 29

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 in Services Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.55	.61
2008	1	.68	.67
2009	1	.57	.57
2010	1	.54	.41
Employee involvement			
2007	.55	1	.60
2008	.68	1	.82
2009	.57	1	.74
2010	.54	1	.66
Leadership			
2007	.61	.60	1
2008	.67	.82	1
2009	.57	.74	1
2010	.41	.66	1

Note. Very strong relationship occurred in 2008 and 2009 between leadership and employee involvement. All other relationships were strong for all 4 years between all of the independent variables.
$p < .01$.

A very strong correlation existed between coworker relations and leadership with an *r* value of 0.72 in 2007. The survey items on coworker relations were not included on the condensed version of the survey in 2008 through 2010. For this reason, no data existed relative to correlation between coworker relations with any of the other independent variables between 2008 and 2010. A strong positive relationship resulted between employee involvement and leadership in all of this subset of data with *r* values ranging from 0.54 to 0.66. A strong positive relationship resulted between employee involvement and coworker relations ($r = 0.55$) in 2007.

This was consistent with the results of the overall organization relative to the relationship between employee involvement and leadership. Thus, the strength of the correlation relationships (very strong to strong positive) between the independent variables with each other supported Hypothesis 2.

Table 30

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 for Executive Team of Health care Organization

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.51**	.58**
2008	1	.51*	.30
2009	1	.53*	.37
2010	1	.64**	.72**
Employee involvement			
2007	.51**	1	.77**
2008	.51*	1	.59**
2009	.53*	1	.53*
2010	.64**	1	.88**
Leadership			
2007	.58**	.77**	1
2008	.30	.59**	1
2009	.37	.53*	1
2010	.72**	.88**	1

Note. Very strong relationship between leadership and employee involvement in 2007 and between leadership and coworker relations and leadership and employee involvement in 2010.
*$p < .05$. **$p < .01$.

Long-term care. Long-term care data were only available for 2010 because the long-term care company was using another associate satisfaction survey tool in 2007 through 2009. Table 32 shows the Pearson correlation coefficients for 2010 between the independent variables for the

long-term care company. The trend with the data was consistent and similar to that shown with the organization for 2010.

The Pearson correlation coefficient for 1 year of data for the long-term care company ranged from 0.45 to 0.66 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong positive relationship existed between each of the independent variables of coworker relations, employee involvement, and leadership with each other. A strong positive relationship existed between coworker relations and employee involvement ($r = 0.66$) and between coworker relations and leadership ($r = 0.60$) in 2010. A strong positive correlation also existed between employee involvement and leadership ($r = 0.45$) in 2010. Again, this result was consistent with the results of the overall organization. The results with the long-term care data subset supported Hypothesis 2.

Summary. In summary, the correlational tests and results for each of the companies' subsets of data and analyses supported Hypothesis 2. Thus, the results supported the second hypothesis that a strong relationship existed between the independent variables of employee involvement, coworker relations, and leadership with each other. The second hypothesis was accepted on the basis of the very strong to strong positive relationships that resulted between the independent variables with each other for the 4 years of data analysis in the companies' subsets of data.

Coworker relations and leadership resulted with the highest positive correlations in 2007, often very strong in strength. Employee involvement and leadership showed higher correlational levels from 2008 to 2010. Employee involvement and leadership resulted with the highest *r* values in the companies of pharmacy ($r = 0.80$), services ($r = 0.82$), and with the executive

team (r = 0.88). Home health showed the narrowest range in r values for the 4 years of data with a range of 0.20. And services showed the widest range in r values for the 4 years of data with a range of 0.41. All data, both for the overall organization and for the companies' subsets of data supported the acceptance of Hypothesis 2.

Table 31

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2007 to 2010 for Part-Time Staff in Health Care Organization

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations			
2007	1	.55	.72
2008	1	-	-
2009	1	-	-
2010	1	-	-
Employee involvement			
2007	.55	1	.66
2008	-	1	-
2009	-	1	.48
2010	-	1	.54
Leadership			
2007	.72	.66	1
2008	-	-	1
2009	-	.48	1
2010	-	.54	1

Note. Very strong relationship occurred in 2007 between leadership and coworker relations. *N* was not valid for correlation results in 2008. Items for coworker relations were not included on the condensed survey for part-time staff; thus, *N* was not adequate for a valid correlation in 2009 and 2010. Correlations between leadership and employee involvement were strong for 2007 and 2009 through 2010 where *N* was adequate.
$p < .01$.

Quantitative analysis conclusion. The Pearson product correlation results for the overall organization and for each of the subsets of company data, in addition to the multiple regression analysis and the one-way ANOVA, supported the acceptance of Hypothesis 1 that a strong

relationship existed between coworker relations, employee involvement, and leadership with commitment. The strongest Pearson product correlation values resulted in 2007, the first year of the study. The subset data from the executive team and from the long-term care company had the least significant results, yet supported Hypothesis 1.

Table 32

Pearson Two-Tailed Correlation Between Coworker Relations, Employee Involvement, and Leadership With Each Independent Variable for 2010 in Long-Term Care Company

Independent variables	Independent variables		
	Coworker relations	Employee involvement	Leadership
Coworker relations 2010	1	.66	.60
Employee involvement 2010	.66	1	.45
Leadership 2010	.60	.45	1

Note. Strong relationships occurred between coworker relations and employee involvement, coworker relations and leadership, and employee involvement and leadership in 2010. The long-term care company was included in survey for the first time in 2010.
$p < .01$.

Hypothesis 2 was accepted on the basis of the very strong to strong positive relationships that resulted between the independent variables with each other for the 4 years of data analysis in the companies' subsets of data. Coworker relations and leadership resulted with the highest positive correlations in 2007, often very strong in strength. Employee involvement and leadership showed higher correlational levels from 2008 to 2010. Organizational data and company subset data were consistent in support of Hypothesis 2. The multiple regression analysis and the one-way ANOVA showed that the three independent variables combined accounted for 69.5% of the variance in commitment in 2007, 56.9% of the variance in commitment in 2008, 48.8% of the variance in commitment in 2009, and 55.7% of the variance

in commitment in 2010. Leadership was the biggest driver of commitment in 2007, and employee involvement was the biggest driver of commitment in 2008 through 2010 as per the multiple regression analysis results.

The researcher sought additional insight and reasons for the quantitative results through the second phase of the study, the qualitative group interviews. The researcher wanted to explore the perceptions of groups of associates from a variety of work groups across the organization related to coworker relations, employee involvement, and leadership and how these were related to their perceptions of teaming, team leadership, and commitment as relative to Hypothesis 1. In addition, the researcher explored how each of the independent variables were related to each other and how leadership was related to timing and support of both coworker relations and employee involvement. Discussion as to an explanation for the quantitative results is addressed in Chapter 5.

Qualitative Research Findings

Purpose. The purpose of the qualitative component was to fully explore the perceptions of groups pertaining to coworker relations, employee involvement, and leadership relative to commitment of associates through the use of nine focus groups. In addition, the researcher's goal was to gain more insight into how each of the independent variables related to each other and how the groups of associates spoke about them. The researcher wanted confirmation on how leadership might serve as the driver of coworker relations and employee involvement and how that was described.

Seventy-five associates were interviewed in nine focus groups, and the groups ranged in size from five to 12 associates. The qualitative purpose evolved throughout the course of the study and emerged after the results from the first phase were quantified. The researcher wanted

to hear the words and thoughts from groups of associates on their beliefs and perceptions related to teaming and team leadership. Thus, questions were asked relative to the attributes necessary for effective teams according to Robbins (2001), Robbins and Judge (2012), and others (Borkowski, 2009). The qualitative design included four primary questions supported by 12 possible secondary questions. The researcher modified the secondary questions in the qualitative phase of the study based on group interview responses. This is often the case with a qualitative design (Creswell, 2008; Creswell & Plano Clark, 2007).

Research questions and rationale. The key questions that were addressed in this phase of the study were the following: (a) What are the perceptions of associates working on various teams representing different levels of commitment and from representative companies within the organization?, (b) What aspects of teaming most relate to associate satisfaction according to teams of associates?, and (c) How does the style of the team leader impact associate satisfaction and the associates' perception of teaming? This study addressed possible answers to these questions by collecting qualitative data from teams. Additional questions emerged after the quantitative phase and during the focus groups, and they were deemed as critical in the reflective and attentive nature of qualitative interviewing.

Relationship of questions to quantitative hypotheses. The answers to the above questions provided more depth to the quantitative data relative to the first and second hypotheses. Answers to the first two questions addressed the first hypothesis, which stated that there was a strong relationship between coworker relations, employee involvement, and leadership with associate commitment. Responses and comments that addressed the second question provided more richness to the question on aspects related to teaming as perceived by the groups of associates. Responses provided to the third question resulted in more enlightenment on

how leadership, in relation to the other two independent variables, was critical to teaming (Robbins, 2001; Robbins & Judge, 2012). The interviews' commentary provided richness pertaining to the second hypothesis. The researcher gained more depth through the direct comments and insight of groups of associates in their spoken words, which could not be gained through a quantitative tool.

Population data demographics. The target population for the qualitative phase of the study was the total work units as identified by the seven division presidents. A total of 249 work units comprised the total population of work units within the target health care organization. The researcher described work units by company and geography. Each had one supervisor that managed that work unit within the structure of each of the seven divisions of the target health care organization. Two hundred and fifteen of the 249 work groups (86.3%) from within the organization's work groups existed in the state of Texas; thus, selecting the focus groups from the state of Texas represented the majority of the population of work groups.

Focus group selection by company and tier. A sample of nine focus groups was selected from a population of 215 work groups from the state of Texas. The researcher selected work groups representing both metropolitan and rural areas of Texas. Six of the work groups were from Central Texas communities: one from Austin, four from surrounding suburb communities of Austin, and one from a rural Central Texas town. Two of the work units were from the Dallas/Fort Worth area, a large metropolitan area. One work unit was from the Corpus Christi area, a smaller metropolitan area in south Texas. The description of work groups as delineated by company and geographical area was shown in Table 3, Chapter 3. Focus groups were selected through a sample of convenience, availability, and willingness.

Groups were selected from each of three tiers as ranked by level of associate commitment on the associate satisfaction survey in the first quantitative phase of the study. The highest tier (Tier 1) groups were those groups with the highest level of work unit commitment as calculated by their average scores on the survey items most related to organizational commitment, having achieved the highest level of scoring on the commitment indicator items or the dependent variables (Corrigan & Douthitt, 2007; Morehead Associates, 2007a, 2007b, 2008, 2009, 2010). The average scores on the commitment items were compared to a national benchmark average. The middle tier (Tier 2) groups represented those groups with a midrange level of commitment indicator scores or average scores at or close to the national benchmark average. The low tier (Tier 3) groups were those groups with low levels of associate commitment as compared to the national benchmark average. Two groups were from Tier 1, five groups were from Tier 2, and two groups were from Tier 3. In this way, the researcher was able to compare similarities and differences in the associates' perceptions on coworker relations, employee involvement, leadership, associate commitment, and teaming behaviors on the basis of not only company origin but also on tier ranking levels as compared to the national benchmark using the Morehead tool (Corrigan & Douthitt, 2007; Morehead Associates 2007a, 2007b, 2008, 2009, 2010). The tier delineation was shown in Table 5, Chapter 3.

Work groups consisted of associates working for one of the seven related health care companies, all owned and managed by the same organizational corporation. Work groups consisted of five to 12 associates as was shown in Table 4, Chapter 3. Work group membership varied according to ethnicity, years of work experience, job classification, age, and gender.

Qualitative Protocol and Process for Data Collection

Focus group questions. Focus group questions were created using the four characteristics of effective teams according to Robbins (2001): work design, composition, context, and process. The characteristic of work design referenced Robbins' (2001) team definition of complimentary skills. The characteristic of composition referenced a team definition of positive synergy (Robbins, 2001). Context referenced the team definition of individual and mutual accountability (Robbins, 2001). And process referenced the team definition of development of collective goals (Robbins, 2001). Questions for focus groups were developed around the four key characteristics and definitions of effective teams as captured by Robbins (2001) and supported by others.

Focus group questions were posed in an open discussion format. The four primary questions that the researcher asked were the following: (a) How does the work unit work together to accomplish their goals?, (b) What enhances workplace satisfaction?, (c) What enhances the teaming experience?, and (d) What facilitates teaming? Secondary questions were asked as follow-up to the primary research questions. Sixteen questions existed in totality, but not all secondary questions were asked in every interview (see Appendix J). Secondary questions were customized based on responses to the first four primary questions. The researcher explored the perceptions of associates that may be helpful in tailoring and administering actions to assist in improving work environment and associate satisfaction in the future.

Focus group logistics. The researcher conducted focus group interviews from August 27, 2012 to November 6, 2012. The researcher followed a consistent process for arranging, conducting, and analyzing focus group data.

Champion or gatekeeper. The researcher worked through a company or division president or senior vice president to identify possible work groups and focus group champions. The focus group champion then assisted in arranging a meeting time and location as well as communicating group details to associates. The focus group champion, in all cases, was positive and supportive in facilitating the date, time, and location of the group meeting. He or she also assisted in communicating with associates. The champion was, in all cases, the supervisor of the focus group but did not participate in the focus group interview.

Focus group meeting location. Each branch office had a conference or meeting room, which served as an interview site for the open-ended interviews. The researcher arranged a site meeting room through the branch office gatekeeper and insured the meeting room was scheduled in advance with the appropriate person. Each of the meeting rooms had a door to insure privacy. The exact interview location at each focus group site and the office gatekeeper's job title was indicated in Table 4, Chapter 3. The researcher provided light refreshments to show respect to the associates who volunteered to assist with the study.

Researcher practiced reflectivity in the process. Qualitative open-ended focus groups occurred in the summer and fall of 2012. Work unit managers did not attend the focus group interviews. In some cases, the work unit leader or manager socialized and greeted work group participants and then exited for the focus group questioning. The researcher served as an instrument within this phase of the research and thus switched from an impartial observer to an involved participant within the scope of research. The researcher followed the recommended principles of conducting interviews as presented by Rossman and Rollis (2003, pp.169-204).

Letter explaining study. The researcher provided a letter to potential participants explaining the research study, the design and process, the voluntary nature of participation,

contact information for questions, and advisement of informed consent (see Appendix H). A hard copy of the letter was provided in advance to each participant in each group. The Letter to Potential Focus Group Participants is located in the Appendices as Appendix Figure 6.

Use of consistent agenda and collection of informed consent. The researcher posted and followed an agenda for each of the focus groups. The agenda was posted on a white flip chart, and this same flip chart was used in every focus group. The focus group agenda was shown in Figure 3, Chapter 3.

The researcher started the focus group by thanking participants and explaining the voluntary nature of the study process. The researcher also explained that responses would be recorded as group responses and no individual identities would be known. After an explanation of the study and prior to conducting the group interviews in a discussion format, the researcher explained the Informed Consent form and paused to answer any questions (see Appendix I). Participants read and signed the Informed Consent Form prior to the researcher proceeding with questions. Signed Informed Consent forms for each focus group were maintained in a labeled folder by focus group number in a secured and locked location along with other group interview transcripts, researcher's notes, and data.

Pilot focus group. The researcher conducted the first focus group as a pilot and made adjustments to the qualitative interview process. This process included distributing the participant letter in advance, arranging the meeting room through the informal gatekeeper, explaining the informed consent, conducting the open-ended focus group interview, audio recording the interview, providing refreshments, and then transcribing the data.

Means of establishing credibility, trustworthiness, and rigor. A field journal, use of a peer debriefer, and critical reflexivity were practiced to enhance reflexivity and soundness of the

interview phase of the research. Disciplined subjectivity was used to enhance the authenticity of participants' responses during the qualitative phase. Interviews were conducted using a semistructured format and then recorded, transcribed, coded for trends, and checked periodically for accuracy. Transcripts, notes, and coding documents were checked and rechecked several times at different times to insure accuracy and completeness of data. Techniques, such as triangulation, to insure accuracy and soundness of data and of research results were attempted for both the quantitative and qualitative phases of this research.

Recording, transcription, and storage of data. Group interviews were audio recorded. The researcher recorded copious notes during the sessions, making notes of her observations including inflections of voices, laughter, pauses, and other nonverbal behaviors in the group's response. Audio recordings were then transcribed and reviewed for accuracy of content and transcription by the researcher three times. Any names or identifiable information was eliminated from the transcripts so as to not distract from the research analytic process or expose identities. All recorded and transcribed data, field journal notes, theme-coding tables, and any other information was stored in a locked and secured location to protect the integrity of the data and group participants. Discussion of data occurred only with a peer debriefer, and details of individual or company identities were not discussed.

Qualitative Data Analysis

Data reviewed from group perspective. The researcher reviewed transcripts for completion and accuracy several times. The researcher then marked the questions with responses, recorded notes on themes, and highlighted pertinent responses. The transcripts were highlighted and marked with key notes and themes. The researcher reviewed the transcripts from a group perspective and no individuals' names were evident as the researcher reviewed or coded

the transcribed documents. For the purposes of presenting results, themes, and providing support for the themes, the researcher noted focus groups as being associated with Tier 1, 2, or 3 in the text.

Theme coding in transcripts and the development of theme matrices. Once the researcher marked up and highlighted themes within each of the nine transcripts, the researcher constructed matrices, one for each of the 16 qualitative focus group questions. Each of the nine groups was recorded in the left column and then each transcript was reviewed for themes. The themes were recorded across the top column of each matrix. Repetitive themes across multiple focus groups became evident using the matrix approach. Tier 1 themes were noted as such and represented best practices in the notes. The researcher captured similar descriptions and comments from groups relative to the themes in the note portion of the matrix documents.

Sixteen matrices existed in total. The researcher created the tables manually and then recreated them in Excel format overlaying the themes with the quantitative variables from the first phase of the study. These qualitative focus group theme-coding tables can be found in the supplemental materials entitled “Qualitative Coding Tables for Chapter 4.” The researcher reviewed the coding matrices and transcripts more than a dozen times to identify previously missed themes and to cross-check the themes with the quantitative variables. The researcher recorded insights and observations in a journal as she reviewed transcripts and matrices. Themes that emerged as trends or patterns are presented in a condensed format within abbreviated tables in this chapter. The results, along with the full coding tables, are referenced in the Appendices.

Text concept maps and correlations. After transcripts were reviewed for themes and matrices were constructed, questions and interviewer comments along with behavioral expressions or observations were eliminated from the transcripts. Three versions of transcripts

for each of the nine groups were saved individually. The first transcript version included responses only for the first four primary questions. The second transcript version included responses for all interview questions. The third transcript version included responses for the fifth interview question on trust, since that was a theme that emerged and was also of interest to the researcher. The three different versions for each of the nine groups were loaded into "Wordle" (Feinberg, 2008) to produce word clouds based on word frequency. The researcher first attempted combining all group responses by question for word cloud production, but the file was too large for the software's capacity. The researcher, therefore, resorted to produce and analyze word clouds by group using the three different versions of transcripts as described.

A second online software application, "Text is Beautiful" (Rogers & Stuart, n.d.) was used to produce concept maps, concept theme webs, and correlation wheels for Tier 1, Tier 2, and Tier 3 responses. Because of the amount of data and responses for the Tier 2 groups, a representative sample of responses was used to load in for Tier 2 groups. One Tier 2 group from each company was used in the concept, theme, and correlation visualizations. Leximancer software technology (2010) incorporated statistical algorithms for mapping semantics, themes, and correlations based upon co-occurrence of words together and modeling. The word clouds, concept maps, concept webs, and correlation wheels provided additional reflexivity and vigor to support the researcher's manual coding and matrices development on themes.

Qualitative Themes Related to Hypotheses in Quantitative Phase

The researcher posed four primary open-ended questions supported by 12 possible secondary questions. All 16 matrices showing trended themes from the nine focus groups can be found in the supplemental materials. In this chapter, trended themes were condensed in abbreviated tables for the purpose of presenting the results. Tier 1 group themes are indicated by

an asterisk and were considered as best practices. The researcher sought to differentiate the comments and responses between Tier 1, 2, and 3 groups because the vision behind qualitative research has continued to ultimately be action-oriented research with differences made in leadership training. Such topic is discussed further in Chapter 5.

Qualitative themes related to associate commitment (DV) and coworker relations, employee involvement, and leadership from quantitative phase. The following presentation of qualitative results focuses on the four primary focus group questions supported by responses to the secondary questions. The qualitative results gave increased meaning to the strong relationship between the independent variables of coworker relations, employee involvement, and leadership with commitment that was found in the quantitative phase. The findings of the qualitative focus groups provided more meaning and depth to the results of the quantitative phase pertaining to

Hypothesis 1.

The second qualitative focus group question, which asked participants what enhanced workplace satisfaction, was meant to draw out perceptions from groups of associates relative to the first hypothesis. The sixth qualitative focus group question, which asked associates to describe their work environment, provided additional responses relative to the second question. Both questions focused on the groups' insight and discussion on commitment and the factors that lead most to commitment.

How groups described commitment. Group responses to focus group Questions 2 and 6 are provided in the supplemental materials. An abbreviated table of trended themes for these two key questions related to associate commitment (DV) is shown in Table 33. The full coding scheme is provided in the detailed tables in the supplemental materials. The researcher provided

direct quotes, stories, observations, and behaviors related to the key themes. The stories, discussion, and thoughts as expressed by all of the groups provided priceless detail and depth related to the perceptions of team members with regard to commitment, coworker relations, employee involvement, and leadership. And how they expressed their thoughts reminded the researcher of her passion for caring for others and how honored and humbled she was to have served with such quality individuals and leaders.

The seven most frequent themes that surfaced in the nine focus group interviews were the following: (a) having friends on the team; (b) trusting team members; (c) making a difference; (d) liking their patients, their patients' families, and their jobs; (e) having flexibility with work schedules; (f) feeling valued, appreciated, and recognized; and (g) earning better pay and benefits. Each of the themes was represented by each of the independent variables of coworker relations (CR or IV1), employee involvement (EI or IV2), and leadership (L or IV3). In addition, all the themes were discussed and related to workplace satisfaction, which is synonymous with associate commitment, the dependent variable.

Five of the seven focus groups discussed liking their patients, their patients' families, and their jobs. They also discussed how being valued, appreciated, and recognized were critical in their workplace satisfaction or commitment. Four of the seven focus groups emphasized that having friends on the team, trusting team members, making a difference, having flexibility with work schedules, and earning better pay and benefits related to their workplace satisfaction. Twelve other themes were identified in the discussion and are included in supplemental files for Question 2 and 6. Further discussion, including direct group quotations, paraphrased statements, examples, and stories, is presented in this section to support the most common themes. Comments are also differentiated as being extracted from the transcripts of Tier 1, 2, or 3 groups.

Coworker relationships and empowerment relative to associate commitment.

What members said about others. Focus groups that discussed general positive regards for satisfaction and commitment also made generally positive or very positive comments about their coworkers. One of the Tier 1 focus groups stated the following: "I like the nurses. The nurses help out 100%. They help, so we have awesome nurses that never refuse to help. . . . the certified nurse assistants [CNAs] are great . . . the CNAs are covering for us" (personal communication, November 6, 2012).

Many of the focus groups discussed the word "team" and "teaming" before the researcher asked or interjected the word. Groups made it clear that "here, we all work together as staff. We like it here" (personal communication, November 6, 2012); "there is no way we could be as productive without each other" (personal communication, November 2, 2012).

Table 33

Trended Themes for Qualitative Focus Groups on Workplace Satisfaction

Qualitative theme	Quantitative independent variable
Having friends on the team	CR (IV1)
*Trusting team members	CR and L (IV1 and IV3)
Making a difference	EI (IV2)
Liking their patients, their patients' families, and their jobs	EI (IV2)
Having flexibility with work schedules	EI and L (IV2 and IV3)
Feeling valued, appreciated, and recognized	EI and L (IV2 and IV3)
Earning better pay and benefits	Organization

Note. * = Tier 1 theme or best practice. Full coding tables with all themes for the qualitative focus group Questions 2 and 6 can be found in the supplemental materials.

Work family. Almost all of the focus groups, representing Tier 1, 2, and 3 work groups related their satisfaction to their emotional bond with their coworkers, and most of the work groups referred to their coworkers or work team as their work family. One Tier 1 focus group said, "we have kind of become like a family, so we know each other. We know each other's strengths and weaknesses, know who to turn to, and who will help us" (personal communication, November 6, 2012). This particular group referred to their work family throughout the interview. The length of employment in the group ranged from 2 years to 17 years, so many of the associates had worked together for years. They also explained how coworkers had left and returned to work at the facility because of the teamwork that was lacking in other facilities but was present in this particular facility.

Associates spoke of openness and relating to each other when speaking about their coworkers and work family. A Tier 2 focus group commented, "I think we are all kind of personally involved in each other's lives. . . . we aren't afraid to tell each other about our life" (personal communication, August 28, 2012). And a Tier 3 focus group commented immediately, "the feeling you have a family. You are here 8 hours a day, 5 days a week, and they know everything about you; trust me, it goes back to the team" (personal communication, November 2, 2012).

Trust. Groups discussed trust from two perspectives: trust in coworkers as team members and trust in and from their supervisor. A Tier 2 group declared that the first thing that enhances workplace satisfaction is "Trust. I would say trust that we would have with each other" (personal communication, September 13, 2012). Another of the Tier 2 groups said that being able to rely on their team members to help them with patients was first and foremost to contributing to workplace satisfaction. This team later commented how all the team members "have good

communication skills, care about the patients as much as I do . . . this represents teamwork" (personal communication, November 1, 2012). One of the same Tier 2 groups later talked about trust from and with their supervisor:

> . . . a breath of fresh air . . . I go back to that word, trust. They hired me, they trust me to do what it is that they hired me to do, and no one is always looking over your shoulders. It's like I am treated like an adult, and I respect and love that. (personal communication, September 13, 2012)

The group related the supervisor's trust in the team members to autonomy, which connected both leadership and employee involvement, bound by the "glue" of trust.

Employee involvement and wanting to make a difference. Groups from all three tiers discussed how liking their patients, their patients' families, and their jobs were primary for their satisfaction and commitment. They discussed being committed to making a difference to their patients and families. Many of them talked about their patients as if they were their own families. A Tier 1 focus group, for example, commented on the emotional attachment that the associates experienced for their patients or residents:

> We have fallen in love with every one of the residents, even the ones that are hard to please. There are some that are hard to please, but we cry when they pass away. Coworker E told me about Mrs. X dying, and I started crying. Coworker E was trying to console me and telling me not to cry and that she was in a better place, and I couldn't believe she was gone. (personal communication, November 6, 2012)

A Tier 2 focus group shared a story highlighting the vulnerability experienced as caregivers for clients:

> You find yourself driving from a client's house in tears because you have taken it on for so long, and not personally having it deflated, and the next thing I know is I am listening to a song, tears are falling, and I was like, 'What is it?' But it's not that one individual; it's a combination of stuff. (personal communication, September 13, 2012)

Many of the groups told stories of how they visited and provided services on their own time or on the weekends for their patients as if the patients were their own parents. From the same Tier 1 focus group, an associate told a story:

> We have a CNA (certified nurse assistant) at night that [*sic*] will bring us pull-ups for the residents that [*sic*] are incontinent, but don't have family members to help out. They actually bring them, and stock their closets for them. . . . Yeah, her sister, she works two jobs, she will leave her 2-10 job and come straight over here. She is awesome. (personal communication, November 6, 2012)

Another story came from a Tier 2 focus group:

> I like the people. My patient, that's my 'Mama.' I brought her home. It wasn't on the company's time, but I took her to my house. She doesn't have anybody and if you see this lady, you've got to love her. They were taking all this woman's money, and she didn't know anything. She really needed me to be there for her. (personal communication, September 13, 2012)

And because the client did not have family, the caregiver in the focus group later explained that she would go, on her own time, to the grocery store for the client on the weekends so the client would have food.

Groups talked about liking their jobs and making a difference as well. A Tier 1 group said, "we all love it and that's why we haven't left. We enjoy our work" (personal communication, November 6, 2012). And when a group's environment was negative, the group stated that they were frustrated because they loved their work and vocation (personal communication, September 11, 2012). Even the Tier 3 focus group that talked about having fun, as discussed in the next section, made it clear that their first priority was to "make sure that we deliver the right services to our patients and patients come first" (personal communication, November 2, 2012).

Fun. Focus groups talked about having fun while serving the patients and residents. They related fun back to contributing to workplace satisfaction and commitment (personal

communication, August 28, 2012 & November 2, 2012). A Tier 2 focus group talked about the environment being "super laid back here . . . we get the work done, but we celebrate . . . music plays in the background, which is nice too" (personal communication, August 28, 2012). This same group later added, "We can still have fun and get things done, and we are gaining a friendship between one another" (personal communication, August 28, 2012). As one Tier 3 focus group said, "We just work on having fun, make it enjoyable, and if we are having fun, the patients are having fun" (personal communication, November 2, 2012). Another team member from this same group, later in the interview, reiterated how "the team was happy, brought a positive attitude to work, liked to have fun, trusted each other, relied on each other, helped each other and the patients in turn had fun" (personal communication, November 2, 2012).

The work groups integrated several themes together as related to their teams, their relationships, and their relationships with their patients and workplace duties. All groups included examples of individuals, caregivers, and leaders showing how driven and committed to care they were. Even the Tier 3 focus groups cited that "they love their jobs" and that is why they are committed (personal communication, October 23, 2012).

Patients' contributions to associates. Several groups also said it was important to them when patients, clients, or residents provided positive feedback or recognition as this reinforced their commitment (personal communication, October 23, 2012). One of the focus groups positively and openly recognized the beautiful contributions to the home health caregivers' lives through the wisdom and history they shared.

> And these generations of elderly people are passing away, and they have a lot of wisdom to give. At the end of the visit, I love to have some time to just sit there and talk, and I love that. They are more open; they like to tell you about their experiences in life. I like to see wisdom from them to help me prepare so that when I am there, I have been better prepared from growing older. (personal communication, November 1, 2012)

Through their stories and examples, individuals in every focus group demonstrated their joy with their work and their commitment to their patients, clients, and residents.

Leader sets the stage for commitment through employee involvement.

Flexibility. Groups discussed the importance of flexibility to their satisfaction. One Tier 1 group, representing the services division, related flexibility to being able to work periodically from home (personal communication, August 27, 2012). The group recognized that the supervisor or leader established autonomy and trust through allowing associates to occasionally work from home when working on a project requiring concentration or focus. One associate stated, "especially if we are doing something that is out of the ordinary or sometimes stuff that is in the ordinary. It's a great way, and I get more done" (personal communication, August 27, 2012). Another group member stated:

> I am excited about the work-from-home days. We have that and that should tell you that they trust you to work from home, and the fact that you can set appointments during that day and not having to worry about when you take 2 hours off because I have a doctor's appointment, and when you work from home it gives you that flexibility. (personal communication, August 27, 2012)

Another associate stated:

> It gives me more than an hour of my time back, because of coming in with traffic. I wake up, wash up, and don't even have to worry about what I am wearing. And, it also saves the gas. But I mainly like the time it saves. (personal communication, August 27, 2012)

That same work group discussed how flexibility was granted in the start time to the workday. Another Tier 2 focus group also discussed the importance of flexibility in the schedule. A working mom in the group said that she appreciated being able to pick her son up from school on certain days (personal communication, August 28, 2012).

Another Tier 2 focus group in the home health company commented on the flexibility of scheduling:

> I like it because I can set up my own schedule around my own time, and it allows me one-on-one with a patient instead of one nurse to 10 patients. It also gives me an opportunity to make a difference in lives. (personal communication, November 1, 2012)

This same group went on to say later:

> I think the flexibility is what it really is by being in home health. I just like every time you talk to a different patient, and it's a different environment. You just get to see how different people live, and I always think that is neat to see. . . . you just get to experience a lot of people . . . and learn from those people too . . . seeing a new patient is an educational experience that in itself is just wonderful. (personal communication, November 1, 2012)

This group integrated flexibility and diversity with being able to make a difference, really emphasizing how the structure and environment supported their motivation for working in health care and incorporated employee involvement.

Groups commenting on the flexibility of scheduling also positively recognized that the supervisors were approachable. They were thankful:

> [for] having a boss that [*sic*] you can work for, and she gives us so much freedom in terms of she is not over our shoulders watching us. She lets us accomplish the tasks the way that we need to [*sic*]. (personal communication, August 27, 2012)

For this Tier 1 group, flexibility was the first thing that the group mentioned and discussed extensively as being important to their commitment and satisfaction. Not only was flexibility important to them, the associates recognized that the leader was responsible for setting up the environment to be flexible. They described her as being approachable to listen to their issues concurrently with setting up flexible systems that worked for them.

Another Tier 1 focus group addressed flexibility by describing how their supervisor or administrator knew their personal challenges and supported them. They said, “she works with us and with personal problems. She is there every step and understands where other places wouldn’t put up with that” (personal communication, November 6, 2012). A Tier 3 focus group praised their supervisor for “not micromanaging” them and they complimented her by saying, “She does

let our strengths come through, and we all have our strengths" (personal communication, November 2, 2012). They said both flexibility in management style coupled with verbal recognition, such as "you all did so good," led to "happy employees who are productive employees who lead to happy patients and a company that will make money" (personal communication, November 2, 2012).

Being valued, appreciated, and recognized. Groups emphasized that support provided to them by their supervisors indicated to them that they were valued. One Tier 2 group said that their satisfaction was enhanced when "knowing your feelings matter and that your concerns that you bring up, make a difference to your employer" (personal communication, September 11, 2012). This group also agreed that the manager's follow-through on concerns further validated their concerns and was a supportive behavior. Another Tier 2 group spoke positively about their manager listening to their concerns, "hearing us out and taking time to resolve whatever issues we have" (personal communication, September 13, 2012), and this again was in response to having trust in the manager and feeling valued. Being asked for opinions, feedback, input, and advice consistently was one Tier 2 focus group's behavioral example of how the supervisors "made them feel valuable. They are genuinely concerned about our happiness here" (personal communication, August 28, 2012). Another Tier 3 group's first response on how satisfaction was enhanced in the workplace was "feeling appreciated" and "having the boss tell you about their appreciation" (personal communication, November 2, 2012). This same group said that appreciation created a positive work environment, productive staff, and happier patients.

One of the focus groups from Tier 1 talked positively about their supervisor and how she provided recognition by handing out gift cards for "zero deficiency surveys," having barbeques, and giving other gifts for work well done, in addition to verbal praise. The group recognized

their supervisor's care and concern for them and spoke about her positively in the community and to their peers (personal communication, November 6, 2012). One of the Tier 3 focus groups stated that receiving verbal recognition from the management team was important to their satisfaction and commitment. Specific examples that the group cited to support their commitment were, "saying good job and sharing percentages from the clinical documentation system" (personal communication, October 23, 2012). This work group went on to discuss how they felt "recognition had been put on the backburner" in the facility and that management was "very quick to point out what's not being done right, more so than what is being done right" (personal communication, October 23, 2012). Lack of feedback and recognition was related to their lack of satisfaction and Tier 3 standing. The same group at another time discussed how a family council recognition form process "had fallen off" (personal communication, October 23, 2012). Systems for recognition and feedback had not consistently been managed or deemed important by the supervisor and the management team. A great deal of time for this particular focus group was consumed with what was not supporting the team's satisfaction and commitment.

Role of the organization with associate commitment.

Although most of the groups discussed how increased pay and benefits were important to their satisfaction, many declared that their work and the positive support of their peers, work team, and leader were more important than pay or medical benefits. This was consistently expressed in Tier 1, 2, and 3 focus groups. One of the Tier 1 focus groups, for example, listed a number of associates who had worked for the facility since it opened. The facility was 25 years old and one of their coworkers, who was the supervisor of the laundry facility, had worked for the company for 25 years. When the researcher asked why, the group said, "they were very nice

to her, and they offered very good benefits, safe environment, medical insurance . . . they gave her room for advancement" (personal communication, November 6, 2012). On the other hand, one of the Tier 3 focus groups discussed how wages had been frozen and increases withheld. The annual review process demotivated them because it was not paired with any type of compensation change (personal communication, October 23, 2012). In this particular group, the majority of the conversation brought to light dysfunctional or absent multiple systems, which was consistent with the other responses in this group.

Summary. The nine qualitative focus groups provided many stories, examples, and rich discussion, which provided more meaning to what coworker relations, employee involvement, and leadership actually meant to associates. Their words and stories provided more depth and perspective in what was most important to them and their commitment. The term "work family," for example, described how important coworker relations were to associates. The groups' responses had common themes of the relationships with friends on their work teams and how the reliance on team members created a trust and bond between work family members. They, in essence, emphasized what teaming is all about: acting as a family, being equally committed to patients and making a difference, being transparent with each other, being supportive and reliable for each other, and having fun with each other. Several groups acknowledged how the supervisor or leader cared for them and about them, serving as a work family leader or member.

The stories that groups shared about their commitment to their patients and dedication to making a difference demonstrated consistently the self-motivation and drive of the associates in all tier work groups. Self-sacrifice was evident in their stories and examples. Many of the groups said that the work environment or benefits were not the best, but what they most loved were their patients and their work. They liked making a difference and that was the reason they and their

work family came back each day. And through their commitment to their patients and work, associates most enjoyed their work place when the leader and team created a fun environment. The teams integrated “fun” with “positive work environment” with “happy associates” and with “happy patients.”

Flexibility was important to associates in all tier work groups as well. They appreciated having flexibility with work schedules and work location, having autonomy, having a variety of patients, and having their supervisor’s support. Groups recognized how the supervisor was responsible for creating flexibility in work processes and environment. In addition, being valued, appreciated, and recognized by their supervisor was important to associates. Simple recognition and a “good job” or verbal “thank you” was more frequently discussed than elaborate rewards. A supervisor asking for feedback and responding to associates’ concerns was linked to being valued. Through focus group members’ natural descriptions and examples, they integrated coworker relations, employee involvement, and leadership with workplace satisfaction and commitment. And certainly the metaphors, user-friendly language, and specific examples were priceless in identifying what is most meaningful to associates’ commitment.

Qualitative themes related to Hypothesis 2 in quantitative phase. The following presentation of qualitative results focuses on the three remaining primary focus group questions supported by responses to the secondary questions. The qualitative results gave increased meaning to the strong relationship between the independent variables with each other that was found in the quantitative phase. The findings of the qualitative focus groups, which were based on responses to Questions 1, 3 through 5, and 7 through 16, provided more meaning and depth to the results of the quantitative phase pertaining to Hypothesis 2. The researcher wanted to know if one of the independent variables was more prominent than the others and how they were

discussed and interrelated according to the associates' perspectives. The researcher was also interested in how leadership (L or IV3) was related to timing and support of both coworker relations (CR or IV1) and employee involvement (EI or IV2).

Since the remaining interview questions and responses addressed the characteristics and definitions of effective teams as per Robbins' (2001) framework, the results were grouped in a methodical fashion. The Appendices include the remaining 14 matrices in detail. Abbreviated tables with key themes relating coworker relations, employee involvement, and leadership are provided in the relative sections for simple presentation. Discussion related to trends, implications, and conclusions are discussed in Chapter 5.

How focus groups discussed coworker relations, employee involvement, and leadership together: Common themes perceived to contribute to teaming. The third and fourth focus group questions were meant to reveal aspects of coworker relations, employee involvement, and leadership with teaming and team leadership. The researcher also wanted to gain insight into Robbins (2001) characteristic of composition and definition of positive synergy through the third and fourth focus group questions. Since Questions 3 and 4 were similar, their results and supportive interview text, examples, and stories are combined in the presentation of results. The researcher intentionally asked about teaming in slightly different ways to obtain more robust information.

Group responses to focus group Questions 3 and 4 are provided in the matrices in the supplemental materials. Abbreviated tables of trended themes for these two questions relating coworker relations (CR or IV1), employee involvement (EI or IV2), and leadership (L or IV3) with each other and with teaming are provided in Tables 34 and 35. The full coding scheme is provided in the detailed tables in the supplemental materials.

When the focus groups were asked what enhanced the teaming experience, they most frequently identified helping each other, having friends on the team, spending time together, and having mutual obligations and commitments. Eight of the nine focus groups identified helping each other and having friends on the team as two key ways to enhance teaming. Seven of the nine focus groups identified spending time together and having mutual obligations and commitments as ways to enhance teaming. Although not included on the abbreviated table, associates reported liking aspects of the team and having open communication as secondary to enhancing teaming.

When the focus groups were asked what *facilitated* teaming, they again cited having friends on the team, helping each other, having trust within the team, being dedicated to patients and patients' families as a team, and spending time together. In addition, problem solving and having open communication with the manager or leader was discussed as facilitating teaming. Secondary themes are included in supplemental material for Question 4. The themes overlapped, so the results are discussed together. Interestingly, eight of the nine focus groups brought up their "team" or "teaming" before the researcher asked, highlighting the importance of the concept in their work and work environment.

Coworker relations and the team.

Helping each other. The focus groups from all tiers talked about the comfort and support in knowing that their coworkers were willing to help them when they needed help. The help and support was first identified to be physical in nature. One Tier 1 focus group said that "just knowing that your team can back you up and help out" enhanced teaming (personal communication, August 27, 2012). That same focus group proceeded on to say the following:

> It's always nice to know that you can depend on your team members whenever you need help. They are always willing to help out. It makes coming to work better when you have

> a good working relationship among us, and we are like friends at work. It makes it easy to say, 'Hey, I need this help.' (personal communication, August 27, 2012)

Table 34

Trended Themes for Qualitative Focus Groups on Teaming Experience)

Qualitative theme	Quantitative independent variable
*Helping each other	CR (IV1)
*Having friends on the team	CR (IV1)
*Spending time together	CR (IV1)
*Having obligations and commitments	EI (IV2)

Note. * = Tier 1 theme or best practice. Full coding tables with all themes for the qualitative focus group Question 3 can be found in the supplemental materials.

Table 35

Trended Themes for Qualitative Focus Groups on Teaming Facilitation

Qualitative theme	Quantitative independent variable
Helping each other	CR (IV1)
Having friends on the team	CR (IV1)
Spending time together	CR (IV1)
Trusting team members	CR (IV1)
Being dedicated to patients and their families as a team	CR and EI (IV1 and IV2)
Nature of work	EI (IV2)

Note. No Tier 1 patterns or best practices observed. Full coding table with all themes for the qualitative focus group Question 4 can be found in the supplemental materials.

Another Tier 1 focus group associate stated "I have much respect for my nurses and CNAs. You learn to appreciate each other, and this is the best thing you can say because we all have to work together to get the job done" (personal communication, November 6, 2012). Thus,

providing help and support served to build respect and appreciation among work group members. A team member from a Tier 2 focus group gave an example of how the team volunteered to treat her patients while she was with her daughter in the hospital for 3 days. She acknowledged that her coworkers helped her by allowing her to take care of her family emergency (personal communication, November 1, 2012).

Group members added that coworkers also supported each other emotionally or morally and often showed their support by way of phone calls or conversations when out in the field. A Tier 2 focus group replied, "The teamwork . . . knowing we can rely on each other . . . it's so easy to feel like you are all out there by yourself, so it's nice to have someone you can call" (personal communication, September 11, 2012). Another Tier 2 focus group discussed the maturity and discipline needed in coworkers and team members to be able to help on a team. An associate said, "If you don't have that maturity in life in general, then you don't have that understanding to your coworkers or being willing to help and respect each other. There is a lot of maturity that is needed" (personal communication, November 1, 2012).

Other members of the team discussed discipline and experience in working autonomously as contributing to helping the team. They referenced the physician being on the team yet not having a full clinical picture of a patient in the home. The focus group discussed how clinical discipline, maturity, decision-making, and autonomy were needed for team members to be able to discuss the patient's status and full range of behaviors, "giving the whole picture" with the physician and other team members. The team gave an example of a patient with mild dementia telling a physician about her status, being believable, but not entirely accurate in how the patient relayed her situation. They talked about identifying yet undiagnosed conditions occurring with the patient and relaying those conditions to the physician. The team members talked about

needing to have maturity, discipline, clinical expertise and compassion in talking with the physician and providing a full perspective of the patient's status and doing this in a respectful manner.

Knowing team members on a personal level. Focus groups openly recognized during the group interviews the value of knowing each other on a personal level and the value of personal relationships in their ability to team at work. One Tier 1 focus group stated the following:

> I also think that it helps us to be a better team in that we get together on a personal note. . . . we go to lunch—not all the time . . . but I wouldn't mind spending my lunch hour with any one of these women. (personal communication, August 27, 2012)

Another member of the group went on to say, "I feel like a true friendship here. We can all go to lunch and talk about our personal lives, and ask for advice and stuff. It isn't always work related" (personal communication, August 27,2012). Another member followed up by saying, "we have common respect for one another, and we like one another, but we are also tied to the same deadline" (personal communication, August 27, 2012).

And in building relationships with each other, the focus groups highlighted how they exposed their vulnerability with team members in getting to know each other personally, and then they provided sequential remarks that they did not worry or were not afraid to appear stupid or incompetent when asking for help. A Tier 2 focus group explained, "When I started here, I think that everyone was so personable and so easy to get along with. So I wasn't scared to ask for help and stuff, which that helps. Everyone seems to get along so well" (personal communication, August 28, 2012). This same group explained how personal relationships had not always been strong on the team. When they were asked what had changed on the team, the focus group explained that certain individuals, who talked about others, had left the team. The team

established more positive relationships and trust increased with the exit of these personalities per their perspective.

Focus groups acknowledged the diversity on the teams, diversity of opinions, and diversity in the manner in which team members accomplished tasks: "You have your way of doing it, I have my way of doing it, and ultimately, we are going for the same goal" (personal communication, November 1, 2012). This team said that they had developed a mutual respect for everyone's contributions to the care of the patient. They also acknowledged that they each complimented each other's skills, "where one person is weak, another is strong" (personal communication, November 1, 2012). A Tier 3 focus group further acknowledged the acceptance of each other that the team had developed:

> We can't all be the same . . . flexibility is important. . . . we accept each other's strong personalities . . . we are very open about how we feel . . . a strong personality is a strong personality, but you can't take it personally. You need to accept it, like you dish it, and you need to be open and say, this is what I perceived it to be. . . . it works for our team, we have a good dynamic. (personal communication, November 2, 2012)

Different focus groups from all three tiers referred to the emotional connection through words, such as "caring for each other," "compassion" (personal communication, September 13, 2012; November 1, 2012), "personable" (personal communication, August 28, 2012), "personalities" (personal communication, September 13, 2012; November 2, 2012), "relationship with each other" (personal communication, September 11, 2012), "friends and know each other" (personal communication, September 13, 2012), "like each other" (personal communication, November 2, 2012), and "caring for coworkers just as much as caring for clients" (personal communication, September 13, 2012). All the work groups, through their words, examples, and laughter, demonstrated the importance of their connection and relationships with each other.

Learning with and from each other. Both Tier 1 focus groups acknowledged that they learned from each other when they helped each other in the workplace. They remarked that they viewed this learning or "cross-training" as positive. One Tier 1 focus group member clarified:

> I don't mind helping out. I think that it is a learning process because when I am helping my coworker, I am learning all of this other stuff that I wouldn't have been exposed to [*sic*] . . . it makes me exposed to more things. (personal communication, August 27, 2012)

Learning was also emphasized from a process improvement perspective. In another Tier 1 focus group from another company, a team member said, "sometimes they share with me how to do it better or how I might make it easier on my back when working with a resident or how to make it easier on the resident" (personal communication, November 6, 2012).

Spending time together. Focus group members regarded spending time together as being valuable and often linked the time spent with team members as allowing them to build personal relationships and to learn how the other team members worked. One Tier 1 group stated the following:

> For me, that is spending personal time and getting to know them a little better. It gives you sense of how the person is, and you get to see how they are and personalize it. You get to see their integrity and seeing how they work too. If they follow through, and if they offer to help, then its things like that. (personal communication, August 27, 2012)

This same group stated that taking time to build personal relationships with team members also helped to establish trust within and between the team members. Taking the time to build personal relationships helped to "build confidence" in team members for later times when confidential information needed to be shared or "vented" (personal communication, August 27, 2012). Tier 1 and 2 focus groups (personal communication, November 6, 2012 and November 2, 2012) related the length of time and tenure with which they had worked with each other as contributing to their repeated reference to their work family.

> We've known each other a long time. . . . It's like we aren't here to like each other, but at the end of the day, we might have disagreements or whatever, but at the end of the day, we've got the job done, tomorrow is another day, and we are family. (personal communication, November 6, 2012)

Collaborative employee involvement.

Mutual obligations and commitments. The Tier 1 focus groups integrated their discussion of building personal relationships and spending time getting to know each other with their acknowledgement that they and their coworkers had a mutual goal to take care of clients, patients, residents, or customers and "get the job done" (personal communication, August 27, 2012; November 6, 2012). And they placed value on personal relationships and spending time getting to know their colleagues as a means to better "get the job done" or serve their patients or customers. A Tier 2 focus group promoted each team member individually and the team collectively for caring about their work and caring equally about the patients. They discussed how the team collectively did their best job for their clients and customers.

> There are over 30 people in this office, and I don't work with every individual person. But I can't think of one employee on this floor who doesn't care about what he or she does, from the receptionist who answers the phone, asking how you are doing every day, to the coordinator working on staffing. I think we all care. That's what makes us a great team. (personal communication, September 13, 2012)

Another Tier 2 focus group stated briefly that "doing your job to the fullest . . . service . . . you've got to take it serious . . . attitude . . . and sense of humor" all contributed to making the team better (personal communication, September 13, 2012). It was evident that multiple focus groups and many associates resonated with this collaborative and individual dedication to the patients and their work.

Nature of the work. Focus groups recognized that each of them were dependent on their coworkers because all of their roles were intertwined. They provided examples of interdependence. One Tier 2 focus group nurse gave an example of how her job would be a lot

more demanding if she did not have a home health aide who could do the showering. The group used the word "fusing" to describe how their roles were interdependent or were "molded together" (personal communication, November 1, 2012).

Most of the teams, six of the nine, discussed how communication contributed to the teaming experience and because of the interdependence of each of the team members' roles in the care of the patients or clients, communication was positive when it was present and critically necessary. A Tier 2 focus group discussed the importance of scheduled communication to accomplish their work. They discussed the importance of attending case conferences to relay patient information and the different perspectives observed by different team members.

> I think it's important that when we do have our case conferences, that everybody is here; . . . I think that helps build team unity . . . we get a lot out of it . . . being able to converse about patients and what's going on . . . yes, that one tad bit of information that somebody thinks isn't important, may be huge. (personal communication, November 1, 2012)

The focus group emphasized that the face-to-face interaction was more valuable than phone conversations and that staff who did not attend, missed out on having a full report on the patient's status and teaming.

A Tier 3 focus group identified communication as the most critical element necessary for teaming. They repeatedly provided examples of how absent communication from their supervisor distracted from the teaming environment in their facility (personal communication, October 23, 2012). The communication systems this particular team described were impersonal because it did not involve speaking directly to an individual. They described the communication as "trickle down" in approach, and the primary means of communication were via e-mail, electronic record keeping, and an employee box. This focus group's description of teaming was vastly different from most of the other focus groups. The researcher found herself considering the opportunities or "low hanging fruit" if the opposite from what was present and how they

described the environment to be were true. The researcher also looked for delineation from this group's presentation with the Tier 1 and 2 groups.

Leader's expectations and transparency. When the researcher asked what facilitated team work, one Tier 1 focus group gave credit to the supervisor in the preemployment phase. She said that the supervisor set the expectation to work on a team in the job interview, so she knew before she accepted employment that teamwork was expected. In addition, the associate explained that the work team participated in her interview process, and she knew from the interview that "it put my mind set in that mentality already. I was ready to work on a team" (personal communication, August 27, 2012).

A Tier 2 focus group acknowledged that building personal relationships and establishing "respect and cohesiveness" started with the supervisor's behavior and style of management.

> When you have a good manager, one that you can trust and depend on, over the team, the team is better . . . I've always thought it was important for someone who is not afraid to get personal with his or her employee, and coming from somewhere where that was an issue, and coming here—it's great. The supervisor isn't afraid to get personal with you. (personal communication, September 13, 2012)

The same team also explained the following:

> If you have someone as a manager that doesn't trust you, doesn't believe in you, and you [as an employee] don't believe in her, you don't believe in her skills, or you don't think she knows what she is doing, . . . morale goes down. You have to respect your manager, and she needs to respect you. I love it here. It just makes for more happy human beings and not just workers. If you have 'happy worker bees,' the cooperation is going to flourish, and the team is productive. (personal communication, September 13, 2012)

The focus group discussed a number of times how the supervisor's transparency and willingness to build relationships with team members set the tone for the team to establish those same good and transparent relationships with each other.

Establishment and maintenance of team trust. Through the building of relationships, spending time with team members, and joining together to care for patients and accomplish work

tasks, trust was described as resulting in the team. Trust was deemed as critical for the team's work in all groups. A Tier 2 focus group said, "having a relationship with team members and with time, you learn to trust them" (personal communication, September 11, 2012). This same Tier 2 focus group related the ability for team members to communicate timely with each other to the establishment of trust through that timely and dependable communication. A CNA stated the following:

> My appreciation is having my nurses and that they know that I am going to get the work done, that I am going to give my patients the best care, and that they know without a doubt that I am going to give them the best of care. It makes me feel comfortable when I call that I will get a call or text back within 5 minutes. They (the nurses) do their very best at communicating on patient changes, needs, and status. (personal communication, September 11, 2012)

This same Tier 2 focus group later discussed the implications from not receiving open or timely communication from senior managers. They related scenarios where patients had missed care because of a lack of communication relative to changes or referrals from senior managers. They discussed how relationships and trust were negatively impacted due to the lack of communication.

Themes resulting from focus group Question 5. The discussion about the importance of trust emerged from the focus groups before the researcher posed the question, how is trust developed? In some of the focus groups, the researcher asked the question slightly different, how is trust enhanced or improved? Once Question 5 was posed, eight of the nine groups, representative of all three tiers, emphasized that getting to know each other was most critical in building trust among the team. Six of the nine groups, representative of all three tiers, provided discussion, examples, and behaviors that emphasized consistency of attendance and follow-through as key to building trust. Secondary themes that emerged relative to trust were spending time together, honesty, and mutual respect. Table 36 provides the common themes that resulted

from groups' responses to the qualitative focus group Question 5. The supplemental material for Question 5 provides a more detailed table of themes. All the common themes related to trust possessed a common relativity to the independent variable of coworker relations (CR or IV1). And yet trust emerged in the responses to other interview questions.

Getting to know coworkers as a mode to identify other themes. Repeatedly, focus groups started their conversations about trust with building relationships and getting to know their coworkers as a means for them to observe trustworthy behaviors and qualities. They used getting to know their coworkers as a triage for whom on the team they could depend. A Tier 1 focus group stated the following:

> spending personal time with coworkers and getting to know them a little better . . . gives you a sense of how the person is . . . to see their integrity and to see how they work too . . . if they follow through and if they offer to help. (personal communication, August 27, 2012)

Table 36

Trended Themes for Qualitative Focus Groups on Trust

Qualitative theme	Quantitative independent variable
*Getting to know each other	CR (IV1)
Consistent attendance and follow-through	CR (IV1)
Spending time together	CR (IV1)

Note. * = Tier 1 theme or best practice. Full coding table with all themes for the qualitative focus group Question 5 can be found in the supplemental material.

Openness and vulnerability. One Tier 2 focus group emphasized when team members were open, transparent, and vulnerable, trust was created (personal communication, November 1, 2012). They further described how this applied to patient care. If a team member encountered a clinical technique or patient scenario that he or she did not have experience with, then that team member had to be open and vulnerable to ask for help, risking his or her professional reputation.

This was critical so as to not put the "patient in jeopardy" (personal communication, November 1, 2012). The coworker asking for help would be in a vulnerable position, and the coworker should not respond negatively or judgmentally to the request for help or guidance.

A Tier 2 focus group noted that the trust was mutual or bidirectional. Each team member had to be able to be vulnerable and open with his or her coworkers at some time or another. They respected each other that when those times or calls for help came, each of them responded in a respectful manner. They also relayed how this mutual trust occurred up and down a reporting chain, from registered nurses (RNs) with licensed vocational nurses (LVNs) to LVNs with certified nurse assistants (CNAs) and back up the reporting chain of command (personal communication, November 1, 2012). Another Tier 2 focus group applied the mutual trust to necessary communication relative to a risk management incident (personal communication, September 13, 2012). Several focus groups thus emphasized the need for "maturity" on the part of coworkers to respect other team members' request for help, to value their feelings of vulnerability, to "maintain confidentiality" as appropriate, to recognize that team members "had good and bad days," to "give individuals hugs when needed" (personal communication, August 27, 2012; November 1, 2012; November 6, 2012; November 13, 2012).

Extending trust. Focus groups described how new team members "automatically had to trust coworkers" or had to have extended blind trust (personal communication, November 1, 2012). And at a later time in the interview, an associate said that over time, trust was "earned" and the quality of dependability emerged (personal communication, November 1, 2012). Another focus group highlighted that "you take risks to start to trust" or "you are taking a chance" the first time (personal communication, October 23, 2012). One team member talked about how she, in particular, "tested coworkers" with increasing amounts of personal confidential information to

determine if she could trust them. She said that if a coworker "passed" the test, she "shared more with them" the next time (personal communication, November 1, 2012). This team member also said she used this method to determine in whom she could confide on the team and whom to let in her "circle" (personal communication, November 1, 2012).

Consistency, follow-through, and dependability. Focus groups discussed how consistent follow-through and consistency of behavior created dependability. They said, "trust is earned by actions" and "builds up over time" (personal communication, November 1, 2012). Another group stated, "keeping your word" and "doing what you say you are going to do" represented consistency and follow-through, both building trust (personal communication, September 13, 2012). Another group said, "It takes time, years of working together" to build trust (personal communication, October 23, 2012). One Tier 2 focus group's first response for how to build trust was consistency: "If you see them consistently doing what they are supposed to be doing and they are doing a good job, then you trust them to complete the job successfully" (personal communication, August 28, 2012). The team described the opposite to be true. They described inconsistent behavior and follow-through led to a team member "letting you down" (personal communication, August 28, 2012).

The same Tier 2 focus group related "work ethic," "having a sense of urgency," "follow-through," and "attendance" together to dependability.

> I think people actually stepping up the offering to help when he or she sees someone falling behind. That is a good thing too. Or that the person is going to be there when you need him or her . . . even attendance will make you trust someone too. (personal communication, August 28, 2012)

Another Tier 2 focus group provided an example of how the function of good risk management is dependent on the field staff reporting incidents to the risk management coordinator. Once the risk management coordinator was aware of the incident, she acted on the situation.

> We have to trust that once communication is given, once I pass the ball, you [to the risk management coordinator]are going to make the lay-up and do what you need to do. I have to trust that the risk management coordinator is going to act on the information, and she has to trust me that I'm going to report the incident to her. (personal communication, September 13, 2012)

The group further applied the aspect of mutual accountability of "doing their jobs" for the team to be successful.

> Everyone has their position, and they are doing their best. I think everyone is committed to doing that. You have to be committed, or it's going to show up. You have to have that trust if we are going to be successful. (personal communication, September 13, 2012)

Two focus groups highlighted the ramifications of not consistently following through: "For every time you don't follow through, you lose that trust. It takes 3 or 4 times longer to regain that trust, and it is easier to lose trust than gain it" (personal communication, October 23, 2012). Another focus group said, "and if you lose trust, it hinders the whole working relationship and hinders patient care. It goes back to the patient time and time again" (personal communication, September 11, 2012).

Some focus groups (two Tier 2 groups and one Tier 3 group) applied consistency and dependability to their supervisors. One Tier 2 focus group used words like "listening," "trying to help," "being fair," "character," and "showing respect" to describe their supervisor or manager (personal communication, September 13, 2012). They assumed the question was relative to their relationship with their supervisor. Another Tier 2 focus group and a Tier 3 focus group discussed the concept of "follow-through" or "lack of follow-through" by their manager with a negative reference. Both groups provided examples when the managers had not responded or followed through after concerns were brought to their attention (personal communication, September 11, 2012; October 23, 2012). The Tier 3 focus group also stated that their supervisor did not ask for feedback or allow associates to share their ideas. This behavior, in addition to not following up

on concerns or issues, further decreased their trust in him (personal communication, October 23, 2012). As a result of consistent behavior of not following through, the work groups did not have a high level of trust in the managers.

Honesty. One Tier 1 focus group discussed honesty both in action and in word. A team member said she knew her purse and belongings were safe exposed to the team: "I like it here because I trust the people that I work with [*sic*]. . . . I can leave my bag with money, and I have never had anything missing" (personal communication, November 6, 2012). This was an example of honesty in action. That same group discussed how they knew that fellow coworkers did not speak poorly about each other in the absence of each other. The group talked about being "open and honest with each other" and chose not to "gossip" (personal communication, November 6, 2012). This was an example of honesty in word.

A Tier 2 focus group said that a team member who "drops the ball" on a task has the responsibility of being honest and say, "I am so sorry. I was wrong. What can I do to help or correct the situation?" (personal communication, September 13, 2012). The focus group acknowledged that all individuals and teams make mistakes. They also added that the quicker an individual owns the mistake and apologizes, the quicker the team can resolve the mistake, make improvements in the process, and move forward. They discussed the importance of honesty to the team and to trust in the team to move forward.

Respect and equality. Groups discussed how they respected each other through examples. Some CNAs in a group talked about how the nurses respected and listened to what they reported on a patient's condition.

> Anything that we need, it's done and it's because, in my opinion, behind every good nurse is a great CNA. We are the ones that see the patients every day, and without their ears and eyes, it's kind of hard for them to know. We don't tell them how to fix it and

> that is where the trust comes in. Our nurses trust us and our opinions, what we are telling them. That makes it a lot easier. (personal communication, November 6, 2012)

The group further added that when reporting an urgent need with a patient, the nurses respected their insight and "checked the patient right away" (personal communication, November 6, 2012). They discussed how respect and trust was equally offered to each other when caring for patients. A Tier 2 focus group discussed how appreciation and recognition of being trustworthy further promoted trust within the team. They said that positive reinforcement in a "thank you" encouraged additional trust (personal communication, November 1, 2012).

Feelings that resulted. After describing how trust was developed, many groups and group members naturally concluded that feelings of positive regard resulted: "Every single person in this room I can trust, and I love knowing that because it's very comforting" (personal communication, November 1, 2012). One Tier 1 focus group member from another group said, "she feels better" after being able to trust a coworker or her team (personal communication, August 27, 2012). Another Tier 1 focus group member expressed that the trust in the team "made the job a lot easier" (personal communication, November 6, 2012). A Tier 3 focus group member similarly said that trust by a supervising clinician "helped us out" as professionals (personal communication, November 2, 2012). A Tier 3 focus group further expressed appreciation that clinicians respected the assistants' views and expressed appreciation for the clinicians' humility.

> And that is appreciated that the evaluating person doesn't come in and think they have all the answers and doesn't dictate what should be done, and they are open to what you have to say, and we collaborate together and that is best for the patients. (personal communication, November 2, 2012)

Mutual gratitude and appreciation resulted after coworkers were able to trust each other as per most of the focus groups. This further reinforced the theme of mutual respect built through the establishment of trust.

Focus groups addressed qualities necessary in team members when trust was violated to restore positive feelings and coworker relations. A Tier 2 focus group discussed that it was also important for teams to "forgive," "not hold grudges," "not get feelings hurt," "not get offended easily," "not take things personally," "let things slide off and be forgiving," "have a sense of humor," and "appreciate the good and the bad" in each other when coworkers violated trust or team commitments (personal communication, November 1, 2012; September 13, 2012). One focus group related mutual respect and forgiveness that team members offer each other, "recognizing that we're all trying to do the best we can, and we all care for our patients," to providing grace when a coworker breaks trust (personal communication, September 13, 2012). They made the point that the coworker did not intend to do malice (personal communication, September 13, 2012). Maturity was again integrated into how a work team effectively managed to rebuild trust.

And finally, focus groups connected the value of trust in the team to the delivery of ultimate patient care and quality. They said, "it is best for the patients" (personal communication, October 23, 2012; November 1, 2012; November 6, 2012; September 11, 2012; September 13, 2012). Focus groups discussed the value of trust to patient care with passion and commitment.

Goal setting and accomplishment. The researcher posed the following first focus group interview question: How does the team work to accomplish goals? A secondary question, which asked participants how goals were identified, was asked of some of the focus groups as the twelfth question. Both questions sought more insight from the nine focus groups on team process as an effective team characteristic and on collective goal setting as defined by Robbins (2001). Groups' responses to focus group Questions 1 and 12 are provided in the matrices in the supplemental materials, respectively. An abbreviated table of trended themes for these questions'

responses is provided in Table 37. The full coding scheme is provided in the detailed tables in the supplemental material for Question 1 and 12. The researcher provided direct quotes, stories, examples, observations, and behaviors related to the key themes to support the common quantitative variables in the groups' responses.

Accomplishing goals and the work process was more the focus of this particular study. Thus Question 1, which asked about how the work group accomplished goals, was primary. All groups responded to Question 1. A secondary question with regard to setting goals was asked later in the interview process. Because of the emergent nature of the semistructured interview process, the twelfth question was not posed to every group. Three of the nine groups answered Question 12.

Of the three groups that were asked how goals were identified and set, all three groups responded that goals were set as a team and that the leader or manager guided the planning. Two of the three groups discussed how the senior executive or supervisor was involved in the identification of team goals with the goal planning orchestrated or guided by the direct manager or supervisor. The three groups that responded to the question on goal setting were Tier 1 and 2 groups. Goal setting and team planning represented both coworker relations (CR or IV1) and leadership (L or IV3).

Checking in with the team, helping each other, and work autonomy surfaced as predominant themes in response to the question, how does the team accomplish goals? Checking in with the team and helping each other provided more insight into coworker relations (CR or IV1) and teaming, and work autonomy and best effort provided additional support to employee involvement (EI or IV2) and teaming. Eight of the nine groups, representing all three tiers, included discussion on helping each other. Seven of the nine groups, representing all three tiers,

included discussion on checking in with the team and on having work autonomy and giving best individual effort.

Executive, leader, or strategic direction on setting team goals. All three focus groups that responded to the question on setting goals identified that the team goal or benchmark was originally set by an executive or leader and then managed by the supervisor and team (personal communication, August 27, 2012; August 28, 2012; September 11, 2012). Focus Group 1 and Focus Group 2 recalled the exact team goal immediately and that they both were time-driven. Focus Group 1 had a target day of the month, "the eighth day" to accomplish their goal, and

Table 37

Trended Themes for Qualitative Focus Groups on Accomplishing and Setting Goals

Qualitative theme	Quantitative independent variable
Checking in with the team	CR (IV1)
*Helping each other	CR (IV1)
Setting goals as a team	CR (IV1)
Team planning guided by leader	CR and L (IV1 and IV3)
Best individual effort and autonomy	EI (IV2)

Note. * = Tier 1 theme or best practice. Full coding tables with all themes for the qualitative focus group Questions 1 and 12 can be found in the supplemental materials.

Focus Group 2 had a target time each day that they were to accomplish their team goal, "at noon" (personal communication, August 27, 2012; August 28, 2012). Focus Group 1 identified the goal was set by the senior vice president, and Focus Group 2 identified that the goal was set by the president. Focus Group 1 further explained that their original team goal was the 20th of the month and over time, the executive team had moved the deadline up to the 8th of the month.

> We are just told that we are going to close by this day. So we have had to work more efficiently to get to that day and start some of our tasks sooner, and to plan it. . . . it took everybody. Everybody had to contribute. (personal communication, August 27, 2012)

Focus Group 2 , a Tier 2 work group, described a system and expectation set by the company president to meet two goals daily. The president had set up a system with competition between teams and a board for tracking progress through the day. This work group's product was time-sensitive for the needs of the patients. Deliveries were set to go out twice daily, the first of the goals for delivery shipping was noon: "With the system, you will be able to see because it is all color coordinated in groups, and so you can just go over the color and leave and get it done . . . we are working towards a noon departure" (personal communication, August 28, 2012).

Work Group 3, another Tier 3 work group, Focus Group 3 acknowledged that goals and directives were given from "corporate on down" and were based on the "Quality Assurance and Performance Improvement (QAPI) initiative" (personal communication, September 11, 2012). They said that the work group "used to have the team meetings and certain goals were talked about and how to reach them. . . . but it [meetings] haven't occurred since this management team has been here" Thus, Focus Group 3's perception was that the goal setting and planning process had been discontinued.

Challenge and problem solving as team. Focus Group 1, a Tier 1 work group, accepted the ramping up of their team goal by their senior vice president. They accepted the challenge and worked together to problem-solve, "we had a big 'lean' meeting to figure out how we were going to do it" (personal communication, August 27, 2012). This same team stated that their supervisor "didn't really care who, how, or what, as long as it was done" (personal communication, August 27, 2012). This specific team also related how they each took ownership of the challenge and worked collaboratively to set a plan for achieving their goal. Similarly, Focus Group 2, a Tier 2

work group, accepted their team goal and worked to prepare and solve it together. Both Focus Groups 1 and 2 positively accepted and planned as a work team, whereas Focus Group 3 voiced frustration that their goal-setting process had ceased with new leadership.

Immediate assumption of individual goal setting. The researcher observed that in two of the three focus groups, the researcher had to either clarify the question on goal setting to be applied to "team goal setting" or, after a period of time, redirect the group. Group members either assumed goal setting was intended to be individual goal setting or the group deterred to another topic (personal communication, August 27, 2012; September 11, 2012).

Accomplishing team goals. All focus groups from all tiers responded to the first interview question pertaining to goal accomplishment. Themes that surfaced most frequently were checking in with the team, offering to help others or requesting help, prioritizing in an ongoing manner, and working autonomously and working to one's personal best for the team. One team also discussed positive feelings and celebration after accomplishing goals.

The researcher observed that the word "team" was used for the first time unprompted in four of the nine groups, and one group used the word "family" pertaining to "work family" in response to the very first question on accomplishing goals (personal communication, August 28, 2012; September 11, 2012; October 23, 2012; November 2, 2012; November 6, 2012). One focus group used the word "interdisciplinary team" in their first response, very early in the interview (personal communication, November 2, 2012). The appearance of "team," "work family," and "interdisciplinary team" in the very first response indicated how predominant of a concept "teaming" was in the health care settings.

Checking in with the team. Focus groups responded that they checked in with the team very early in accomplishing goals. They had various ways of checking in. Focus Group 1 said

they "sent out an e-mail to everybody to see who was doing what" (personal communication, August 27, 2012). Focus Groups 2 and 8 said they "put their heads together" or they "bounce ideas off each other" in an ongoing and informal basis (personal communication, August 28, 2012; November 2, 2012). At one point, Focus Group 8 stated that they engaged in "open and consistent communication" and at another point referred to it as "constant regrouping" (personal communication, November 2, 2012). Two of the focus groups used formal meetings, such as "morning meetings," to share updates and progress towards collective goals (personal communication, September 11, 2012; November 6, 2012). The meetings were shared as a way to maintain ongoing accountability towards the achievement of team goals. Focus groups said that meetings offered a means to "keep on top of us," "make sure things are followed up on by all shifts [*sic*]," and "verbalize concerns" (personal communication, September 11, 2012; November 6, 2012). Whether the communication was electronic, informal, or formal, five of the nine teams said they used communication to accomplish team goals (personal communication, September 11, 2012; September 13, 2012; November 1, 2012; November 2, 2012).

With communication being critical for "checking in with the team" on goal accomplishments, the researcher asked for more clarification and more specific examples from the focus groups. Through this process, several groups provided clarification that often a team member assumed the role of communication facilitator amongst team members on collective goal accomplishments. Focus Group 4 provided an example:

> [the coordinator steps in when] we [the care attendants] are having a problem with a client so all can be aware of what the plan is [*sic*] . . . we all have to be on the same page. If we are not, then we aren't doing good customer service [*sic*]. (personal communication, September 13, 2012)

Focus Group 7 identified communication between case manager, field nurses, and therapy staff as critical, and they related this to scheduling of patient care in a home health

environment (personal communication, November 1, 2012). They described a scenario in which a patient may be admitted to the hospital and have significant changes made to the patient's care. It was emphasized as critical that communication about a change in the patient's care occur between team members so that team members may not arrive to provide care and have the patient not be there or have the patient discharged from the hospital with increased medical complications: "It requires a lot from everybody, as far as communication goes. We all have to communicate with one another or we get nowhere, and nobody knows what is going on with therapy, nursing, or the family" (personal communication, November 7, 2012). This same group used their electronic documentation system and a feature known as a "follow-up note" to keep other team members informed real-time with patient changes including reminders, physician visits, hospitalization, new medication, therapy status updates, last-minute lab work, and reassessment information. Ongoing "checking in with the team" via their electronic tool helped the work group accomplish the most important goal of quality patient care in the home.

Only one out of the nine groups did not check in with the team at all. The group was a care model in a large metropolitan area where the work group was spread out and assigned individual home clients. Nonskilled needs were provided in the home to maintain clients in their homes versus alternative facility placement. A group member responded, "We just have supervisors here. We are all just individuals here, and we work away and never see each other" (personal communication, September 13, 2012). The group recalled the entire work group only having one group meeting, and the meeting was a social gathering. Several of the group members, having worked for the company for 16 and 26 years, had never attended a work group meeting. And many of the group members attending the focus group were coming to the office for the very first time.

Proactive offer to help and request for help. When focus groups talked about teaming to accomplish goals, they revealed how team members proactively offered to help. A quality of Tier 1 focus groups was that team members took the initiative to offer help to other team members versus the team member needing help having to ask (personal communication, August 27, 2012; November 6, 2012). One Tier 1 focus group stated the following:

> There are some things that we have to accomplish. That is usually for whomever has a little bit of free time, they will ask, 'Hey, what do you need help with?' or 'This needs to get done, I will take care of it.' And we will just volunteer and help each other out. (personal communication, August 27, 2012)

Another Tier 1 focus group described a scenario that occurred when a crime had been committed in the neighborhood where the facility was located. The team had been proactive and without being asked by the administrator, "locked down the facility" so no one entered or left the facility until the danger had been cleared. The group member stated, "We take the initiative. We protect our residents" (personal communication, November 6, 2012). In addition to proactively offering help to coworkers as discussed by Tier 1 focus groups, Tier 2 and 3 focus groups discussed how coworkers in a teaming effort were comfortable asking for help. Eight of the nine work groups discussed how coworkers asked each other for help.

Several of the focus groups discussed how important it was for team members to know each other's roles and to cross-train each other in their roles and duties with the rationale that team members could then better help each other (personal communication, August 28, 2012; September 13, 2012). A Tier 2 focus group clarified the following:

> it helps that everyone knows how to do everything, instead of just having designated typists or designated filers. . . . because you never know when help is going to be needed. . . . when someone needs help with a function, then somebody jumps in and helps them. (personal communication, August 28, 2012)

Knowing fellow coworkers' roles and having been cross-trained in fellow coworkers' roles offered the team flexibility and efficiency in succeeding with team goals (personal communication, August 28, 2012; September 13, 2012).

A Tier 3 focus group outlined, in detail, how the team asked each other for help to provide the appropriate and correct level of care:

> There are three disciplines in one unit and with three disciplines, you always have different things that work, and you have to have ways to communicate with each other in order to provide services and the exact amount of services to that patient; there can be days when this patient doesn't work well, there can be days when this patient does not do well with one therapy, and you have to talk it with your colleagues so that they can help you. I would say that it has to be a team effort. There is no way that you can survive and be a success unless you can work as a unit; work as one. (personal communication, November 2, 2012)

Focus Group 7 used their electronic medical record system to ask for help in accomplishing their goals (personal communication, November 1, 2012). One focus group said that they asked for help from their supervisor (personal communication, September 11, 2012). Another focus group responded that they asked for help from their higher power: "We pray" (personal communication, September 11, 2012). This group openly acknowledged their request for divine help, and it may have been more prevalent than initially observed if groups had been brutally honest.

Ongoing prioritizing. Focus groups discussed how the team continually reconvened to reprioritize or regroup in a way to adapt to changes. One Tier 1 focus group reflected that "we know each other's strengths and weaknesses . . . as a work family" in how best to accomplish certain aspects of the goal (personal communication, November 6, 2012). They referenced this ongoing tooling in both an informal way and a formal way through the morning meetings. A Tier 2 focus group said it was the coordinator's role to "inform the client and the caregiver" of the same plan of care in an ongoing manner (personal communication, September 13, 2012). And a

Tier 3 focus group in a difficult-to-staff rural area described a situation where ongoing prioritizing and "constant regrouping" happened more frequently due to the constant changes in staff and use of traveler staff (personal communication, November 2, 2012). The team approach took on a different meaning with this focus group as a result of constantly changing team members and because communication was required more frequently as a result.

Self-management and autonomy. Focus groups discussed the expectation both from the supervisor and from themselves as team members to be self-managing, self-starting, and motivated to accomplish goals and tasks on their own. Autonomy and working to the best of one's ability was a desirable quality of individual team members that also surfaced in the discussion. For example, a Tier 2 focus group member stated expectations for being a member on the team:

> You have to manage yourself. There is nobody really over your shoulder managing you. So, if you don't do well with that, then it is probably difficult for you to succeed . . . you need to be a self-starter and multitasker. . . . and know what you need to be doing when one thing is over. (personal communication, August 28, 2012)

Teams transferred expectations of self-management and ownership collectively to the team. Focus Group 6 stated, "we have the ability to get whatever we need accomplished" (personal communication, October 23, 2012). Focus Group 8 further stated, "we take ownership of a situation instead of either sitting back and hoping it will get solved or giving the problem to the manager to solve. We come up with a solution and then let the supervisor know" (personal communication, November 2, 2012). Collective problem solving, ownership, and action were related and discussed concurrently with trust and dependability.

Celebrating wins. A Tier 1 focus group presented one best practice and that was celebration and the feelings of success when the team accomplished a team goal (personal

communication, August 27, 2012). Only this one group discussed celebration and the positive feelings resulting from accomplishing a goal.

> it seemed like an impossible task, but we got there. It feels good to get there. I guess getting together and figuring out how we are going to get there and seeing that we can do it made it very fulfilling. (personal communication, August 27, 2012)

Making and acting on decisions. The researcher posed questions to the focus groups on making decisions, accountability, and task completion. Focus group Questions 9, 11, 13, and 14 included questions on making and acting on decisions. Question 9 asked, how are you individually involved in making decisions? Question 11 asked, how is accountability practiced on the team? Question 13 was, how do you know who does what? And Question 14 posed, how do you know when to move forward with a task or project? The researcher intended these questions and their corresponding responses to address work design, more specifically task identity, and in addition, performance evaluation and accountability, which are subcomponents of context (Robbins, 2001). All of the questions relative to this area of teaming were secondary questions and not posed to all groups. As a result, lack of clear themes surfaced for each question individually. Some of the responses and themes also surfaced through the responses to primary questions already addressed.

The supplemental materials include apparent themes for Questions 9, 11, 13, and 14, respectively. The tables also indicated the groups to which the questions were posed. Coding and labeling in the tables according to the associated quantitative variables consistently follow previous presentation of results in previous sections. Table 38 includes abbreviated and consolidated themes. Presentation of results includes direct quotes, stories, examples, observations, and behaviors related to key themes to support the quantitative independent variables.

Table 38

Trended Themes for Qualitative Focus Groups on Making Decisions

Qualitative theme	Quantitative independent variable
Making and revising decisions as a team	CR (IV1)
Making decisions on their own and trying them (+)	EI (IV2)
Not able to make own decisions—top-down decisions (–)	EI (IV2)

Note. No Tier 1 patterns or best practices observed. Full coding table with all themes for the qualitative focus group Question 9 can be found in the supplemental materials. Comments relative around certain themes and with certain questions polarized as either positive or negative and are indicated as such with (+) or (–), respectively.

Involvement in making decisions on a continuum. Question 9 as a secondary question was posed to five of the nine groups. Responses were either positive or negative in extremes. Table 38 indicates whether the themes were positive or negative. Also, it appeared that decision-making and autonomy with decision-making fell on a continuum from making and revising decisions totally autonomously to not being able to make any decisions individually or as a team. Team decisions, which included revising decisions, were related to coworker relations (CR or IV1) and individual decision-making was related to employee involvement (EI or IV2).

Making and revising decisions as a team. Three of the six groups, from Tiers 1 and 2, were able to make and revise decisions as a team (personal communication, August 27, 2012; August 28, 2012; September 11, 2012). One Tier 1 focus group stated, “we are given the freedom if we have new ideas or new processes to go ahead and do them and teach everyone our new idea” (personal communication, August 27, 2012). This same team replayed a dialogue in which they met, asked each other how they were going to do something, brainstormed possible solutions, and took a vote with “majority ruling” (personal communication, August 27, 2012). The team members accepted the team decision and supported the decision to move forward.

When asked how the team corrected a decision, they provided some steps, "we talk about it, we acknowledge it, we revamp it, we revisit it and work out an alternative solution, and we keep trying to find a way that works" (personal communication, August 27, 2012). This same focus group maintained composure and calmness as they described their team process to revise and act on decisions. They also managed up their supervisor in that they said their supervisor supported them to make decisions and try new things, "she encourages it, and she likes it" (personal communication, August 27, 2012).

Another Tier 2 focus group member explained that when she had difficulty with determining the best decision as an individual, she would bring the issue or decision to the "stand-up meeting" and "throw it on the table" to gain ideas and direction from the team (personal communication, August 28, 2012). She also mentioned that she relied on other team members to provide past experiences and advice related to the decision based upon their collective experience. Similarly, another focus group described how they used the "interdisciplinary clinical meeting" to involve all of the care team in making decisions about patients. And individual team members said that the supervisor would "then make patient decisions based on that team discussion" (personal communication, September 11, 2012). Thus, the team meeting was used in advance of an individual decision or action.

Individual decision-making. Four of the six groups, representing all three tiers, responded that individuals were able to make decisions on their own (personal communication, August 27, 2012; August 28, 2012; September 11, 2012; October 23, 2012). A Tier 1 focus group quoted their supervisor as saying, "do what you think" and that the supervisor encouraged individuals on the team "to make most decisions on their own and try them out" (personal communication, August 27, 2012). This same group applauded the supervisor for encouraging each of them to

think self-sufficiently, and they appreciated her confidence in each of them individually and as a team. Another Tier 2 focus group member explained that she accepted and needed to "make the right decisions" on her own. She also added that her supervisor was "confident" in her skills and decisions and "trusted" her to do the right thing and "fix the problems" (personal communication, August 28, 2012).

One focus group emphasized the necessity of making clinical care decisions independently while in the field and in patients' homes:

> When it comes to care, you kind of have to make a decision on the spot on certain care issues. So you are kind of alone on that and sometimes as far as a procedure goes, you just have to keep in mind and make the decision that is best for the patient. (personal communication, September 11, 2012)

Some focus groups said they were not able to make individual decisions autonomously and decisions were made in a top-down fashion (personal communication, September 11, 2012; September 13, 2012; October 23, 2012). Group members that lacked the ability to make their own decisions were presented negatively. The groups presenting this style of decision-making were lower scoring Tier 2 and Tier 3 focus groups. Groups, in which they perceived that their opinions or ideas were not "valued," in which they verbalized that managers spoke in a condescending fashion to them, in which they verbalized that they were not included in decision-making pertaining to the facility or patients assigned to them for workload, in which corporate policies or procedures were made void of concern for the caregiver in the field and of which they did not have ownership or were powerless, were groups echoing this negative theme (personal communication, September 11, 2012; September 13, 2012; October 23, 2012).

Not shown in the condensed Table 38 but evident in the more detailed table in Appendix S, were some examples of decision-making in between these extreme themes. Focus Group 3 stated that they were able to make some decisions on their own (personal communication,

September 11, 2012). Groups 1 and 4 explained that they would discuss the decision first with their supervisor and obtain approval first before making the decision (personal communication, August 27, 2012; September 13, 2012). In some outlier cases, a group member was either asked not to make decisions, not to discuss decision-making with the supervisor, or was given negative feedback from the supervisor when making decisions (personal communication, September 11, 2012; September 13, 2012; October 23, 2012).

Accountability and task completion. Focus group Questions 11, 13, and 14 asked about accountability of task completion in the work group and in the workplace. Because these questions were secondary questions, they were posed to only three of the nine groups. Some of the themes had surfaced previously in the focus groups in response to the primary questions. Table 39 includes the trended themes and is a condensed version of the tables found in the supplemental materials.

Table 39

Trended Themes for Qualitative Focus Groups on Accountability and Task Completion

Qualitative theme	Quantitative independent variable
Helping each other	CR (IV1)
Self-accountability	EI (IV2)

Note. No Tier 1 patterns or best practices observed. Full coding tables with all themes for the qualitative focus group Questions 11, 13, and 14 can be found in the supplemental materials. Communication (CR), Unspoken Team Workflow (L & CR), and Check Dashboard (L & CR) were indicated in two of the three responses to the three questions.

Self-accountability and peer accountability. Two of the three focus groups discussed self-accountability of team members, of team members owning tasks, and of team members being proactively responsible for completion of tasks. One Tier 2 focus group stated the following:

> I think people here, if they know if they have done something wrong, or they haven't been working as hard, they will say, 'Sorry, I know, it's my bad.' I don't think I have encountered anybody here that has tried to put the blame on anybody else. So I think self-accountability. (personal communication, August 28, 2012)

This same group highlighted systems and means by which group members were able to track their individual progress. They discussed the use of a "numbers board" that was displayed for the team to view team members' number of successful prescription refills as well as including "an error log" (personal communication, August 28, 2012). The group said the tool existed both on a white board in the work area and also on the computer dashboard.

Another Tier 2 focus group emphasized the comfort of team members holding each other accountable.

> we hold each other accountable. . . . We just automatically expect each other to do our jobs because we have built this relationship and we know that if we didn't do it, we are only human so, therefore, we just go and do our jobs. (personal communication, September 13, 2012)

The group went on to say, "we have mutual respect for one another, and we want each other to be accountable. But at the end of the day, that is up to the individual" (personal communication, September 13, 2012). The focus group paired granting of grace, humility, and respect with holding their peers accountable for tasks. They also related self-accountability with peer accountability. This same Tier 2 focus group concluded that "it's all about respect. . . . You have respect for one another and treat them the way you would want to be treated. You do the next person the same way" (personal communication, September 13, 2012).

Helping each other. The focus groups that responded to Focus group Questions 11, 13, and 14 discussed how they helped each other and did so by proactively volunteering or automatically covering a task that needed to be done. A Tier 1 focus group said, "There was hardly a conversation because somebody just spoke up and said, 'I will do this.' . . . I thought

that I would just do this one" (personal communication, August 27, 2012). A Tier 2 focus group explained how an individual on the team "surveys what is happening" and which team members are in process with which specific tasks. The team member will then, without verbalizing, work on another task that needs to be done (personal communication, August 28, 2012). Another Tier 2 focus group from another company division stated, "I think we pretty much have each other's back because if we didn't, we wouldn't be here" (personal communication, September 13, 2012). Each of the teams relayed examples where individual team members, without solicitation or even without speaking, immediately helped in doing the work; they did not think if a task was in their specified job duties. It appeared to be a natural and spontaneous process in how each group described helping each other.

From another perspective, a Tier 2 focus group recounted how their current management did not help them in comparison to a previous management team. They mourned how the lack of help and support by their manager deterred from accountability and accomplishing care for the patients. They discussed how "a meeting" took priority over "starting a new patient on care" with their current manager (personal communication, September 11, 2012). The perceived lack of help by the manager deterred from the team accomplishing their purpose and goals. The work group perceived the manager's behavior to be unhelpful and aversive.

Systems of communication. Focus groups reported the use of various communication tools and systems to help in the promotion of accountability and to better help each other. Focus Group 1, a Tier 1 group, talked about an informal meeting in which the team engaged and accomplished a task before the formal team meeting with the supervisor (personal communication, August 27, 2012). Focus Groups 1 and 2 used the formal team meeting, sometimes called the "stand-up meeting" to communicate on accountability (personal

communication, August 27, 2012; August 28, 2012). Focus Group 2, a Tier 2 group, used a number board, a schedule, the dashboard on a computer, and "unsaid workflow" as mechanisms to remain on task and accountable as a team (personal communication, August 28, 2012). All the communication systems had been designed and directed by their supervisor or the president of their division. Focus Group 4, a Tier 2 group, emphasized how they were "good listeners" to their clients and to each other in accomplishing the right tasks for the benefit of the clients and the team. The focus groups, in essence, related "listening" to respect and mutual help for each other (personal communication, September 13, 2012).

Team leadership style. Leaders and leadership did not arise as primary responses for most of the questions and topics. And yet, leadership and leaders were related and discussed as setting the systems in the workplace and positively supporting the presence of the characteristics and results presented thus far. In addition, groups also discussed that when leadership was not present, supportive, or positive, results were often discussed as negative or counter to the team's purpose.

The researcher posed two questions to the focus groups directly related to the leader and leadership. Focus group Questions 7 and 16 asked group members to describe the leadership style related to the work environment and to describe the relationship with their supervisor. The researcher aimed to obtain insight into an effective team and specifically leadership related to mutual accountability as a characteristic of an effective team (Robbins, 2001). Question 7 on leadership style was posed to all nine focus groups, although it was not a primary research question. Question 16 on relationship with supervisor was posed to only two of the nine focus groups. The responses to Question 16 overlapped and coincided with the responses to Question 7; therefore, trended themes from both questions are indicated in Table 40.

The supplemental materials include apparent themes for Questions 7 and 16, respectively. All of the themes resulting from Questions 7 and 16 related to leadership as an independent variable in the quantitative phase of the study. Some of the leadership themes were positive, some neutral, and some negative as discussed by focus groups. Table 40 includes abbreviated and consolidated themes. Presentation of results includes quotes, stories, examples, observations, and behaviors related to key themes that support insight into team leadership as perceived by groups of associates.

Approachability. The most common theme addressed by focus groups related to the style of leadership in the work units was one of approachability and openness. Five of the nine focus groups, representing all three tiers, highlighted how their supervisor or manager was

Table 40

Trended Themes for Qualitative Focus Groups on Leadership Style and Relationship With Supervisor

Qualitative theme	Quantitative independent variable
Approachability of supervisor	L (IV3)
Positively cares and supports others	L (IV3)
*Finds time to help and respond	L (IV3)
*Transparent	L (IV3)
Establishes a casual work environment	L (IV3)

Note. * = Tier 1 theme or best practice. Full coding tables with all themes for the qualitative focus group Questions 7 and 16 can be found in the supplemental materials.

approachable and open. The grouping of words most frequently used by the focus groups was the practice and use of "an open-door policy" (personal communication, August 27, 2012; August 28, 2012; September 13, 2012; November 1, 2012; November 6, 2012). One Tier 1 focus group described their supervisor in this way: "I feel very able to go in and talk to her about something

personal. . . . She is flexible with stuff. . . . We are able to talk to her about stuff" (personal communication, August 27, 2012). And as a result of the group's ability to talk openly with their supervisor, they said they "were able to trust her" (personal communication, August 27, 2012). Another Tier 1 focus group declared, "it's awesome. . . . There is always an open door. They will never turn you away or make you feel that you can't do it" (personal communication, November 6, 2012). In both Tier 1 groups, representing two different divisions and health care environments, the ability of the team members to be able to walk in their supervisors' offices and talk or seek advice in an open fashion without criticism appeared to be the first thing mentioned in responding to the question. They also connected this approachability and openness with the establishment of trust.

Comments from Tier 2 focus groups were consistent with Tier 1 focus groups. Supervisors or managers were described as "easy to talk to," and one team said that the supervisors were "present and sometimes we talk . . . they are here" (personal communication, August 28, 2012). In this same focus group interview, the team described their leader as "approachable" and "down to earth" (personal communication, August 28, 2012). Another Tier 2 focus group said, "Once you go into her office, and sit and talk to her, she really hears you out. She is there for us. . .she's open to hearing what everybody has to say" (personal communication, September 13, 2012). A similar response resulted after being asked Question 16 by this group. This group described their supervisor's willingness and interest to hear feedback, ideas, and concerns from team members. This sentiment was present in both Focus Groups 2 and 4. Another Tier 2 focus group connected involvement by their leader with the team in describing the open-door policy: "She gets involved when she sees patients. She has an open-door policy" (personal communication, November 1, 2012). Thus, focus groups linked approachability with

other leadership qualities, such as being present, showing interest in feedback, caring, and offering to help. It often was described as being a required foundational element before other qualities or themes were described.

One focus group described the opposite of approachable and described a lack of leadership as a result. This group's first response to Question 7 on leadership style was that it was one of "avoidance and no follow-through and one that avoided communication and confrontation" (personal communication, September 11, 2012). This group clarified that they perceived the leaders to not want confrontation because approaching a concern was equitable to confrontation: "because they approach a subject, it doesn't mean that they are being confrontational, it means that they are following through. . . . it shouldn't be viewed as confrontational" (personal communication September 11, 2012).

Creating a casual work environment. Approachability and openness was followed by discussion on how leaders in Tier 1 and 2 work groups created a casual and relaxed work environment, one in which team members expressed "freedom and autonomy to work" (personal communication, August 27, 2012; August 28, 2012; September 13, 2012; November 2, 2012; November 6, 2012). Focus Groups 1, 8, and 9 described the leadership style as one of "flexibility" and one in which the "supervisor does not micromanage" (personal communication, August 27, 2012; November 2, 2012; November 6, 2012). One expressive Tier 2 focus group described the leadership style as "more laissez-faire," and the next statement was relative to openness and asking for feedback: "They ask for our input. . . . and they are easy to talk to" (personal communication, August 28, 2012).

One focus group, although they described their supervisor as approachable, mentioned how the supervisor only responded to messages delivered by specific team members. And the

focus group perceived this as “peeping around the corner,” “snitching,” or “tattletaling” (personal communication, September 13, 2012). The team members learned to be careful or guard what they said around certain team members as a result. Thus, the openness was guarded not specifically to the supervisor but was guarded with specific coworkers who were taking information and transferring it with their respective filter to the supervisor (personal communication, September 13, 2012).

Transparency. Approachability and openness was a precursor to the quality of a supervisor’s transparency and willingness to be real and authentic. Four of nine Tier 1 and 2 focus groups highlighted leaders’ transparency as characteristic of the work environment. In a Tier 1 focus group, the team relayed an example of how the leader expressed in a team meeting how every one of the team members was valuable and important. She expressed gratitude for each of them. They commented on her character by saying, “She doesn’t have the sense of ‘I have to be this strong.’ . . . She is a true person, and we have seen her emotions and not in a bad way” (personal communication, August 27, 2012). The focus group perceived their leader’s openness with her emotions to be positive, true, and real. The focus group related this openness of her character and sentiments to their ability to trust her as a leader.

Another Tier 2 focus group related transparency to the supervisor’s behaviors of being down to earth. They commented that they had seen her “with or without makeup or dressed up, wearing workout clothes, having bad days, pigging out” and likened their relationship with their leader to that of a marriage, seeing each other in “sickness and in health” (personal communication, August 28, 2012). This particular group laughed and had a sense of humor in relaying examples of how they had observed their leader to be transparent and related to their own “down to earth” experiences (personal communication, August 28, 2012).

In contrast, a Tier 3 group, observed discrepancies in behavior between two of their leaders. These leaders demonstrated a lack of transparency and created an environment of distrust and low team motivation as a result. Team members described their leadership as "wishy-washy," having "lost trust and credibility with staff due to the mixed messages" from the two primary leaders (personal communication, October 23, 2012). The presence of transparency was described in a positive way as supporting the team when present in Tier 1 and 2 focus groups and creating distrust and low morale when not present as relayed by a Tier 3 focus group. Both showed the importance of the theme.

Caring for and helping others. Six of the nine focus groups, representing all three tiers of satisfaction, used the words "cares" or "caring" to describe their leaders. Again, groups relayed examples of how supervisors offered "help" and "support" with the foundation of approachability and an "open-door policy" (personal communication, August 27, 2012; August 28, 2012; September 13, 2012; November 1, 2012; November 2, 2012; November 6, 2012). A Tier 1 group provided an example of how the supervisor asked the group in weekly staff meetings, "how can I help you?" and then gave the team guidance for success (personal communication, August 27, 2012). The group also relayed how this same supervisor "set apart 30 minutes just to help me out. She will find time to help you out, even when she is really busy" (personal communication, August 27, 2012). Another Tier 1 supervisor was known to say to the team, "you can do it" and thus served as a cheerleader in addition to offering help and support (personal communication, November 6, 2012).

Focus Group 2 said of their management team, "they take a personal interest in you. It's pretty nice. They care about who you are. They have faith in us" (personal communication, August 28, 2012). It was important to the team that the manager was sincerely interested in them

as individuals. Focus Group 7 relayed how the supervisor was "supportive" and "involved herself with the patients" to help the team. They explained how she physically helped the team in addition to providing moral support (personal communication, November 1, 2012).

Focus Group 8 described their supervisor as "hands-off" and identified this as a positive quality. They said of her, "she lets us shine, and she reigns us in when she needs to. . . . she lets us do our jobs as clinicians" (personal communication, November 2, 2012). The group recognized how this leader was skilled "with the numbers" and complimented the team's work as clinicians while supporting them from an administrative perspective. The team also recognized that the leader managed differently with "different situations" (personal communication, November 2, 2012). They described this as a "blend and balance" in her style of helping (personal communication, November 2, 2012). In short, being approachable and transparent, promoting a casual work environment, and caring for and helping team members were relayed as important in supporting the teams from all tiers of engagement.

Corporate leadership. When focus groups were asked about the characteristics of company leadership, a couple of the groups noted that company leaders were "disconnected" from patient care and "impersonal" with their associates, who happened to be the teams providing direct patient care (personal communication, November 1, 2012; November 2, 2012). Both groups recounted how the previous CEO, president, or corporate nurse visited the work units to meet with staff, to have fun with staff, to recognize quality care, to educate and train, and to communicate. This behavior equated to, "it felt like we were a family" (personal communication, November 2, 2012). Both groups explained, in their own ways, that the current executive leaders did not visit the field, and the groups' perception was that a transition had occurred "from patient care to paper care" (personal communication, November 1, 2012).

They conveyed that their perception was that executive leaders focused on growth and financials and not on the quality of patient care or the associates' well-being. One group also questioned the company's financial stability because the focus group members had not met or seen the new company president (personal communication, November 2, 2012). Mistrust was associated with the executive leaders as a result of lack of presence, lack of communication, and lack of approachability.

Importance of recognition and feedback. The researcher posed Question 10 to focus groups, which asked how they received recognition. In addition, the researcher posed Question 15 to the focus groups, which asked how they received feedback. Both questions were secondary questions and not posed to all groups. Question 10 was posed to six of the nine focus groups, and Question 15 was posed to two of the nine focus groups. Because recognition and feedback were means of reinforcing team behavior and both were secondary questions, the themes were consolidated into Table 41 for presentation and discussion purposes. The supplemental materials include details on themes for Questions 10 and 15, respectively. Themes in Table 41 and the respective figures in the supplemental materials are coded in relation to the quantitative independent variables as with previous sections. Themes pertaining to recognition and feedback provided more insight into the importance of employee involvement as provided by both leaders and the organization. Examples, quotes, behaviors, and observations are described as relayed by the focus groups that responded to Questions 10 and 15. Responses from Tier 1 and 2 groups resulted for these two questions.

Recognition by clients. Four of the six focus groups that responded to Question 10 celebrated their recognition by clients, patients, and customers. Focus groups directly providing

patient care emphasized the significance of positive feedback from their clients and patients. The recognition by their patients validated their internal motivation and purpose to care for others. Focus group members stated that recognition by patients and families came in the form of cards, letters, e-mails, or in verbal reports to supervisors or management (personal communication, September 11, 2012; September 13, 2012). One focus group member provided a meaningful connection to her purpose for providing care:

> One day I am going to end up in this position, praying not, but I just give the care that I know that I would want for myself or for a family member. Once they are an adult, twice a child, so they step into a second childhood, and I feel like we have to give them that attention, and we have to give them that time. If I can drag myself out there, I am going to take care of my patients. . . . I had to tell my Mama just a couple of months ago that we have reversed roles. (personal communication, September 11, 2012)

Thus, when team members received recognition from clients or patients, they felt an accomplishment in caring for their own and a reinforcement of their life's mission. Some of them also related to the care they were providing for which they recognized as a "pay forward" care, knowing at some point they or their family would need care.

Table 41

Trended Themes for Qualitative Focus Groups on Recognition and Feedback

Qualitative theme	Quantitative independent variable
Recognition by client, patient, or customer	EI (IV2)
Lapel pin, certificate, and thank you note from executive team	EI and L (IV2 and IV3)
Recognition by executives	EI and L (IV2 and IV3)
5,10,15, etc. annual work anniversary recognition	Organization

Note. No Tier 1 patterns or best practices observed. Full coding tables with all themes for the qualitative focus group Questions 10 and 15 can be found in the supplemental materials.

Recognition by supervisors and executives. In many cases, recognition by clients and patients surfaced through the recognition by supervisors and executives. Focus Groups 3, 4, and 5 provided examples of how clients' families had called associates' supervisors about the excellence of individual team members (personal communication, September 11, 2012; September 13, 2012). Focus group members relayed stories of how they received a thank you letter from a supervisor or an executive along with a lapel pin for their excellent service to a client or patient (personal communication, September 11, 2012; September 13, 2012).

> My supervisor had written in a letter that she had received a call from a client's mother stating that I was the best case manager that the family had ever had . . . that I was always persistent, calm, and kind . . . she sent me the letter from the family for my records along with the pin. (personal communication, September 13, 2012)

Other group members consistently relayed stories of recognition by their executives through public recognition in meetings, signed letters, and the receipt of lapel pins or gift cards (personal communication, August 27, 2012; September 11, 2012; September 13, 2012).

Focus Groups 2 and 4 stated that associates were recognized through "Employee of the Quarter" or "Employee of the Year" (personal communication, August 28, 2012; September 13, 2012). Focus Group 1 told of a story of how an event celebration was planned for the team at Six Flags Fiesta Texas in recognition of completion of a major company project and how meaningful that effort was to the work group as a whole (personal communication, August 27, 2012). Focus groups also discussed the significance of informal acknowledgement and thanks. A simple "good job" or "a supervisor saying, 'thank you'" was explained to be just as meaningful as public or formal recognition by some focus group members (personal communication, August 27, 2012; August 28, 2012). So, recognition by supervisors and executives was most frequently discussed by focus groups and was associated with methods of public recognition, personal recognition both verbally and in writing, and at times paired with a small gift.

Recognition by coworkers. One focus group relayed an example of how a coworker left a muffin or a small gift on coworkers' desks to recognize a kind act or service. Apparently, associates did not know who was leaving the muffins and small gifts until a later period of time. At the time of the focus group, the team members knew the coworker's identity and additionally relayed how this same coworker always showed care and concern for each of them by stopping by their desks and providing a word of encouragement (personal communication, September 13, 2012). This story was told in response to this particular question on recognition. But with every primary question, all focus groups, from all tiers, relayed how their fellow team members provided meaning, joy, motivation, and positive reinforcement when that recognition was not immediate from supervisors. The groups' purpose and common commitment to the patient was reinforced by the response of their coworkers.

Organizational program for recognition. Four of the six groups brought up an organization-wide recognition program for years of service. The company awarded a lapel pin, letter, and certificate for years of service in 5-year increments for 5 years and beyond (personal communication, August 28, 2012; September 11, 2012; September 13, 2012). A great deal of discussion did not revolve around the organizational program, other than it existed and various associates had received their rewards. Some negative sentiment was relayed in the fact that since the program had recently been implemented, the company did not go back retroactively and award for years of service that had already passed before the implementation of the program. Thus, team members having served for 8 years, for example, had not been recognized and would need to wait until their 10-year anniversary for recognition. In one respect, this one aspect of the program negatively reflected on the program, and the effect was counter to the intent (personal communication, August 27, 2012).

Methods of feedback. The two focus groups addressing Question 15 said they received feedback from their supervisor either directly "through daily and weekly stand-up meetings" (personal communication, August 28, 2012) or "through an e-mail from their supervisor or senior vice president" (personal communication, August 27, 2012). Focus Group 2 said that they preferred a "direct and no-nonsense approach" from their supervisor (personal communication, August 28, 2012). Feedback was addressed in focus group responses to primary and secondary questions and ranged from direct feedback to written feedback to behavioral feedback by supervisors, leaders, and coworkers. The researcher observed that focus group members were aware of various forms of feedback and used the feedback to either reinforce or change their performance. They continually relayed an internal sense of commitment and drive to provide excellent care and service to their patients, clients, and to each other.

Tier 1 Focus Group Best Practice of Collaboration

Throughout the coding, analysis, and presentation of all the qualitative results, the researcher utilized color schemes to tie back focus group themes to the qualitative phase of the study and most specifically to the qualitative independent variables. In addition, themes from Tier 1 focus groups were noted with an asterisk in the tables of results. These Tier 1 themes can be considered best practices. Table 42 includes all the themes characteristic of Tier 1 focus group responses. One can quickly see that all three independent variables are represented in the Tier 1 group themes.

Qualitative themes tied to coworker relations (CR or IV1) as a quantitative independent variable were most prevalent as related to Tier 1 focus group best practices and themes. As shown in Table 42, the themes related to coworker relations were most prevalent related to accomplishing and setting team goals, the teaming experience, and working through team

conflict. Collaboration was evident through helping each other, having friends on the team, liking teaming aspects, learning from each other, spending time together, listening to each other, and working things out amongst each other. Trust surfaced in Tier 1 focus group responses relative to workplace satisfaction. The leadership themes (L or IV3) most prevalent in the responses from Tier 1 focus groups were transparency and the leader finding time to respond and help their work teams. The order of themes or variables was not the focus of this particular study.

Tier 1 Focus Group Visual Representation of Predominant Words and Concepts

After transcripts were reviewed for themes and matrices were constructed, questions and interviewer comments along with behavioral expressions or observations were eliminated from the transcripts. Three versions of transcripts for each of the nine groups were saved individually. The first transcript version included responses only for the first four primary questions. The second transcript version included responses for all interview questions. The third transcript version included responses for the fifth interview question on trust, since that was a theme that emerged and was also of interest to the researcher. The three different versions for each of the nine groups were loaded into "Wordle" (Feinberg, 2008) to produce word clouds based on word frequency. The researcher first attempted combining all group responses by question for word cloud production, but the file was too large for the software's capacity. The researcher, therefore, resorted to produce and analyze word clouds by group using the three different versions of transcripts as described.

A second online software application, "Text is Beautiful" (Rogers & Stuart, n.d.), was used to produce concept maps, concept theme webs, and correlation wheels for Tier 1, Tier 2, and Tier 3 responses. Because of the amount of data and responses for the Tier 2 groups, a representative sample of responses was used to load in for Tier 2 groups. One Tier 2 group from

each company was used in the concept, theme, and correlation visualizations. Leximancer software technology (2010) incorporated statistical algorithms
for mapping semantics, themes, and correlations based upon co-occurrence of words together and modeling, supported by other researchers (Smith & Humphreys, 2006).
The word clouds, concept maps, concept webs, and correlation wheels provided additional reflexivity and vigor to support the researcher's manual coding and matrices development on themes.

Figure 13 displays the word concepts produced from all Tier 1 group qualitative responses in a word cloud (Rogers & Stuart, n.d.). More frequently cited words are shown in larger font. The words "work," "day," "time," "person," and "home" were the most frequently occurring words in the Tier 1 responses, in descending order according to frequency of use in the transcripts. Words that mapped together more frequently in the transcripts are shown in the same color. The word "team," displayed in red, mapped and occurred more frequently with the following words: "supervisor," "tell," "talk," "feel or felt," "gives or gets," "needs," "doing," "coming," "care," and "able."

Figure 14 displays a concept web according to all Tier 1 group themes (Rogers & Stuart, n.d.). Words appear grouped according to themes and co-occurrence with other words in the transcripts. Words with a greater relationship are located closer to each other and are connected by lightly shaded lines. In some cases, strongly related words are on top of each other. The word "team" is in close proximity to the word "supervisor" in the red-themed grouping of words. The word "home" intersects with "work" in the blue-themed grouping. The words "coworker" and "trust" are included in the orange-themed grouping. And the words "nurses," "CNAs," "family," and "facility" are related in the pink-themed grouping.

Table 42

Tier 1 Focus Group Themes or Best Practices as Observed From Qualitative Focus Group Interviews

Focus group questions	Themes	Quantitative independent variable
(Questions 1 and 12) Accomplishing and setting goals	Helping each other	CR (IV1)
	Having friends on the team	CR (IV1)
(Questions 2 and 6) Workplace satisfaction	Trusting team members	CR and L (IV1 and IV3)
	Focusing on the project	EI (IV2)
(Questions 3 and 4) Teaming experience	Helping each other	CR (IV1)
	Having friends on the team	CR (IV1)
	Liking aspects of the team	CR (IV1)
	Learning with each other	CR (IV1)
	Spending time together	CR (IV1)
	Having obligations and commitments	EI (IV2)
(Question 7) Leadership style	Finding time to help and respond	L (IV3)
	Transparent	L (IV3)
(Question 8) Working through conflict	Listening to each other	CR (IV1)
	Working it out amongst themselves	CR (IV1)

Note. Not every question's responses included Tier 1 themes or best practices; therefore, they were not included.

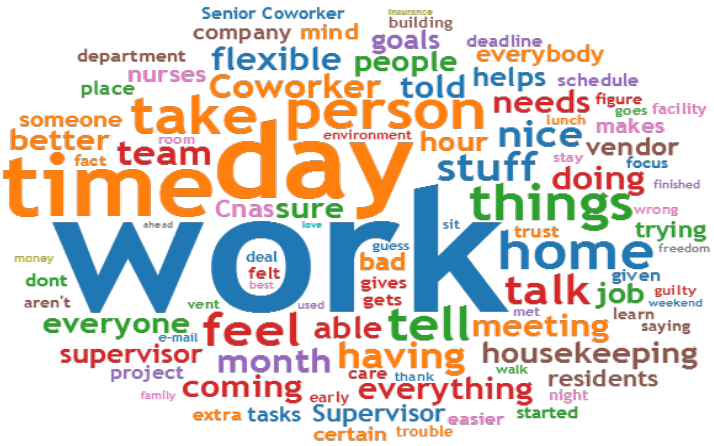

Figure 13. Concept cloud for Tier 1 group responses. The word concept cloud was created using transcripts from Tier 1 focus groups using "Text is Beautiful" (Rogers & Stuart, n.d.). The concept map shows more frequent words in larger font and also organizes words by theme color.

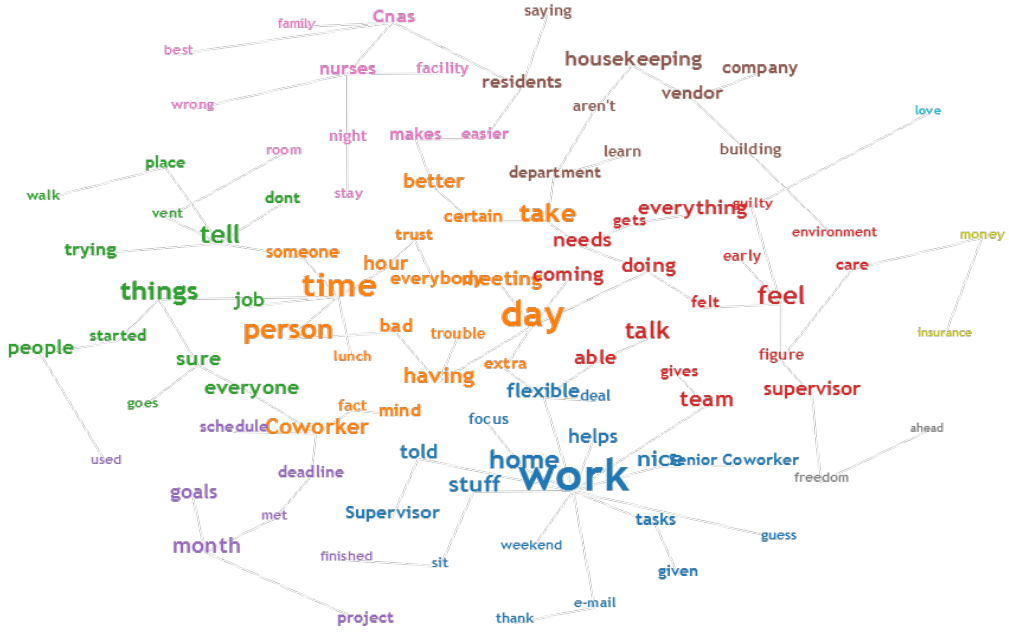

Figure 14. Concept web for Tier 1 group responses. The word concept web was created using transcripts from Tier 1 focus groups using "Text is Beautiful" (Rogers & Stuart, n.d.). The concept web shows more frequent words in larger font and also groups words by theme color. Words with a greater relationship are located closer to each other and connected by lightly shaded lines. In some cases, strongly related words are on top of each other. The words "supervisor" and "team" are used frequently and show a relationship to each other.

One of the Tier 1 focus groups' responses is displayed using "Wordle" (Feinberg, 2008). Focus Group 9's transcript for responses to the four primary questions was loaded into "Wordle" and the diagram is shown in Figure 15. The word cloud in "Wordle" shows most frequently

occurring words but does not map them according to themes. The words “help,” “years,” “like,” “work,” “company,” and “make” were predominant in the transcript.

Positive Themes From Select Tier 2 Focus Groups

The concept cloud produced from select Tier 2 focus group transcripts using “Text is Beautiful” (Rogers & Stuart, n.d.) provided insight into positive themes. Figure 17 displays the visualization. Select focus group transcripts were used due to the inability

Figure 15. Focus Group 9 word visualization on interview primary questions. The word cloud was created using the transcript from the Focus Group 9 interview on primary questions using “Wordle” (Feinberg, 2008). The word cloud displays more frequent words in larger and more prominent text.

of the software to process all of the transcripts for all of the Tier 2 groups in totality. The data file for all Tier 2 groups was too large for the software to manage. The researcher selected three Tier 2 groups, each representing a different company. Transcripts from Focus Groups 3, 4, and 7 were selected for creating the word concept cloud.

The most frequent word in the select transcripts was “patient” followed by “work,” “coworker,” and “time.” The words “patient,” “nurses,” “care,” and “communication” were related together, and these words are indicated by an orange color-coding representing a common theme. The words “work,” “coworker,” “time,” “management,” and “person” were associated

with one another and coded with a blue color-coded theme. The words “people,” “team,” “day,” and “talk” were frequently associated and coded with a green color. And the word “trust” is indicated in red and associated with “tell” and “somebody.” The researcher noted how prevalent and central the word “patient” was in the visualization. This is similar to how all of the focus groups in their interviews spoke of their sole purpose in caring for patients, and they often spoke of their commitment to their patients.

Figure 16 shows just how closely “nurses” and “communication” were to the word “patient.” The words in both the concept cloud and concept web, Figures 16 and 17, respectively, coincide with the themes identified by the researcher in analyzing and coding all nine of the transcripts. Liking their patients, their patients’ families, and their jobs, trusting team members, and making a difference surfaced not only in the analysis and coding of the transcripts, but those same themes are reflected in the word frequency and relationships resulting from the visualization output from “Text is Beautiful” (Rogers & Stuart, n.d.). The researcher attempted to use the visualization approach to triangulate results in this qualitative phase. The visual concept cloud and web for the select Tier 2 focus group transcripts further reinforced the findings from the coding and analysis of the focus group responses.

Focus groups emphasized trust within the team in response to multiple interview questions. Figure 18 shows a visualization of all group responses to Question 5: How is trust developed? Words, such as “coworker,” “work,” “going,” “know,” “like,” and “think,” appeared frequently in the responses to Question 5. The words “time,” “personal,” and “team” are apparent in the visualization as well. The visualization triangulates with how focus groups described the importance of “getting to know their coworkers at work,” “the need to spend time together,” and the “personal nature of communication building trust” (personal communication,

August 28, 2012; September 11, 2012; September 13, 2012; November 1, 2012). These were themes that resulted from the coding and analysis of the focus group transcripts. Those themes were reflected in the visualization.

Figure 16. Concept cloud for select Tier 2 group responses. The word concept cloud was created using transcripts from select Tier 2 focus groups using "Text is Beautiful" (Rogers & Stuart, n.d.). Groups 3, 4, and 7, representing different companies, were selected. The concept map shows more frequent words in larger font and also groups words by theme color.

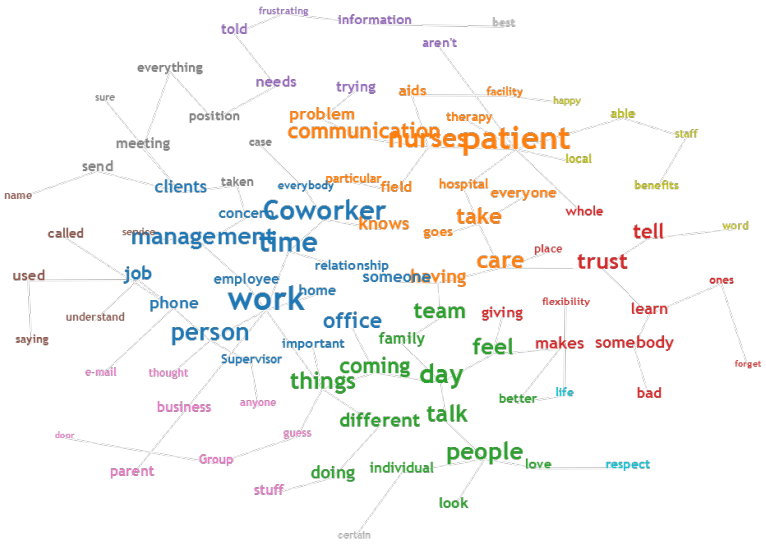

Figure 17. Concept web for select Tier 2 group responses. The word concept web was created using select transcripts from Tier 2 focus groups (Groups 3, 4, and 7) using "Text is Beautiful" (Rogers & Stuart, n.d.). The concept web shows more frequent words in larger font and also groups words by theme color. Words with a greater relationship are located closer to each other and connected by lightly shaded lines. In some cases, strongly related words are on top of each other.

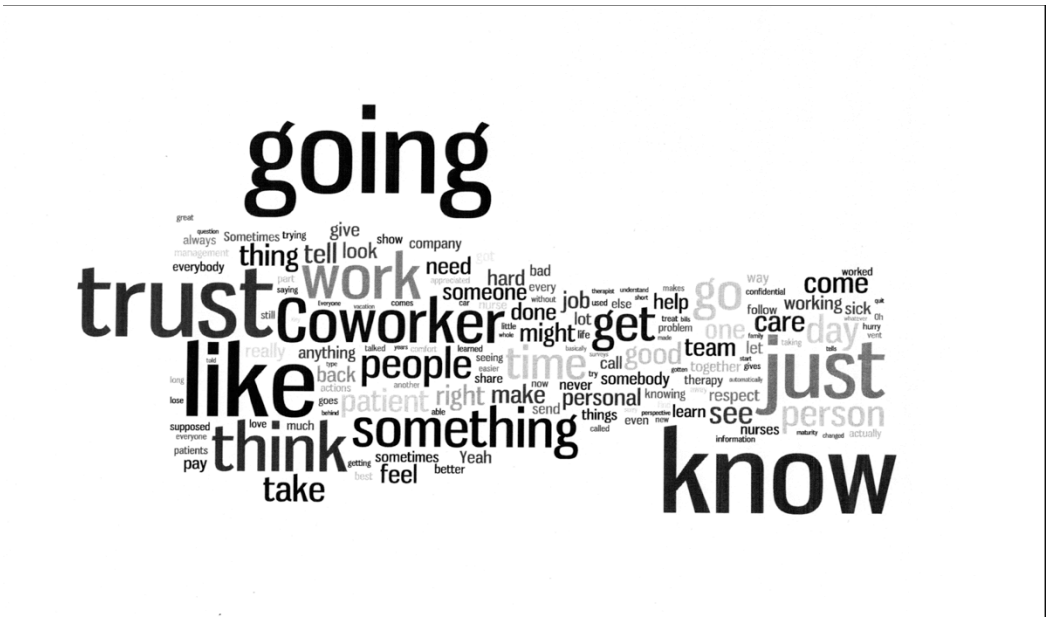

Figure 18. Focus group visualization on trust. The word cloud was created using transcripts from all focus groups regarding the question on trust using "Wordle" (Feinberg, 2008). The word cloud displays more frequent words in larger and more prominent text.

Themes in Tier 3 Focus Groups

Surprisingly, Tier 3 focus groups emphasized the same themes as the Tier 1 and 2 groups in response to focus group interview questions. Often their approach in responding to the questions was negative due to their negative experience with their work teams, within their work environments, and with their supervisors. They were open in expressing what was missing, but they certainly emphasized the importance of qualities in the team. Figures 19 and 20 show how similar the word concepts and themes were in the Tier 3 focus group transcripts. The word "work" is seen as the most prevalent word in Tier 3 responses. And "work" is related to "team," "trust," and "time." The evidence of a negative filter of these groups is apparent in the words "challenge" and "micromanaging," which appear in the same color grouping as "trust," "team," and "work."

Figure 19. Concept cloud for Tier 3 group responses. The word concept cloud was created using transcripts from Tier 3 focus groups using "Text is Beautiful" (Rogers & Stuart, n.d.). Focus Groups 6 and 8 were selected. The concept map shows more frequent words in larger font and also groups words by theme color.

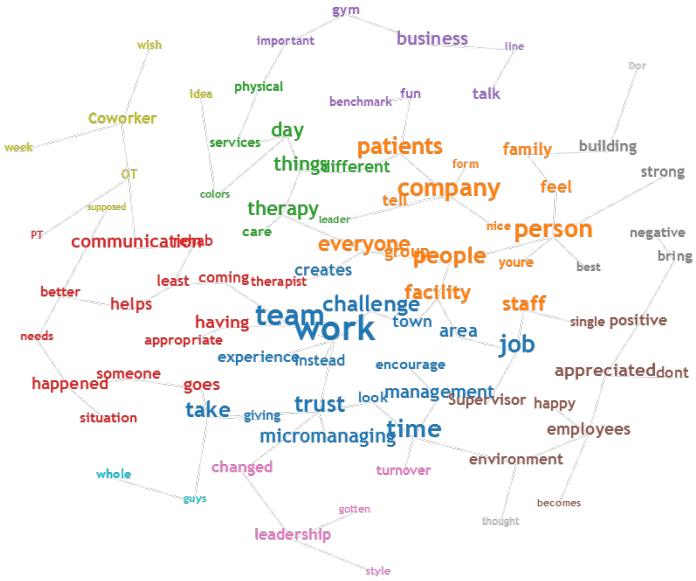

Figure 20. Concept web for Tier 3 group responses. The word concept web was created using select transcripts from Tier 3 focus groups (Groups 6 and 8) using "Text is Beautiful" (Rogers & Stuart, n.d.). The concept web shows more frequent words in larger font and also groups words by theme color. Words with a greater relationship are located closer to each other and connected by lightly shaded lines. In some cases, strongly related words are on top of each other.

Summary: Provision of Depth of Quantitative Results

Purpose and logistics. The purpose of the qualitative phase of this study was to fully explore the perceptions of groups of associates relative to commitment, coworker relations, employee involvement, and leadership, variables associated with teaming and team leadership. The researcher sought to gain insight into associates' perceptions of teaming. Seventy-five associates were interviewed in nine focus groups, and the groups ranged in size from five to 12 associates. The qualitative purpose evolved throughout the course of the study and emerged after the results from the first phase were quantified. The researcher wanted to hear the words and thoughts from groups of associates on their beliefs and perceptions related to teaming and team leadership. Thus, questions were asked relative to the attributes necessary for effective teams according to Robbins (2001) and Robbins and Judge (2012). The qualitative design included four primary questions supported by 12 possible secondary questions. The researcher modified the secondary questions in the qualitative phase of the study based upon group interview responses.

Groups were selected from all three tiers of commitment scores and from all divisions or companies. Group interviews were recorded, transcribed, analyzed, and coded, and then themes were identified. Transcripts were reviewed multiple times for accuracy and subsequently for coding of themes. Themes were then cross-referenced back to the dependent variable of associate commitment and to the independent variables of coworker relations, employee involvement, and leadership. The cross-referenced themes were color-coded and labeled with cross-referenced variables. In this way, predominance of themes related to one of the variables was immediately apparent. Concept maps and webs along with word clouds as produced from two separate software applications were used to analyze full transcript interviews. In this way, the researcher triangulated qualitative data analysis.

Insight into associate commitment. The seven most frequent themes that surfaced in the nine focus group interviews related to focus group Question 2 were the following: (a) having friends on the team; (b) trusting team members; (c) making a difference; (d) liking their patients, their patients' families, and their jobs; (e) having flexibility with work schedules; (f) feeling valued, appreciated, and recognized; and (g) earning better pay and benefits. Each of the themes was represented by each of the independent variables of coworker relations, employee involvement, and leadership. In addition, all the themes were discussed and related to workplace satisfaction, which is synonymous with associate commitment, the dependent variable.

The term "work family," for example, described how important coworker relations were to associates. The groups' responses had common themes of the relationships with friends in their work teams and how the reliance on team members created trust and a bond between work family members. The supervisor was included and referenced often as the leader of the work family. The essence of "teaming" was relayed in how groups of associates related to each other, helped each other, joined in their commitment to care for their patients and clients, and even had fun together.

Insight into coworker relations, employee involvement, and leadership as related to the perception of teaming. Focus groups responded to Questions 3 and 4 on what contributes to teaming by discussing those aspects that they believed to be critical to the experience of enhanced teaming: helping each other, having friends on the team, spending time with each other, having mutual obligations and commitments, having trust within the team, and being dedicated to patients and families as a team. Liking aspects of the team, problem solving together, and having open communication with each other and with their supervisor were discussed as secondary and supportive to the primary themes. Focus groups predominantly

discussed teaming from a perspective of their relationships and commitment with and to each other and with their leaders were often discussed secondarily. Leaders were presented as setting up systems to support the teaming experience and as setting the tone and expectations for the team. Thus, coworker relations and employee involvement were predominantly discussed relative to teaming with an underlying acknowledgement that the supervisor or leader sets the stage for those two variables to occur.

Blending team help and communication with leader guidance and individual autonomy in setting and accomplishing goals. Checking in with the team, helping each other, and having work autonomy surfaced as predominant themes in response to Question 1: How does the team accomplish goals? Focus groups first discussed the team's role in checking on the status of certain goals and work tasks. Accountability and ongoing prioritization were elements of checking in with the team on accomplishing goals. Tier 1 and 2 focus groups explained how they proactively looked to help fellow team members without being asked and described a variety of methods by which they proactively helped. Work groups discussed the importance of self-sufficiency, competence, and responsibility. To this question, responses were blended showing themes representing both coworker relations and employee involvement with regard to accomplishing goals.

Question 12 was a secondary question about setting goals as a team. Focus groups that answered this question said that, generally, team goals originated from a senior leader and were handed down to supervisors and subsequently work teams. Focus groups described the method of setting goals as either positive or negative and their description seemed to relate to their tier. Tier 1 focus groups described a more inclusive and positive goal-setting process guided by the

supervisor or leader. Tier 3 focus groups described the goal setting as more authoritarian without their ability to give input.

Responses to secondary questions. Secondary interview questions revolved around the areas of making and acting on decisions, team leadership, and the importance of recognition and feedback. Making and acting on decisions fell on a continuum from teams having the ability to make and act on decisions on their own to not being able to make any decisions on their own. The ability of the team to act on their own was associated with their supervisor's leadership style and openness and also with the tier that the focus group represented. Questions on leadership and relationship with the supervisor resulted in themes related to the leader's approachability, the leader creating a casual and relaxed environment, transparency on the part of the leader, and the leader caring for and helping team members. In their responses, focus groups recognized how leaders set the tone for the work environment through their behavior and demeanor. Focus groups relayed the importance of client, customer, peer, and supervisor recognition and described a variety of methods as to how they received recognition and feedback. Recognition ranged from personal and individual acknowledgment, informal "thanks" to formal letters, cards, lapel pins, certificates, and public recognition. Most groups agreed that they appreciated direct feedback. In short, all the focus groups provided abundant information related to themes in associate commitment, coworker relations, employee involvement, and leadership relative to teaming and team leadership. Conclusions, implications, and recommendations are provided in Chapter 5.

Chapter 5: Discussion and Implications

Purpose and Introduction

The purpose of this two-phase, sequential explanatory mixed design was to first examine the relationship between coworker relations, employee involvement, and leadership with associate satisfaction as perceived by health care associate work units in seven health care companies. These seven health care companies were part of a parent health care organization operating in 13 states. The independent variables of coworker relations, employee involvement, and leadership were selected because the three operational categories on the established associate satisfaction survey, developed by Morehead Associates (2007a, 2007b, 2008, 2009, 2010), included survey items most inclusive of determined characteristics associated with effective teams (Borkowski, 2009; Robbins, 2009; Robbins & Judge, 2013). Teaming is prevalent in health care and has been shown to be effective in better meeting patient outcomes (Avlund et al., 2002; Cameron, 2005; Hassan et al., 2002; Press Ganey, 2010, 2013; Tempest & McIntyre, 2006).

Press Ganey (2010, 2013) and others have shown that associate satisfaction, also known as commitment or engagement, is a precursor of patient satisfaction and outcomes. Patient satisfaction and outcomes have continued to grow in importance, since providers' pay-for-performance reimbursement is now dependent on quality and outcomes. Let us not forget that demographic trends show that while the number of elderly and debilitated patients requiring care is increasing, the number of licensed health care professionals is decreasing. And because interprofessional health care teaming has been demonstrated to produce better outcomes, this study was designed to provide more specific insight into the relationship of each of the independent variables related to teaming with associate satisfaction and with each other using a

4-year database inclusive of a variety of health care companies. The strength of relationships and coexistence of the variables was included in the purpose of this study.

The ratings on the three independent variables and the one dependent variable were included in the data gathered using a 4-year database from an established associate satisfaction survey (Morehead Associates, 2007a, 2007b, 2008, 2009, 2010). Examining the relationship between the three independent variables and the dependent variable was the primary purpose of this study's two-phase design. The secondary purpose was to examine the relationship between the independent variables. Information from the first phase was explored further in a second qualitative phase.

In the second phase, qualitative semistructured interviews were conducted to explore what makes an environment conducive to teaming and team leadership as perceived by groups of associates in nine work units. Work units from each of three tiers were selected to obtain aggregate data. Work units were also representative of the seven different health care companies. The rationale for including a second phase of qualitative semistructured interviews was to gain further insight from associates relative to the quantitative findings.

Qualitative group aggregate data were compared to and built upon characteristics of effective teams and team leaders as identified by Homans' group theory (Homans, 1950), Adair's leadership model (as cited in Thomas, 2008), and more contemporary work by Ancona (1992), Ancona and Bresman (2007), Kouzes and Posner (2002), Robbins (2001), Robbins and Judge (2012), and Borkowski (2009). Special characteristics of health care teams and team leaders have emerged from studies, experts, and authors in the areas of management, leadership, and organizational culture (Ancona, 1992; Ancona & Bresman, 2007; Avund et al., 2002; Borkowski, 2009; Cameron, 2005; Carpenter, 2005; Clevenger, 2007; Cohrs et al., 2006;

Connors, Smith, & Hickman, 2004; DeLoach, 2003; Dunn, 2010; Hassan et al., 2002; Homans, 1950; Karsh et al., 2005; Kirkman-Liff, 2004; Mulcahy & Betts, 2005; Poole & Hollingshead, 2005; Robbins, 2001; Robbins & Judge, 2012; Ryan-Woolley et al., 2004; Solomon et al., 2004; Tempest & McIntyre, 2006; Thomas, 2008; Toofany, 2007; Van Norman, 1998; Whatmore, 1999).

Hypotheses and Variables

Hypothesis 1 was that a strong relationship existed between the three independent variables of coworker relations, employee involvement, and leadership and the dependent variable of associate satisfaction. Hypothesis 2 was that a strong relationship existed between each of the independent variables with each other. The hypotheses were based on characteristics of effective teams, characteristics of work environments leading to teaming, and the necessary qualities of a team leader as emergent of the function of the teams (Albrecht, 2012; Ancona, 1992; Ancona & Bresman, 2007; Avund et al., 2002; Borkowski, 2009; Cameron, 2005; Carpenter, 2005; Clevenger, 2007; Cohrs et al., 2006; Connors et al., 2004; DeLoach, 2003; Dunn, 2010; Hassan et al., 2002; Homans, 1950; Karsh et al., 2005; Kirkman-Liff, 2004; Mulcahy & Betts, 2005; Poole & Hollingshead, 2005; Robbins, 2001; Robbins & Judge, 2012; Ryan-Woolley et al., 2004; Tempest & McIntyre, 2006; Thomas, 2008; Toofany, 2007; Van Norman, 1998; Whatmore, 1999).

These independent variables that were identified in advance integrated into a model showing characteristics of effective teams (Borkowski, 2009; Robbins, 2001; Robbins & Judge, 2012). The researcher integrated effective characteristics of teams and accepted team functional definitions as established by notorious experts in the field of organizational development (Borkowski, 2009; Robbins, 2001; Robbins & Judge, 2012) with specific, previously established

categories of survey items (Morehead Associates, 2007, 2008, 2009, 2010). Table 43 shows the integration of effective team characteristics and team definitions as identified by Robbins (2001) with independent variable categories.

Table 43

Effective Team Characteristics, Definitions, and Independent Variables

Effective team characteristic	Team definition	Independent variable as per Morehead survey categories
Work design • Autonomy • Task identity • Task significance	Complementary skills	Employee involvement
Composition • Personality • Roles and diversity • Preference for teamwork	Positive synergy	Coworker relations
Context • Leadership • Performance evaluation • Rewards	Individual and mutual accountability	Leadership
Process • Common purpose • Specific goals • Conflict	Collective goal	Leadership and coworker relations

Appendix A provides a full listing of associate satisfaction survey items used in the quantitative data collection. Survey items were standardized and supported by ongoing validity testing by Morehead Associates (2007a, 2007b, 2008, 2009, 2010). Survey items were coded with their respective independent variables of coworker relations, employee involvement, and leadership with the dependent variable of associate commitment.

Interpretations of Hypothesis 1 Findings: Very Strong to Strong Relationship Between Independent Variables and Dependent Variable

The Pearson product correlation results for the overall organization and for each of the subsets of company data, in addition to the multiple regression analysis and the one-way analysis of variance (ANOVA), supported the acceptance of Hypothesis 1 that a strong relationship existed between coworker relations, employee involvement, and leadership with associate commitment. The Pearson correlation coefficient for all 4 years of data for the overall organization ranged from 0.53 to 0.80 showing statistical significance at a *p* level of .01. At a *p* level of .01, 99% certainty existed that the correlation result was not due to chance. A strong to very strong relationship existed between each of the independent variables of employee involvement, coworker relations, and leadership with the dependent variable of commitment.

Leadership showed the strongest correlation with associate commitment consistently in all 4 years with the highest *r* value of 0.80 in the first year of data collection, which was in 2007. Coworker relations and employee involvement showed the second strongest correlations with associate commitment in all 4 years of data collection with the *r* values of 0.72 and 0.68, respectively, both occurring in 2007. The correlations between leadership and coworker relations with associate commitment were very strong in 2007 as represented by high *r* values of 0.80 and 0.72, respectively. The relationship between employee involvement and associate commitment in 2007 and all other relationships for 2008 through 2010 were strong as represented by *r* values ranging between 0.53 and 0.68.

The multiple regression analysis and the one-way ANOVA showed that the three independent variables combined accounted for 69.5% of the variance in commitment in 2007, 56.9% of the variance in commitment in 2008, 48.8% of the variance in commitment in 2009,

and 55.7% of the variance in commitment in 2010. The one-way ANOVA results for the overall organization supported the results of the multiple regression analysis through the statistically significant fractions of variability (*F* values). Leadership was found to be the biggest driver of associate commitment in 2007 ($\beta_3 = 0.49$), and employee involvement was found to be the biggest driver of associate commitment in 2008 through 2010 ($\beta_2 = 0.48–0.52$) as per the multiple regression analysis results. All subsets of company data and the Pearson two-tailed correlation analyses supported Hypothesis 1 with the divisions of community care and part-time staff correlation results being most similar to the results of the overall organization.

Significant differentiation between this study and previous studies. In general, the strong to very strong relationship between the variables associated with teaming and associate commitment in the current study are supported by results from past and current quantitative research (Albrecht, 2012; Cohrs et al., 2006; DeLoach, 2003; Karsh et al., 2005; Liao, Yang, Wang, Drown, & Shi, 2013). There are, however, some distinguishing differences.

Stronger correlation values. First, the current study's results and correlational values resulted with stronger correlation values at a high significance level compared to previous studies. In the current study, the Pearson correlation values for the independent variables and commitment within the organization, which ranged from 0.53 to 0.80 at a 99% confidence level ($p < .01$), were higher than in other studies that compared a variety of independent variables with commitment. DeLoach (2003) had correlation values ranging from -0.40 at $p < 0.01$ to 0.62 at $p < 0.01$ between 16 independent variables and job satisfaction, the dependent variable (pp. 438–440). Karsh et al. (2005) demonstrated correlation values that ranged from -0.44 to 0.72 at $p < 0.05$ significance level between 16 independent variables and three dependent variables related to job satisfaction and intention to turnover (p. 1268). A more recent study by Albrecht (2012)

between eight variables and organizational commitment resulted in similar correlation values to the current study's correlation values: Albrecht's results ranged from a Chronbach value of 0.42 to 0.77 at a significance level of $p < 0.01$ (p. 846). In addition, the range of correlation values was more narrow, similar to the current study and in comparison to more former studies. In a 2013 study, Yidong and Xinxin reported positive Pearson product correlation values of 0.211 to 0.330 at a significance level of $p < 0.01$ between independent variables and work behavior and intrinsic motivation (p. 449).

Model integrating team independent variables. A second differentiator from the current study and other research correlating various variables is the method in which the independent variables were identified. Various studies identified independent variables using a variety of previous models. DeLoach (2003) used the revised causal model of job satisfaction (RCMJS) and added additional variables to the model "identified in the literature as important determinants of jobs satisfaction" (p. 434). Cohrs et al. (2006) combined items from nine different scales and tools from various researchers and sources originating from the late 1960s to 2000 (pp. 371–372). Karsh et al. (2005) correlated job characteristics and work environment with satisfaction using nine different previous studies and results (pp. 1264–1266). They then merged the various characteristics into a survey questionnaire for self-administration of 6,584 employees in 76 long-term care facilities. Karsh et al. (2005) measured organizational quality environment and stated that the level of "exhibited cooperation and teamwork" was included in this measure (p. 1276). Albrecht (2012) extended the job demands-resources model as established by Bakker and Demerouti in 2007 to include the relationship between organizational-, team-, and job-level resources and employee engagement (p. 844).

A consensus on a valid or standard model of independent variables most related to team and teaming was not evident in past research designs prior to the implementation of the current study. Because a standard model of team variables did not exist, the researcher established a model for selecting independent variables that were associated with teaming in more contemporary literature (Borkowski, 2009; Robbins, 2001; Robbins & Judge, 2012). In this way, the relationships associated with teaming and team leadership were most examined in the current study.

Team variables identified in design of research method. A third differentiator between past research and the current research is that while other studies may have indirectly discussed the independent variables' relationship to teaming in the conclusion, none of the previous studies included independent variables related to teaming in the initial design of studies (Cohrs et al., 2006; DeLoach, 2003, pp. 439–440; Karsh et al., 2005, pp. 1260–1281). While DeLoach (2003) included a variable of team functioning, no significant correlation resulted with job satisfaction, and the results of her study were indirectly related to team leadership in the implications and conclusion of the study. Karsh et al. (2005) linked cooperation and teamwork with their finding of organizational quality environment having the strongest association with commitment in the discussion of the results after the study concluded (p. 1276). And Cohrs et al. (2006) did not integrate teaming or the perceptions of teaming into the discussion or conclusion (pp. 383–388). Recent studies, however, have addressed team variables in the research design as evident in Albrecht's (2012) study (pp. 840–849) and Yidong and Xinxin's (2013) study (p. 445). But the variables related to teaming did not include the comprehensive components of employee involvement, coworker relations, and leadership as in the current study.

Significant implications and points of discussion. The current study presents interesting results deserving of discussion and support by past studies and of implications for the qualitative phase of the study.

Leadership was biggest driver of associate commitment in 2007. Leadership had the strongest correlation values with commitment for all 4 years of data ($r = 0.61$ to $r = 0.80$) at a p level of less than 0.01, and it was also found to be the biggest driver of commitment in 2007 with a standardized regression coefficient of $\beta = 0.49$. The results of this study were consistent with DeLoach's (2003) study results, which indicated that supervisory support was most associated with job satisfaction of individuals on an interdisciplinary hospice team (pp. 438–439). DeLoach (2003) reported a similar regression coefficient of $\beta = 0.63$ for supervisory support as being predictive of job satisfaction (p. 438). And Cohrs et al. results (2006) concluded that participatory leadership was the most important determinant of job satisfaction with three samples of math professionals with a β value of 0.37 at a significance level of $p < 0.001$ (p. 377). In addition, they determined a combination of both internally driven characteristics, known as dispositional variables, with job situational characteristics, known as situational variables, accounted for 54% to 65% of the variance in job satisfaction (Cohrs et al., 2006, pp. 374, 379). The current study's results were also supported by a more recent study by Yidong and Xinxin (2013), which found that employees' perceptions of ethical leadership and group leadership were positively related to both innovative work behavior and intrinsic motivation of employees in two companies in China (p. 449).

Coworker relations had the second strongest relationship with associate commitment in 2007. While leadership had the strongest relationship with associate commitment in the first year of the study, the second strongest relationship existed between coworker relations and associate

commitment ($r = 0.72$) at a 99% confidence level. The relationship between coworker relations and associate commitment remained strong for the subsequent years of the study ($r = 0.61–0.54$). The importance of coworker relations in work engagement was recently reported in a study by Liao et al. (2013). They found that a significant positive relationship existed between team-member exchange and social support from peers in the workplace with work engagement in their study of employees in a large airport in Southern China (Liao et al., 2013, p. 71).

Employee involvement was biggest driver of associate commitment in 2008 through 2010. The current study determined a standardized regression coefficient of 0.48 to 0.52 for employee involvement as a primary determinant of associate commitment in 2008 through 2010. Quantitative results on survey items including associates' perceptions on making a difference, having their ideas and suggestions considered, being involved in making decisions, having autonomy, and having clarity of job responsibilities were combined to equate to employee involvement as an independent variable. Despite the variation in survey item labels, similar results from others supported the importance of employee involvement in determining associate commitment.

DeLoach (2003) reported independent variables of role ambiguity, autonomy, and routinization as having significant relationships with job satisfaction (pp. 438–439). These variables were similar to employee involvement in the current study. Cohrs et al. (2006) concluded that autonomy was one of the three top job characteristics related to job satisfaction (pp. 383, 388), in addition to participative leadership and qualification possibilities. Albrecht (2012) found autonomy to be one of the top four variables that was strongly correlated to organizational commitment (p. 846). And a more contemporary study by Yidong and Xinxin (2013) interrelated the perception of leadership by employees to their work behavior.

This result supported the results of the current study where leadership was the strongest driver in 2007 of associate commitment followed by employee involvement, which was the strongest driver of associate commitment from 2008 to 2010.

Limitations from others addressed in current study. Most of the previous studies included only quantitative methods in the study of the independent variables' relationship with job satisfaction. Some of the studies recognized, in hindsight, the value of adding a qualitative component in future studies to give more clarity to the results (Albrecht, 2012, p. 849; DeLoach, 2003, pp. 440). None of the studies included diverse health care team members nor addressed teaming; they also did not include a qualitative component. The current study addressed previously identified limitations from past research (Albrecht, 2012, p. 849; Cohrs et al., 2006, pp. 387–388; DeLoach, 2003, pp. 439–440; Karsh et al., 2005, p. 1277; Liao et al., 2013, pp. 73–74; Yidong & Xinxin, 2013, p. 452) by including (a) samples generalizable to health care team members, (b) the concept of teaming in the design, and (c) a qualitative phase of discovery to fully explore the perceptions of teams related to variables on teaming and associate commitment and to give guidance in the development of management and leadership training.

Implications for qualitative phase of study. The question of why leadership was the biggest driver of associate commitment in the first year and employee involvement was the biggest driver of associate commitment in the following 3 years of the study was one of the focus areas of the qualitative phase. Prior to the qualitative phase of the study and the review of the quantitative results, the researcher speculated that leadership would be the driver of commitment the first year of the study because the associates had not previously been given an opportunity to express their perceptions on a survey. This was speculated to be positive and reflect positively in the assessment of leadership on the survey and to be apparent in the results. The researcher at

this point in the study questioned the importance of employee involvement in driving satisfaction and wanted to know more about the details. In addition, the importance of coworker relations was evident through the strength of the relationship of coworker relations with associate commitment. The researcher wanted to gain insight into the meaning of each of the independent variables in relation to associate commitment. And the researcher wanted to explore the meaning of the results more through the lens of groups of associates.

Interpretations of Hypothesis 2 Findings: Strong Relationship Between Independent Variables With Each Other

Hypothesis 2 was accepted on the basis of the very strong to strong positive relationships, with a Pearson two-tailed correlation ranging between 0.45 to 0.75 at a statistical significance of 99%, that resulted between the independent variables with each other for the 4 years of data in the overall organization and for the companies' subsets of data. Leadership showed the strongest positive correlation with coworker relations in 2007 for the organization with an *r* value of 0.75. Leadership and coworker relations were strongly positive in strength for 2008 through 2010 with *r* values ranging from 0.60 to 0.62. Coworker relations and employee involvement exhibited strong positive correlational values for all 4 years of data collection from 2007 to 2010 ($r = 0.59–0.64$).

Leadership and employee involvement exhibited the second strongest correlation with each other in 2007 ($r = 0.69$). The strength of the correlation between leadership and employee involvement resulted in a strong positive level for 2008 through 2010 and remained consistently strong positive ($r = 0.45–0.49$). The *r* values ranged from 0.45 to 0.69 for the interrelationship between these independent variables. Some of the highest company subset relationships existed between leadership and employee involvement. The pharmacy and the services companies had

very strong relationships between leadership and employee involvement in 2008 and 2009 (r = 0.80 and r = 0.74, respectively for pharmacy and r = 0.82 and r = 0.74, respectively for services). Variation existed in the strength of the relationships between years and between companies. Each of the variations in correlation for specific companies was addressed with company subset data, which was consistent in support of Hypothesis 2.

Significant differentiation between this study and previous studies. Two of the same significant differences between this study and previous studies existed relative to Hypothesis 2 as with Hypothesis 1. Variance in correlational values between the various independent variables and lack of a standard or consistent model in previous research studies incorporating all aspects of dynamic or effective teaming were not readily apparent in the literature leading up to this study. As a result of a lack of consistency in strength of relationships between variables and a research design and models, lack of clarity and consistent conclusions existed from other work specifically related to teaming (Albrecht, 2012; Cohrs et al., 2006; DeLoach, 2003; Karsh et al., 2005; Liao et al., 2013; Yidong & Xinxin, 2013). The current study united key characteristics and definitions, as previously defined by Robbins and others (Borkowski, 2009; Robbins, 2001; Robbins & Judge, 2012), of effective teams with a research model to collect data on perceptions of the leader, of one's opportunities to make a difference through employee involvement, and on relationships with team peers or coworker relations. The current study provided a balanced approach and a model in the field of study.

Strength in correlational values. The Pearson two-tailed correlation values ranging from 0.45 to 0.75 in this current study relative to the relationship between coworker relations, employee involvement, and leadership were generally higher than the correlation values of other variables in studies on employee commitment or engagement (Cohrs et al., 2006; DeLoach,

2003; Karsh et al., 2005; Liao et al., 2013), with the exception of Albrecht's (2012) study. DeLoach (2003) reported a range of correlation coefficient values of -0.35 to 0.41 at a statistical significance level of $p < 0.05$ and $p < 0.05$ (p. 438). Karsh et al. (2005) reported a range of correlation coefficient values of

-0.33 to 0.52 at a statistical significance of $p < 0.05$ (p. 1268). And Yidong and Xinxin (2013) reported correlation coefficient values of 0.211 to 0.330 at a significance level of $p < 0.01$ to $p < 0.05$ (pp. 449–451).

Albrecht (2012) reported correlation values ranging from 0.29 to 0.71 at a significance level of $p < 0.01$, most similar to the strength in the correlational values of the present study (p. 846). The researchers used not only a Pearson two-tailed product correlation but also structural equation modeling of survey data from a mining company. Cohrs et al. (2006) and Liao et al. (2013) did not disclose correlation values between independent variables because this was not their primary focus.

The current study presented a design inclusive of sound statistical techniques for analyzing the relationships of not only independent variables of coworker relations, employee involvement, and leadership with the dependent variable of associate commitment but also for examining the relationships between each of the three independent variables with each other. Because this was a purpose of the current study, a Pearson product correlation was run on all the independent variables' relationship with each other and these relationships were presented and are being discussed.

Correlation between the three independent variables of coworker relations, employee involvement, and leadership. Correlational analyses between independent variables and a comprehensive list of variables related to teaming in previous studies were not robust, and some

of the studies included intervariable analyses as an afterthought. This is not the case with the current study, which included the intent of the correlational analysis of the independent variables with each other in the research design. For example, DeLoach (2003) included a Pearson product-moment correlation between independent variables but did not report or discuss the relationships between the independent variables because this was not the focus of her study. DeLoach included only one item representing leadership and two coworker relations' items of the 16 independent variables with most of the items representing employee involvement in the current study. Similarly, Karsh et al. (2005) also included a Pearson product-moment correlation between independent variables and did not report or discuss the relationships resulting between the independent variables. Again, this was not the focus of the study. No items were included in the study representing coworker relations, which are an important characteristic of teaming and the team environment (p. 1268).

Furthermore, Yidong and Xinxin (2013) reported perception of ethical leadership, group ethical leadership, and intrinsic motivation as related to work behavior. Using the cognitive evaluation theory model to set the design for the study of variables, they included a variable on leadership (ethical leadership), on employee involvement (intrinsic motivation), and on coworker relations (group ethical leadership; pp. 441–452). Cohrs et al. (2006) did not include cross-correlational analyses or a discussion related to the independent variables in their study. While they recognized and included aspects representing the three independent variables in the current study (i.e., participatory leadership (L), social support (CR), and autonomy (EI)), they put them in a bundle of situational variables and did not report or discuss their interrelationship (pp. 372–388).

The current study included a more representative listing of survey items to capture data and allow for a more thorough and balanced analysis of each of the independent variables representing effective team characteristics (Borkowski, 2009; Robbins, 2001; Robbins & Judge, 2012) as compared to prior studies. Each independent variable was inclusive of three to seven survey items to represent team coworker relations, employee involvement, and leadership. Because Albrecht (2012) included aspects of coworker relations (team climate), employee involvement (autonomy and role clarity), and leadership (supervisor support) in the design of his study, his study serves as support for the current study's results.

Significant implications and points of discussion. The current study's results relative to the relationship between coworker relations, employee involvement, and leadership provide notorious points for discussion and ultimately for further exploration using a qualitative phase.

Leadership's relationship with coworker relations. The strong relationship between leadership and coworker relations for all 4 years of the current study indicate that this relationship is interrelated and deserves further exploration. The researcher speculated that the leader influenced the team's behavior and encouraged team members to support each other. This speculation is explored further in light of the qualitative results and discussion. Past research supports the findings from the current study but on a limited basis.

DeLoach (2003), for example, reported a positive relationship at a significance level of $p < .01$ of 0.36 between supervisory support, similar to leadership in the current study, and team functioning, similar to coworker relations in the current study (p. 438). Albrecht (2012) reported a positive relationship ($r = 0.54$) between team climate and job resources, which included supervisory coaching (L; p. 846). Albrecht was not specific in the survey items capturing data to be included in team climate but referenced vision, clarity, and psychological safety in his study

discussion at one point (p. 849). Karsh et al. (2005) did not include items for study representing coworker relations as compared to the current study (p. 1268). In reviewing past literature, the researcher discovered that teaming and coworker relations were not a primary focus and that they were often omitted from the research design. This created an opportunity for further exploration and contributions.

Leadership's relationship with employee involvement. There was a positive relationship between leadership and employee involvement with a correlation coefficient value of 0.45 to 0.69 in the respective years of the current study. The current study's findings are supported by previous studies, although the constructs of each of the studies have varied in design and use of specific variables. Past studies mostly conjoined leadership and employee involvement as variables in a variety of methods and analyses, none of which are exactly as with the current study's model.

DeLoach (2003) reported an insignificantly positive relationship ($r = 0.02$) between supervisory support (L) and autonomy (EI; p. 438). She reported a stronger positive relationship between supervisory support (L) and task significance (EI), distributive justice (EI), and role ambiguity (EI) ranging from $r = 0.28$ to $r = 0.41$ at a significance level of $p < 0.05$ or $p < 0.01$. Karsh et al. (2005) included two items related to leadership as in the current study: employees get the training needed, and they get feedback (p. 1268). Both of these variables showed moderately positive relationships with subcomponents of employee involvement, task orientation, and task clarity, with correlation values ranging from 0.29 to 0.41 at a significance level of $p < 0.05$ (p. 1268).

One of the more recent studies by Yidong and Xinxin (2013) specifically related perception of ethical leadership (L) to individual intrinsic motivation (EI) with a correlation

value of $r = 0.211$ at a 95% confidence level ($p < 0.05$). And Albrecht (2012) found that supervisory coaching (L) as an aspect of a job resources category served to intrinsically motivate (EI) employees in a mining company, which resulted in increased commitment and attitudes (p. 847). Results of both of these studies support the results of the current study.

Implications for qualitative phase of study. A very strong relationship between leadership and coworker relations and leadership and employee involvement in the quantitative phase of the study led the researcher to explore the connection between leadership and the other two independent variables in the qualitative focus groups. After the analyses of the quantitative results, the researcher was curious about the sequence of occurrence of the independent variables. This order and depth of relationship between the independent variables was explored further with qualitative focus groups and is discussed relative to the results.

Limitations from others addressed in current study. This study's research design was improved by including key characteristics of teaming and statistical analyses to examine the relationships between the independent variables, both of which were limitations in past studies. The current study also has more relative results in the field of health care, which addresses a previous concern of generalizability of past research.

Purpose and Introduction to Qualitative Research Discussion

The purpose of the qualitative component was to fully explore the perceptions of groups pertaining to coworker relations, employee involvement, and leadership relative to commitment of associates through the use of nine focus groups. In addition, the researcher's goal was to gain more insight into how each of the independent variables from the quantitative phase of study related to each other and how the groups of associates spoke about them. The researcher wanted

confirmation on how leadership might serve as the driver of coworker relations and employee involvement and how that was described.

Seventy-five associates were interviewed in nine focus groups, and the groups ranged in size from five to 12 associates. The qualitative purpose evolved throughout the course of the study and emerged after the results from the first phase were quantified. The researcher wanted to hear the words and thoughts from groups of associates on their beliefs and perceptions related to teaming and team leadership. Thus, questions were asked relative to the attributes necessary for effective teams according to Robbins (2001), Robbins and Judge (2012), and others (Borkowski, 2009).

The questions that were addressed in this phase of the study were the following: (a) What are the perceptions of associates working on various teams representing different levels of commitment and from representative companies within the organization?, (b) What aspects of teaming most relate to associate satisfaction according to teams of associates?, and (c) How does the style of the team leader impact associate satisfaction and the associates' perception of teaming? Insight from the first and second of the qualitative questions on perceptions of associates working on teams related to commitment and groups' perceptions on aspects of teaming related to commitment provided more depth and an explanation to Hypothesis 1. Insights gained in response to the third question of the qualitative inquiry related to the leader's style impacting associate commitment and teaming provided more enlightenment relative to Hypothesis 2.

This study addressed possible answers to these questions by collecting responses to open-ended group interview questions from teams. The qualitative design included four primary focus group questions supported by 12 possible secondary questions (see Appendix J).

The researcher modified secondary questions in the qualitative phase of the study based upon group interview responses. This is often the case with a qualitative design (Creswell, 2008; Creswell & Plano Clark, 2007). The original premise for the model of questions aligned with the effective team characteristics and team definitions as presented by Robbins (2001) and further supported by Robbins and Judge (2012) and others (Borkowski, 2009). The list of potential interview questions was created and mapped to work design, composition, context, and process as shown in Table 44.

Important Themes and Aspects of Teaming Emerging From Qualitative Inquiry Relative to Commitment

Evidence that surfaced in the qualitative focus groups relative to commitment and aspects of teaming related to commitment addressed the following qualitative research questions: (a) What are the perceptions of associates working on various teams representing different levels of commitment and from representative companies within the organization?, and (b) What aspects of teaming most relate to associate satisfaction according to teams of associates?

Focus group Questions 2 and 6 explored teams' perceptions on associate commitment. Question 2 asked team members what enhanced workplace satisfaction, and Question 6 asked them to describe their work environment. Responses to both questions were discussed in Chapter 4, and themes are provided in Appendices L and P. Frequent themes in the groups' responses were (a) having friends on the team; (b) trusting team members; (c) making a difference; (d) liking their patients, their patients' families, and their jobs; (e) having flexibility with work schedules; (f) feeling valued, appreciated, and recognized; and (g) earning better pay and benefits. All the themes represented the three independent variables from the quantitative phase of the study. Having friends on the team, trusting team members, and relating to the work team as a work family represented coworker relations as related to associate commitment.

Table 44

Effective Team Characteristics, Definitions, and Examples of Qualitative Interview Questions Relative to Perceptions of Teaming and Team Leadership

First effective team characteristic:	Work design • Autonomy • Task identity • Task significance
Team definition:	Complementary skills
Example questions to explore perceptions of team characteristics:	• Would you characterize your work group as a team? Why? • Describe your role on the team? • How does your role fit with the other team members' roles? • How does each team member accomplish his or her assigned tasks? • How are tasks assigned? • How does your task make a difference? • What happens if a task is not completed the way it needs to be?
Second effective team characteristic:	Composition • Personality • Roles and diversity • Preference for teamwork
Team definition:	Positive synergy
Example questions to explore perceptions of team characteristics:	• Describe the relationships you have on the team with various members. • Describe each of the team members. • How does the leader bring members of the team together? • How do you feel about your team and the members of your team? • What does it mean to be part of your team? • How and why do you like working on a team? • Can you describe the level of trust within your team?

Third effective team characteristic:	Context • Leadership • Performance evaluation • Rewards
Team definition:	Individual and mutual accountability
Example questions to explore perceptions of team characteristics:	• Describe your supervisor. Describe your senior leader (your supervisor's boss). • How does the team leader work with the team? From what company is the leader? • How does the team know when they have completed their task? What happens? • How does the team leader support the team? What does he or she do? • How could the team leader better support the team? What would he or she do? • How does the company support your team? • How could the company better support your team?
Fourth effective team characteristic:	Process • Common purpose • Specific goals • Conflict
Team definition:	Collective goal
Example questions to explore perceptions of team characteristics:	• How does the leader set goals for the team? • Give an example of a time when the work team solved a problem together? What happened? • What happens when all the team members do not see eye-to-eye? • What does the leader do when the team has a problem or conflict? • How does the team make decisions? • What is the leader's role when the team makes decisions? • How does the team address quality and safety? • What happens at the end of a team project?

Making a difference and liking their patients, their patients' families, and their jobs provided insight into the importance of employee involvement related to associate commitment.

Leadership was described as trusting team members, having flexibility with work schedules, and feeling valued, appreciated, and recognized. All the themes were described as important in creating associate commitment.

Importance of the work family in health care. Several groups referred to the team as a work family and openly recognized that the time spent with the work family was often greater than the time spent with their own families. Focus groups discussed having friends on the team, having and building trust in the work family, being frustrated with the work family, and having fun with the work family. Relationships on the team were important in balancing job stress and also in accomplishing the team's priorities and goals. In addition, the word "team" was most often the first word used by groups when asked about commitment.

The work unit or work family, serving as a "social unit" that was created organically to meet the social needs of the group, is based on Homans' (1950) group theory (pp. 271–272, 447–448) and the Hawthorne studies (Borkowski, 2009, pp. 9–10). Homans (1950) described the development of the social unit, known as the work family in this study, as "social organiscism" (pp. 271–272). He also explained how work group behavior *emerged* to meet the social needs of the group. More contemporary researchers have recognized how groups offer "social exchange in the workplace and this social exchange in the workplace is an antecedent to work engagement" (Liao et al., 2013, p. 63). These same researchers have shown not only a correlation between group social exchange and coworkers'personality traits such as extraversion traits but also that "social exchange is a predictor of work engagement" (Liao et al., 2013, p. 63 & 66). Homans (1950) also further expanded that the leader of a group possessed special leader qualities with the purpose of supporting and guiding the group (pp. 423–430). In this study, the leader was

acknowledged by work groups as being the head of the work family. And trust was associated with the leader as a member and leader of the work family.

Celebrating and having fun. Tier 1 and Tier 2 focus groups discussed how the teams experienced fun, celebration, happiness, a positive environment, and a vibrant work area as a work family. Many of the focus groups recognized the stress and focus of their jobs. Groups from all tiers emphasized the need for the teams to enjoy each other, their patients, and to have fun as part of their work. As Kouzes and Posner (2002) stated, "recognition and celebration aren't about fun and games, though there is a lot of fun and there are a lot of games when people encourage the hearts of their constituents" (p. 19). Kouzes and Posner (2002) identified celebration and recognition as a way for leaders to "encourage the heart" (p. 19). Certainly, this concept was evident in the groups' responses about fun related to commitment.

Developing trust. Trust was important to the work families. Focus group Question 5 asked participants how trust was developed. Focus groups discussed how trust was established through team members getting to know each other, through consistency of attendance and accountability, through teams spending time together, and through the practice of openness, honesty, respect, and vulnerability. More committed work groups identified that trust was also dependent on group members' maturity. Maturity was discussed as an important quality to have when it came to building trust, extending trust, and being able to forgive when trust was violated so team trust could be reestablished. In addition, trust was emphasized to be bidirectional and reciprocal. Trust emerged as a theme not only when directly asked about trust but also in response to many of the other questions. It was an important theme.

Trust as an important team and leadership concept is supported by contemporary research and business literature (Covey, 2006, pp. 125–229; Erkutlu & Chafra, 2013, pp. 828–848;

Roussin & Webber, 2012, pp. 317–327). Group responses were indicative of all of the 13 behaviors that promote relational trust as described by Covey (2006). Focus groups described trustworthy behaviors between coworkers and those exhibited by some leaders. Trust was attributed first with leaders modeling trust. And groups acknowledged that trust started with leaders building trust. Furthermore, groups with higher levels of trust said they trusted their leaders more, and they portrayed their leaders as being transparent, authentic, and approachable. Their expansion of trust to their coworkers and work family is supported by Erkutlu and Chafra's (2013) research. They found that higher levels of transparency in leadership positively correlated with higher levels of employees' values, which matched with the organizational values and psychological commitment to the organization and coworkers (Erkutlu & Chafra, 2013, pp. 836–842). Groups also identified that developing trust with team members was a time investment, which is supported by Roussin and Webber (2012, pp. 325–327). The mere aspect of spending time with coworkers allowed coworkers to observe accountability and consistency of behaviors and through this, trust was built.

Potential of leadership in all of us: Associates want to make a difference and have purpose. All focus groups responded with many stories and examples about fellow coworkers going out of their way to care for residents and fellow team members. Their examples and stories portrayed how team members, not in designated leadership roles, modeled initiative, commitment, risk, and integrity to act. The researcher observed everyday leadership in each of the focus groups, not just once, but multiple times. Making a difference, liking their patients, their patients' families, and their jobs, and liking the nature of the work surfaced as prevalent themes driving everyday leadership. These themes surfaced in response to all focus group questions. Health care associates all have the potential to demonstrate extraordinary leadership.

There is hardly any evidence in leadership literature at this point to support this concept or proposed premise. It does have support from leadership author, speaker, and catalyst, Drew Dudley (2010) who commented that "we've made leadership into something bigger than us; we've made it into something beyond us." Dudley, in his 2010 TED talk and in subsequent publications, provided an example of an everyday person being nudged to give a lollipop to a stranger. This one simple, kind leadership act changed the state of a relationship, and his point was that leadership resides in all of us through simple, risk-taking acts that have good intent and have the potential to change the world.

> We need to redefine leadership as being about lollipop moments, how many of them we create, how many of them we acknowledge, how many of them we pay forward, how many of them we say 'thank you' for. Because we've made leadership about changing the world, and there is no world, there are on average six billion understandings of it. . . . and if you change one person's understanding of what they are capable of, . . . you've changed the whole thing. (Dudley, 2010)

In essence, nine focus groups in this study relayed many stories of everyday leadership, where average team members led through their actions on behalf of others to make a difference. The researcher heard a humbleness, humility, and admiration in their stories and examples. The researcher proposes not only that leadership resides in all of us but also that it can be developed in all of us, to be sustained collectively. She also proposes that sustainability of leadership in our global world occurs through leadership development of one person at a time.

United purpose through teaming and teams. Focus group Questions 3 and 4 sought insight into the aspects of teaming that most related to associate commitment according to teams of associates. Question 3 asked participants what enhanced the teaming experience, and Question 4 asked them what facilitated teaming. Helping each other, having friends on the team, spending time together, having common obligations and commitments, trusting team members, liking the nature of the work, and being dedicated to patients and their families as a team surfaced as

themes. All team members that were dedicated to making a difference appeared to unite as a group in order to support their collective goal of making a difference, and the concept of the team supported this common purpose. The social network of the team offered to help, support, and promote making a difference. The teams' commitment to making a difference was discussed in their satisfaction and commitment to the workplace. And in some instances, groups were not happy with the environment or the leader, but they continued to work because of their commitment to making a difference. This was apparent with the lower tier focus groups. Lower tier groups also identified situations where the teams were supportive in the absence of leaders' support. Employee involvement and this united commitment to make a difference appeared to be an internal drive or motivation for doing work in health care. The internal drive appeared to be supported by the team and, in positive cases, by the leader.

Goal setting and accomplishment. Focus group Questions 1 and 12 solicited information on goal setting and accomplishment. Focus group Question 1 asked how teams worked to accomplish goals, and focus group Question 12 asked how goals were identified and set. Question 1 was a primary interview question, and Question 12 was a secondary question; therefore, not all groups responded to Question 12. Focus groups that answered the question on goal setting responded frequently that the team set the goals with their leader's guidance. Tier 1 and 2 focus groups responded to the question on goal setting. Seven of the nine focus groups highlighted the common themes of checking in with the team and helping each other to accomplish team goals. They described an ongoing reprioritizing process and continual communication in checking in with the team. They also discussed and provided examples of how they proactively assisted coworkers with their jobs if it was critical for completing a team-set goal. They applied the concept of the "Golden Rule" in proactively assisting their coworkers to

accomplish work. Cross-training was emphasized as a best practice to assist in helping each other on the team. Celebrating the accomplishment of goals was again discussed in response to these two questions. So with both of these questions, themes representing coworker relations were identified first and primarily in goal setting and accomplishment. In addition, focus groups highlighted how individual team members were committed to doing their best and to working autonomously. Responses on doing one's personal best on the team surfaced after being asked a number of questions, including Questions 3 and 4 on teaming. This theme was coded back to employee involvement.

The premise of accomplishing goals as a team to gain satisfaction is rooted in Porter and Lawler's satisfaction-performance motivation model (as cited in Borkowksi, 2009, pp. 134–135). Teams that set goals have been found to outperform those teams not setting goals according to the goal-setting theory (Borkowski, 2009, pp. 135–137; Kouzes & Posner, 2002, pp. 285–286). Setting goals, obtaining coworker and team commitment, and having a supportive environment further positively reinforce the teams' and individuals' behaviors. Thomas, Bellin, Jules, and Lynton (2012) identified having a clear charter and goals as being one of the three essential qualities of global leadership teams. Goals provide not only focus for teams in changing times but also allow for agility when alterations need to occur as was discussed in the focus groups.

Making and acting on decisions, empowerment, and accountability on the team. Focus groups provided discussion and clarity on how teams made and acted on decisions and how they held each other accountable. Focus group Questions 9, 11, 13, and 14 addressed the areas of team decision-making, empowerment, and accountability. The focus groups said they were happy when they were able to act on their own, make decisions on their own, and even practice self-accountability. Groups resented being unable to make decisions on their own, and

they certainly spoke negatively about the leader who did not allow them to, especially the Tier 3 focus groups. The teams' ability to make and act on decisions translated to empowerment. They discussed the importance of self-accountability and provided examples of how they held each other accountable. High engagement teams making decisions on their own and practicing self-accountability is consistently supported in the literature on motivation, empowerment, and team effectiveness (Borkowksi, 2009, pp. 149–150; Connors et al., 2004; Dunn, 2010, pp. 48–49, 564–565; Kouzes & Posner, 2002, pp. 299–311; McElroy, 2001, p. 331). And these qualities are attributes of distributive leadership, which support the premise that leadership resides in each and every team member and worker (Dunn, 2010, pp. 460–461; Pater & Lewis, 2012, pp. 34–38). It is, therefore, the team leader's role to further enhance leadership in his or her team members through distributive leadership, empowerment, and accountability.

Important Themes Emerging From Qualitative Inquiry Relative to the Interrelationship of Coworker Relations, Employee Involvement, and Leadership

It is not all about the leader. As nine focus groups from all levels of associate commitment spoke, a glaring truth emerged. The focus groups spoke of the team and principles of effective teaming first. They spoke about the importance of their coworkers, their relationship with their coworkers, and their individual beliefs, values, and drive to make a difference first. Then as conversation proceeded, groups recognized and acknowledged that positive leaders created the environment and systems to support team effectiveness and their individual drives or motivation. Even in low tier groups, teams recognized the importance of team characteristics, even if lacking, and how these team characteristics could help the team be able to provide optimal patient care while engaging them as team members. And through this observation countless times and through listening and reflexivity, an underlying principle and paradox

emerged. The leader, who is recognized as the extroverted and dominant presence in a team, company, or organization, may best serve as a creator and platform for the team to perform. Thus, leadership is not about a leader's dominance but the ability of the leader to support and create the dominance of the team through the creation and orchestration of principles, systems, structure, and communication. Is leadership not about having others arrive at the best conclusion without actually stating it as the leader? Leadership coming first and setting the systems to expect and support coworker relations (teaming) and employee involvement was apparent in the way in which the focus groups discussed the themes that emerged. Thus, while the groups mentioned leadership secondarily, they openly recognized how leaders created the environment for them individually and as a team to succeed. In the successful teams, they recognized the leaders as leading and modeling for the work family.

In his 2011 TED talk, Stanley McChrystal, former commander of the United States and International Forces in Afghanistan and four-star general spoke about leading in current challenging times with so many complexities internationally, including leading multiple generations spread out across the globe with different understandings, skill sets, and vocabulary. He spoke of creating a shared purpose in a diverse work team through an "inversion of expertise." He said of contemporary leaders in these challenging times that leaders have to be more transparent, more willing to listen, and be reverse-mentored from their team members or troops. Certainly, the concepts of challenge on the battlefield translate to the health care battlefield. Groups participating in this study demonstrated everyday leadership and wisdom. Collectively they had the best answers and needed most for leaders to listen, learn, and be "mentored up" for the best performance. It appears the best team leaders are the leaders who incorporate the expertise and employee involvement into a collective purpose and shared vision.

And as McChrystal (2011) stated, this style of leadership requires listening and putting away one's ego or thoughts that the leader always knows best.

In her work on followership, Kellerman wrote and spoke about the power of the follower movement (Kellerman, 2008; Center for Public Leadership, 2009). Followers have the power to make changes through pressure on leaders especially in the environment of real-time social media. She made the statement that with the change in technology, followers have the ability to "circumvent leaders in a ways that leaders have not been accustomed" (Center for Public Leadership, 2009). In her own words, "successful whistle-blowers are followers no longer…by creating change, they have morphed into leaders," "they have become agents of change," and "sometimes leaders and managers follow; and sometimes followers lead" (Kellerman, 2008, pp. xix-xxi). And Kellerman wrote about how the qualities of a good follower are similar to the qualities of a good leader (2008, p. 236). Kellerman's findings supported the researcher's results in that team members served more influential leadership roles than the formal team leaders as were discussed in the focus groups.

The leader makes it about others: Style of leadership conducive for teaming. Focus group Questions 7 and 16 asked participants about the style of leadership that most impacted associate commitment and teaming, the third qualitative research question. Specifically, Question 7 asked the participants to describe the leadership style in their work environment, and Question 16 asked participants to describe their relationship with their supervisors. Focus group members' most common response was that a transparent and approachable leader, one who practiced an open-door policy and was authentic and real, was the best leader to impact associate commitment and influence teaming.

Numerous focus groups described leaders who set up systems to accommodate the team. They said leaders provided adaptable scheduling and work locations (in response to Questions 1 and 6), created a casual work environment (in response to Questions 7 and 16), and asked for input and feedback routinely (in response to Questions 1 and 6). Leaders also conducted open and routine meetings with teams, helped set goals (in response to Questions 1 and 12), coached and set goals as needed, set up work management and flow systems, and facilitated interdisciplinary stand-up meetings (in response to Questions 9, 11, 13, and 14). Equally important, leaders led the work family (in response to Questions 2, 3, and 4), acknowledged and valued team members (in response to Questions 1, 6, 10, and 15), cared for team members (in response to Questions 7 and 16), and they recognized and provided feedback to team members (in response to Questions 1, 3, 4, 6, 10, and 15). Moreover, leaders set expectations in advance (in response to Questions 3 and 4), offered to help (in response to Questions 11, 13, and 14), and modeled trust (in response to Question 5). Groups provided realistic and behavioral examples of how leaders promoted an environment and relationships of teaming.

Focus groups did not respond with the word leader to any of the questions with the exception of Question 7, which asked team members to describe the leadership style related to their work environment. And yet through the conversations, leaders were acknowledged as the source of systems, expectations, and first modeling. In many of the responses to many of the focus group questions, groups acknowledged leaders as being responsible for setting up systems and expectations that supported coworker relations and employee involvement. Focus groups recognized that leaders set up flexible schedules, hours, and opportunities to work at home. Focus groups also recognized that leaders supporting employee involvement were approachable to answer questions. And focus groups acknowledged that leaders valued team members' input

and feedback and asked for their feedback. Their style was one of transparency and authenticity. Leaders shared a personal side of themselves to their teams and, in return, also welcomed authenticity from team members. In addition, focus groups recognized good leaders as team leaders that set the tone for good interpersonal relations and that promoted coworker relations and the work family concept that has been described.

Recognition and feedback. Focus group Question 10 asked participants how they received recognition. Focus group Question 15 asked them how feedback was provided. Both questions were secondary questions and thus were not asked of all groups. Six groups responded to Question 10, and only two focus groups responded to Question 15 pertaining to feedback. Recognition by clients, recognition by executives, and recognition by coworkers surfaced as common themes. In addition, associates talked about how they received a personal thank you letter from the team of executives and a lapel pin. Receiving recognition and receiving a personal written or spoken thank you from a leader, executive, or client appeared to reinforce the internal motivation and individual purpose of team members. The recognition and feedback served to reinforce what groups of individuals knew to be true for each of them. Unexpected recognition that serves as a positive reinforcement of an individual's internal drive to make a difference and linked to acts of going above and beyond is supported by Skinner's reinforcement theory and more contemporary experts (Borkowski, 2009, pp. 137–138; Dunn, 2010, pp. 506–507; Kouzes & Posner, 2002, pp. 333–335). As Kouzes and Posner (2002) stated, "personal congratulations rank at the top of the most powerful nonfinancial motivators identified by employees" (p. 334).

Furthermore, groups discussed the importance of positive and specific feedback from their leaders. When leaders provided feedback, coaching, and encouragement, groups spoke positively about their leader and the teams' results. The opposite was true when groups talked

about not receiving feedback or receiving negative feedback. And yet, the lack of feedback or positive encouragement supported the fact that feedback and positive encouragement was critical for the perception of teaming and for obtaining the most productive outcomes from teaming. Focus group discussions on feedback again find support from contemporary sources (Connors et al., 2004, pp. 182–183, 215–216; Kouzes & Posner, 2002, pp. 318–321; Martin, 2007, p. 6; Rath & Clifton, 2009). Recognition and feedback, in conclusion, validated the internal motivation and drive of wanting to make a difference. Leaders who utilized positive recognition and feedback, in essence, created an environment to sharpen team members' naturally occurring intent to lead and make a positive difference.

Servant leadership best supports the team. The groups' emphases on leaders establishing systems, support, and expectations of the team to work together for a common goal as well as leaders modeling transparency and openness reinforce the critical need for leaders to practice and embody servant leadership as a style. Servant leadership, being most effective in putting the needs of a work group, work team, or work family first, is supported not only by Homans' (1950) group theory and Greenleaf's (1977) concept of servant leadership but also by recent empirical work that shows servant leadership is the most effective leadership style to support team effectiveness (Badshah, 2012, p. 57; Duff, 2013, pp. 204, 211–216; Parris & Peachey, 2013, pp. 387–388; Wright, 2009, p. 30). This study showed that groups respected the leaders most who first showed transparency, authenticity, and character and then "rolled up their sleeves" and provided physical help or removed barriers for them as a team. The focus groups told many stories of their leaders' actions, which were consistent with what they said or how they spoke. Groups with the best commitment and coworker relations and who voiced the sentiment of being valued were groups where leaders were described as servant leaders.

Certainly, recent empirical research is showing that servant leadership continues to be most relative and the most effective leadership style to support effective teaming. The current study is consistent and adds to other empirical studies through the qualitative lens of inquiry.

Support and reference to situational leadership. Several focus groups referenced their leaders' abilities to manage specifically to the situation. The groups also defined situational leadership as a leader that keeps the groups' best interest in mind, that adapts his or her leadership style to the motivation, personality, and experience of the coworker and team, and that considers the context of the situation (Borkowski, 2009, pp. 193–195; Dunn, 2010, pp. 483–484, 516–517). Therefore, situational leadership is certainly rooted in the practice of servant leadership. Situational leadership potentially might be a tool or practice used in servant leadership. Additional research is needed to support such a premise or conclusion, but certainly the groups' discussion and responses in the current study support situational leadership as being an outcome of servant leadership.

Role of organizational leadership. Focus groups indicated that corporate or organizational leadership was tertiary in importance relative to commitment and teaming. Groups, at best, identified organizational leadership as neutral if the leadership did not interfere with teaming, commitment, or patient outcomes. When referring to corporate leadership as negative, the organizational leadership distracted from the purpose of the team and from making a difference. Some focus groups wished for organizational leadership to demonstrate positive interest in what the teams in the field positively contributed. In general, teams indicated that corporate leadership was detached, disconnected, uncommunicative, and untrustworthy. In relation to corporate leadership, better pay and benefits surfaced as an organizational theme connected to associate commitment (in response to Question 2). The organization's program of

recognizing work anniversaries surfaced as an organizational theme related to the question on how associates received recognition (in response to Question 10).

The way in which the groups of associates described the organization's influence was consistent with Herzberg's two-factory theory or motivation-hygiene theory (as cited in Borkowski, 2009, pp. 111–113; as cited in Dunn, 2010, pp. 502–504). When the organization and executive leadership was positively present, groups talked about the presence as neutrally related to satisfaction and commitment, more hygiene in nature. Pay, in most instances, was presented negatively and served as a dissatisfier. Focus groups presented benefits neutrally and as such served to prevent dissatisfaction. The organization's 5-year anniversary recognition program was discussed positively by some and yet did not appear to influence commitment or satisfaction. Because of the way in which the program had been administrated with some associates not receiving recognition for past years of service before the program was initiated, the program had created dissatisfaction and resentment by some. The recognition had been negated by the administration policy.

In summary, the qualitative phase of the study provided rich insight into the perceptions of associates in a variety of post acute health care settings. The researcher concluded that coworker relations, also known as the work family, gave validation, value, reinforcement, structure, and support to the internal drive of associates. The work family supported employee involvement or each team member's drive to make a difference. Stronger ties between team members and increased satisfaction and commitment resulted from more time and experiences shared by the work family. Focus groups acknowledged leaders as creating the environment for strong coworker relations and teaming. They also acknowledged the importance of transparency, positive feedback, and recognition in sharpening associates' aspiration for leadership and for

making a difference. Leadership integrated into the team when positive. When negative or absent, leadership negated and devalued the team, coworker relations, and countered associates' drive, internal motivation, and thus countered employee involvement. Servant leadership, including distributive and situational practices, was found to support effective teaming. Organizational support was tertiary relative to associate commitment and served as a hygiene factor when positive and as a dissatisfier and detractor when negative. The qualitative phase of the study provided a richness and depth of insight from which the quantitative inquiry did not provide. The qualitative results supported the quantitative results.

Limitations and Delimitations

A delimitation existed in that the researcher used one model (Morehead Associates, 2007a, 2008, 2009, 2010) for the independent and dependent variables related to associate commitment, coworker relations, employee involvement, and leadership and used a separate model for team characteristics (Robbins, 2001; Robbins & Judge, 2012). The researcher attempted to connect the variables and team characteristics through the inclusion of the qualitative phase of research. An opportunity exists for a more cohesive integration of variables associated with teaming and characteristics of effective teams.

Several limitations existed in the sampling, measures, and analyses. This study treated commitment as synonymous with engagement and satisfaction. Recently these three terms have been delineated and an opportunity exists to clearly define commitment. The use of commitment to mean all these things may have limited the ability to generalize results. Another limitation that occurred in the study is the time between quantitative data collection, qualitative date collection, analyses, and completion of the dissertation. Certainly, the effects of time may have altered the

generalizability of the results. Time may also have been a way to protect participants and further assure their anonymity.

The sample included mostly team members from the day shift, and team members were predominantly female. And due to the nature of individuals participating in the surveys voluntarily, results may have been limited in scope. Coworker relations were not included on the survey administered to part-time staff. This may have altered the results regarding the impact of coworker relations on results by not being truly represented with the part-time sampling. In addition, because all groups did not answer the secondary questions in the qualitative interviews, this may have altered the generalizability to the general health care population. The researcher tried her best to control the delimitations and not impose researcher bias on limitations.

Significance and Implications of Organizational Leadership Practice and Body of Knowledge

A model of leadership emerged from the culmination of both the quantitative and qualitative data. The model is based on the assumption that a leader resides in every person and involves acting with a risk for the good of others. This is applicable to health care as this is the purpose of health care delivery, to help others heal. A person or leader has an internal drive or motivation to make a difference. It is the motivation to lead or to act. It resides deeply within a person and is strengthened and cultivated by the support of coworkers or the team. Teaming and team support compel the associate to make a difference. Leadership enables the associate's drive to come to a point and be most effective. The leader "sharpens" the point or the drive of the associate. The leader supports the "tip" or the "edge" of a leader in every associate, just as the wood supports the tip of the lead in a pencil. Envision this model as the leadership point. And collectively, a box of pencils has the ability to sketch endlessly and effectively.

Significance of Findings to Leaders, Organizations, and Society

Leaders have the responsibility to serve and support their teams in order to offer the most effective care with the best outcomes while including the collective expertise and wisdom of the team and while engaging each individual on the team. The demographics of our aging population and the need to deliver effective care in a time when motivations of younger generations of workers is dramatically different from the past, in combination with the complex implementation of the Affordable Care Act, represents the trifecta of criticality of why studies such as this are so significant and impactful. An opportunity exists for researchers to continue to ask questions regarding perceptions of groups of associates using qualitative and quantitative designs, which

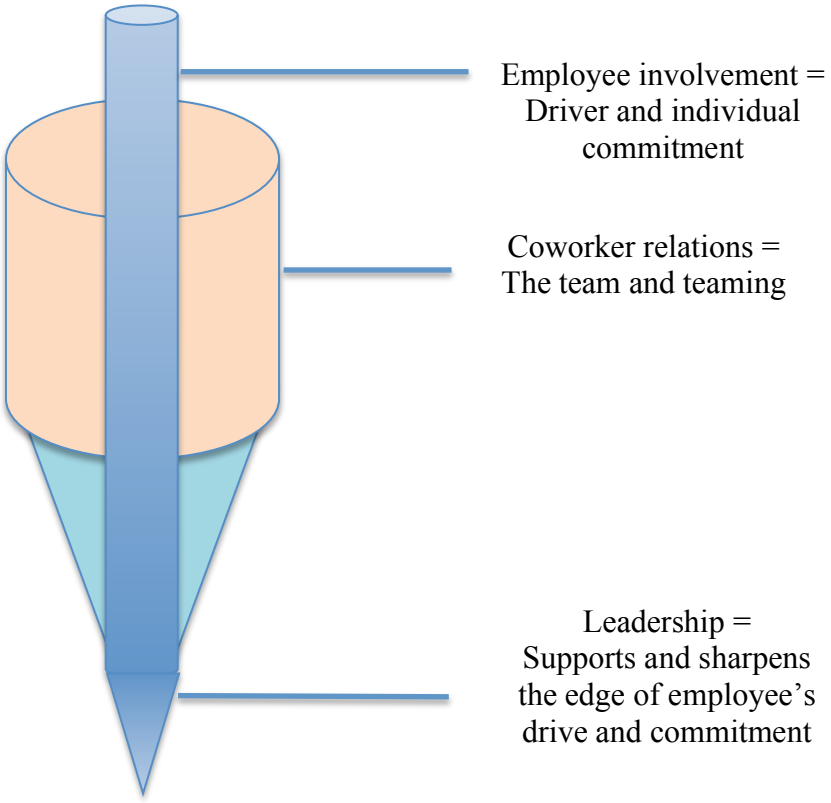

Figure 21. The leadership edge model. Employee involvement is supported by coworker relations and leadership. Leadership forms, sharpens, and promotes empowerment and employees' drive to make a difference.

are not frequently seen in the body of literature. This study has contributed in this way to the body of knowledge, and it certainly has inspired the researcher to continue in this area of investigation.

Recommendations for Future Research

This study has contributed to the body of research on how the team leader can best optimize patient and client results through the support of his or her team. The study has also created additional questions for action research in how to best teach servant leadership, how best to teach leaders teaming skills related to the themes of the study, and how to promote the concept and emerging theory that a leader resides in each and every team member. Questions for further investigation remain pertaining to the specific antecedents of servant leadership. Additional qualitative inquiries will provide further depth in regards to the meaning of the teams and teaming and the most supportive leadership styles. The same study repeated using another of the contemporary teaming models is an opportunity.

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Appendix A

Associate Satisfaction Survey Items With Coding and Variables

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
1	The actions of the person to whom I report support this company's mission and values.	X	MGR				Organizational Alignment	Transformational Leadership
2	This company cares about associate safety.	X	ORG				Employee Respect	Exemplary Professional Practice
3	I like the work I do.	X	EMP				Job-Person Match	
4	My pay is fair compared to other healthcare employers in this area.	X	ORG				Fair Compensation	Structural Empowerment
5	I get the ongoing training I need to do a good job.	X	ORG				Growth and Development	Exemplary Professional Practice
6	I would recommend this company to family and friends who need care.	X	CI	DV	Associate Satisfaction		Commitment Indicator	Empirical Outcomes
7	I would like to be working at this company three years from now.	X	CI	DV	Associate Satisfaction		Commitment Indicator	
8	I have received quality orientation for my role.		MGR				Growth and Development	
9	The person to whom I report is a good communicator.	X	MGR	IV3	Leadership	Context & Process	Leadership	Transformational Leadership
10	I would stay with this company if offered a similar job elsewhere for slightly higher pay.	X	CI	DV	Associate Satisfaction		Commitment Indicator	
11	I would recommend this company as a good place to work.	X	CI	DV	Associate Satisfaction		Commitment Indicator	

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
12	My work allows me to make a difference in people's lives.		EMP	IV1	Employee Involvement	Goal & Work Design	Employee Involvement	
13	Overall, I am a satisfied associate.	X	CI	DV	Associate Satisfaction		Commitment Indicator	Exemplary Professional Practice
14	My work unit works well together.	X	EMP	IV2	Coworker Relations	Positive Synergy	Coworker Relations	Coworker Relations
15	This company cares about its customers.	X	ORG				Quality/ Customer Focus	Quality/ Customer Focus
16	The person to whom I report treats me with respect.	X	MGR	IV3	Leadership	Context & Composition	Leadership	Leadership
17	I enjoy working with my coworkers.	X	EMP	IV2	Coworker Relations	Positive Synergy	Coworker Relations	Coworker Relations
18	This company values associates from different backgrounds.	X	ORG				Citizenship	Citizenship
19	My ideas and suggestions are seriously considered.	X	MGR	IV1	Employee Involvement	How ideas are considered by peers and mgr; Complementary Skills	Employee Involvement	Employee Involvement
20	Associates' actions support this company's mission and values.	X	EMP				Organizational Alignment	Organizational Alignment
21	The person to whom I report cares about my job satisfaction.	X	MGR	IV3	Leadership	Context	Leadership	Leadership
22	Different work units work well together in this company.	X	ORG				Organizational Alignment	Organizational Alignment
23	This company contributes to the community.	X	ORG				Citizenship	Citizenship

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
24	I am satisfied with the recognition I receive for doing a good job.	X	MGR	IV1	Employee Involvement	Influenced by mgr and org culture	Employee Involvement	Employee Involvement
25	Different levels of this company communicate effectively with each other.	X	ORG				Organizational Alignment	Organizational Alignment
26	There is a climate of trust within my work unit.	X	EMP	IV2	Coworker Relations	Positive Synergy	Coworker Relations	Coworker Relations
27	This company conducts business in an ethical manner.	X	ORG				Citizenship	Citizenship
28	I am involved in decisions that affect my work.	X	MGR	IV1	Employee Involvement	Process	Employee Involvement	Employee Involvement
29	This company is environmentally responsible.	X	ORG				Citizenship	Citizenship
30	When appropriate, I can act on my own without asking for approval.	X	MGR	IV1	Employee Involvement	Work Design	Employee Involvement	Employee Involvement
31	I am satisfied with my benefits.	X	ORG				Fair Compensation	Fair Compensation
32	This company provides high-quality care and service.	X	ORG				Quality/ Customer Focus	Quality/ Customer Focus
33	The person to whom I report cares about quality improvement.	X	MGR				Quality/ Customer Focus	Quality/ Customer Focus
34	Physicians and staff work well together.	X	ORG				Organizational Alignment	Organizational Alignment
35	This company supports me in balancing my work life and personal life.	X	ORG				Work-Life Balance	Work-Life Balance

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
36	Information from this survey will be used to make improvements.	X	ORG				Employee Respect	Employee Respect
37	This company makes every effort to deliver safe, error-free care to patients.	X	ORG				Quality/ Customer Focus	Quality/ Customer Focus
38	My healthcare benefits are competitive in the industry.	X	ORG				Fair Compensation	Fair Compensation
39	My paid-time-off benefit is competitive in the industry.		ORG				Fair Compensation	Fair Compensation
40	My work unit is adequately staffed.	X	ORG				Work-Life Balance	Work-Life Balance
41	The amount of job stress I feel is reasonable.	X	EMP				Work-Life Balance	Work-Life Balance
42	This company treats associates with respect.	X	ORG				Employee Respect	Employee Respect
43	I am satisfied with my job security.	X	ORG				Work-Life Balance	Work-Life Balance
44	This company cares about quality improvement.	X	ORG				Quality/ Customer Focus	Quality/ Customer Focus
45	The support services team is helpful, knowledgeable, and treats me with respect.		ORG				Employee Respect	Employee Respect
46	There is a climate of trust in this organization.	X	ORG				Employee Respect	Employee Respect
47	This company provides assistance to help deal with job stress and burnout.		ORG				Work-Life Balance	Work-Life Balance

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
48	The person to whom I report encourages teamwork.	X	MGR	IV3	Leadership	Context & Accountability	Leadership	Leadership
49	I am proud to tell people I work for this company.	X	CI	DV	Associate Satisfaction		Commitment Indicator	Commitment Indicator
50	My job makes good use of my skills and abilities.	X	EMP				Job-Person Match	Job-Person Match
51	My performance evaluations have been conducted fairly.		MGR	IV3	Leadership	Accountability	Leadership	Leadership
52	My work unit provides high-quality care and service.	X	EMP				Quality/ Customer Focus	Quality/ Customer Focus
53	This company provides career development opportunities.	X	ORG				Growth and Development	Growth and Development
54	The person to whom I report values great customer service.	X	MGR				Quality/ Customer Focus	Quality/ Customer Focus
55	I get the tools and resources I need to provide the best care/service for our customers/clients/patients.	X	ORG				Employee Respect	Employee Respect
56	I respect the abilities of the person to whom I report.	X	MGR	IV3	Leadership	Positive Synergy	Leadership	Leadership
57	I selected this company as a place to work because its values reflect my own.	X	EMP				Job-Person Match	Job-Person Match
58	My job responsibilities are clear.	X	MGR	IV1	Employee Involvement	Accountability; Composition	Employee Involvement	Employee Involvement
59	I have received ongoing, quality inservice education for my role.		ORG				Growth and Development	Growth and Development

Item #	Item	Natl HC Avg 2010	Domain	Variable	Operational Term	Rationale for Inclusion	Morehead's Theme	Magnet Component Name
60	Different company leaders work well together to provide a quality continuum of care.		ORG				Organizational Alignment	Organizational Alignment
61	I feel like I belong in this company.	X	EMP				Organizational Alignment	Organizational Alignment
62	Senior management's actions support this company's mission and values.	X	ORG				Organizational Alignment	Organizational Alignment
63	The person to whom I report gives me useful feedback.	X	MGR	IV3	Leadership	Context	Leadership	Leadership
64	I have confidence in senior management's leadership.	X	ORG				Organizational Alignment	Organizational Alignment
65	I believe our new company is positioning itself well for future challenges and opportunities.		ORG				Quality/ Customer Focus	Quality/ Customer Focus

Appendix B

Permission to Use Proprietary Database for Research

Date: December 15, 2011

Kimberly Lee-Layton
UIW Doctoral Student
600 Clark Cove
Buda, Texas, 78610

Dear Kim:

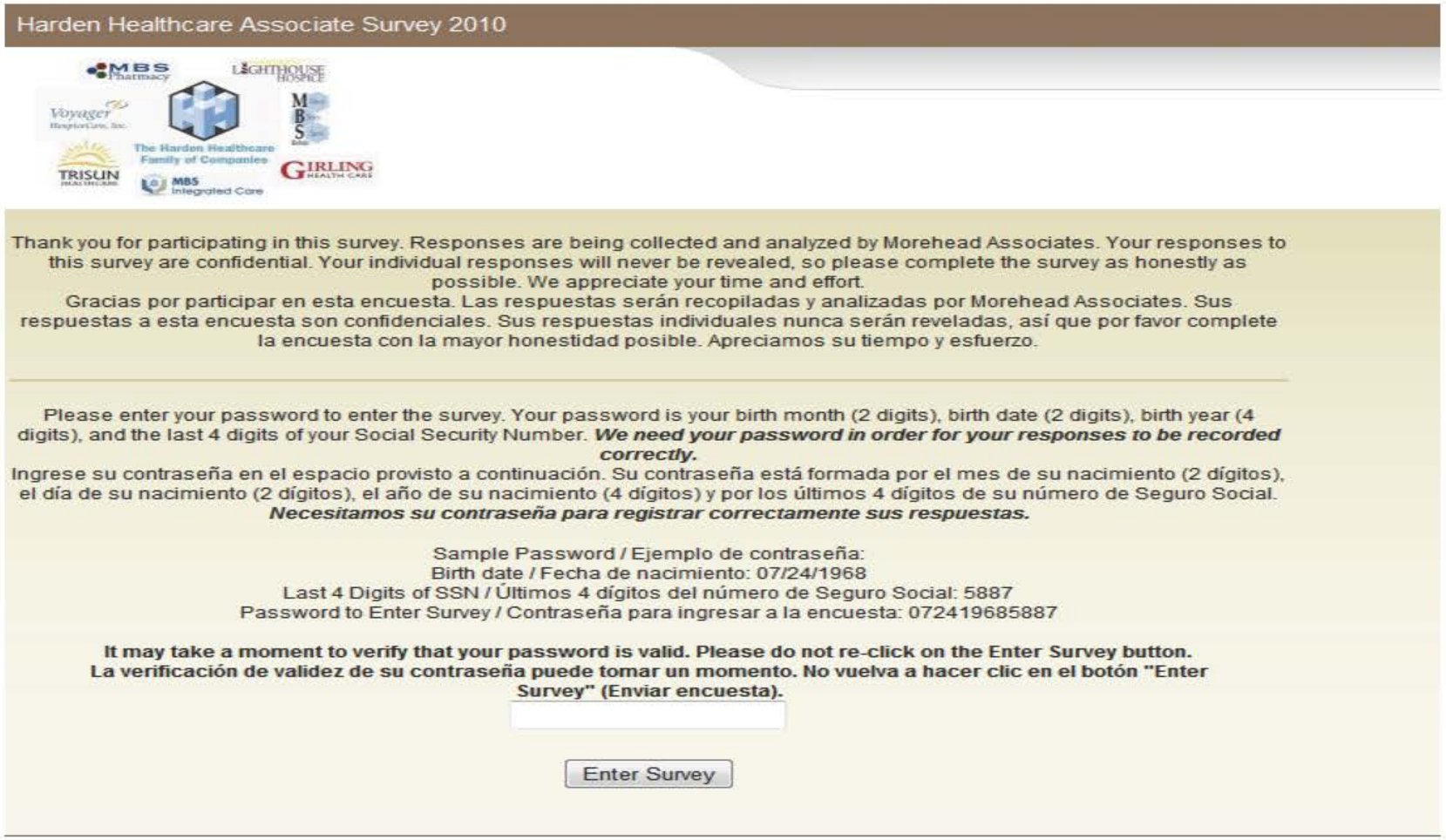
I give full permission to you for your access and use of Harden's collective database from associate engagement surveys for the years of 2007 through 2010 for purposes of research. The data does not contain identifiable information of subjects originally participating in the surveys.

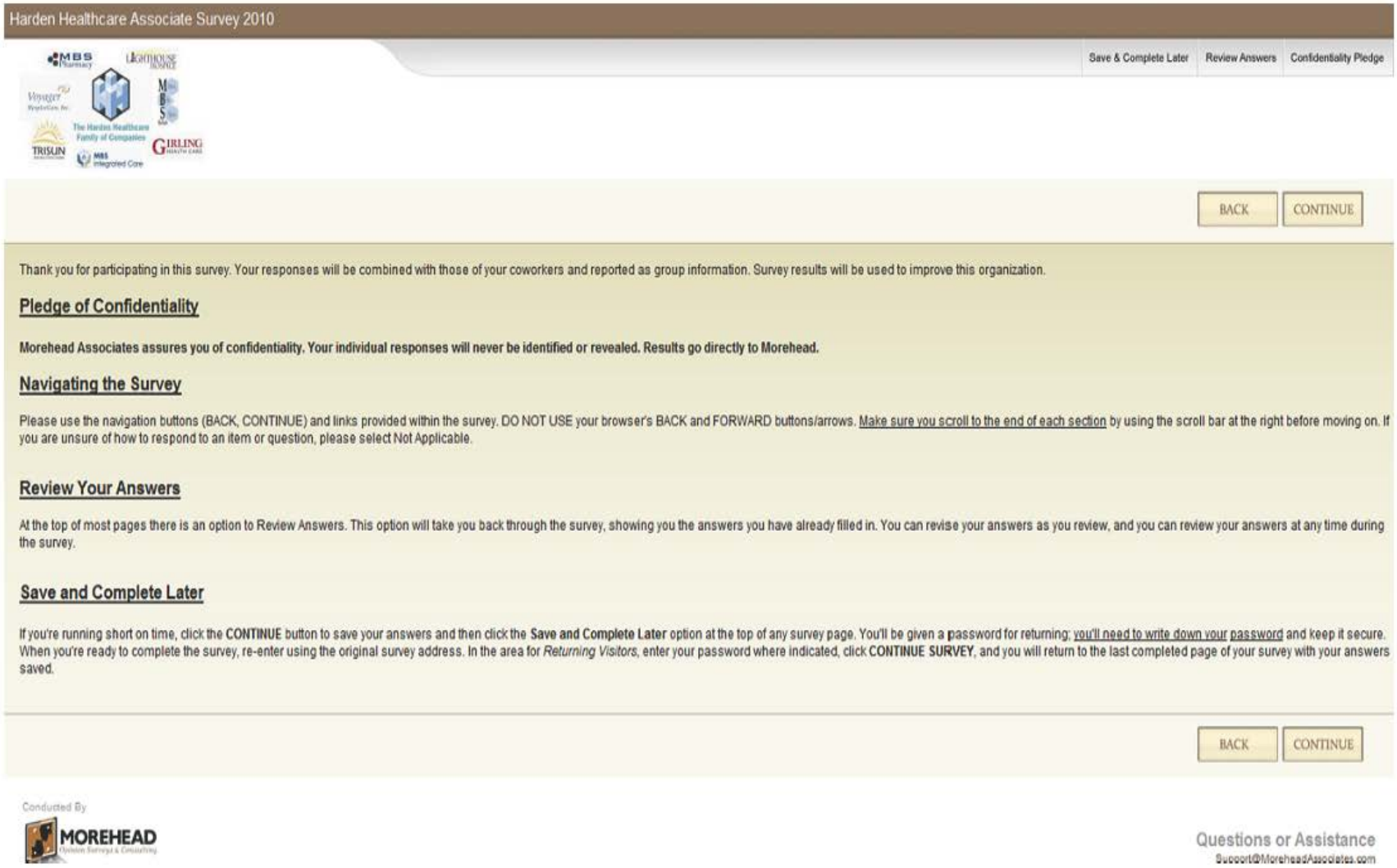
Sincerely,

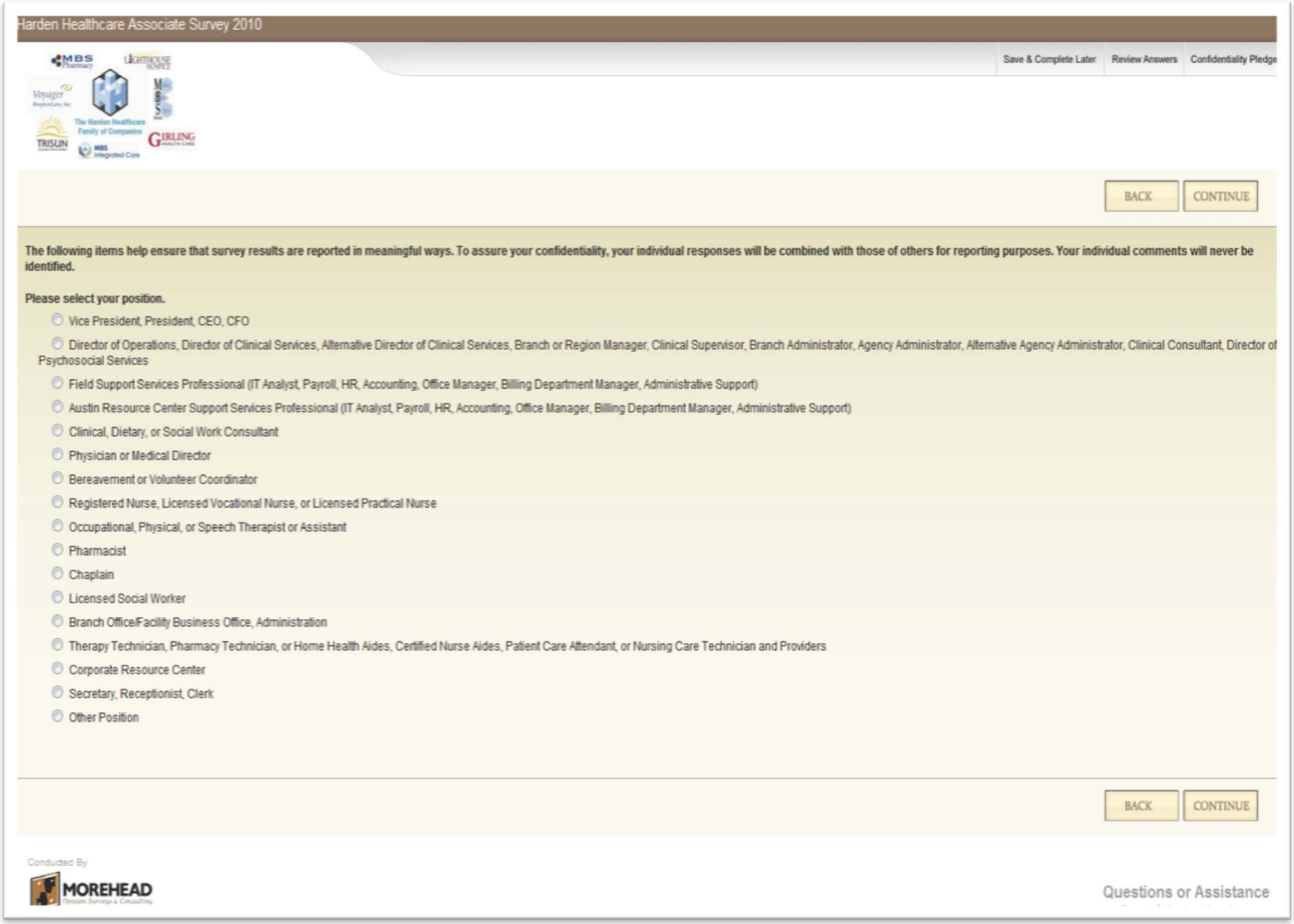
Lew Little
CEO

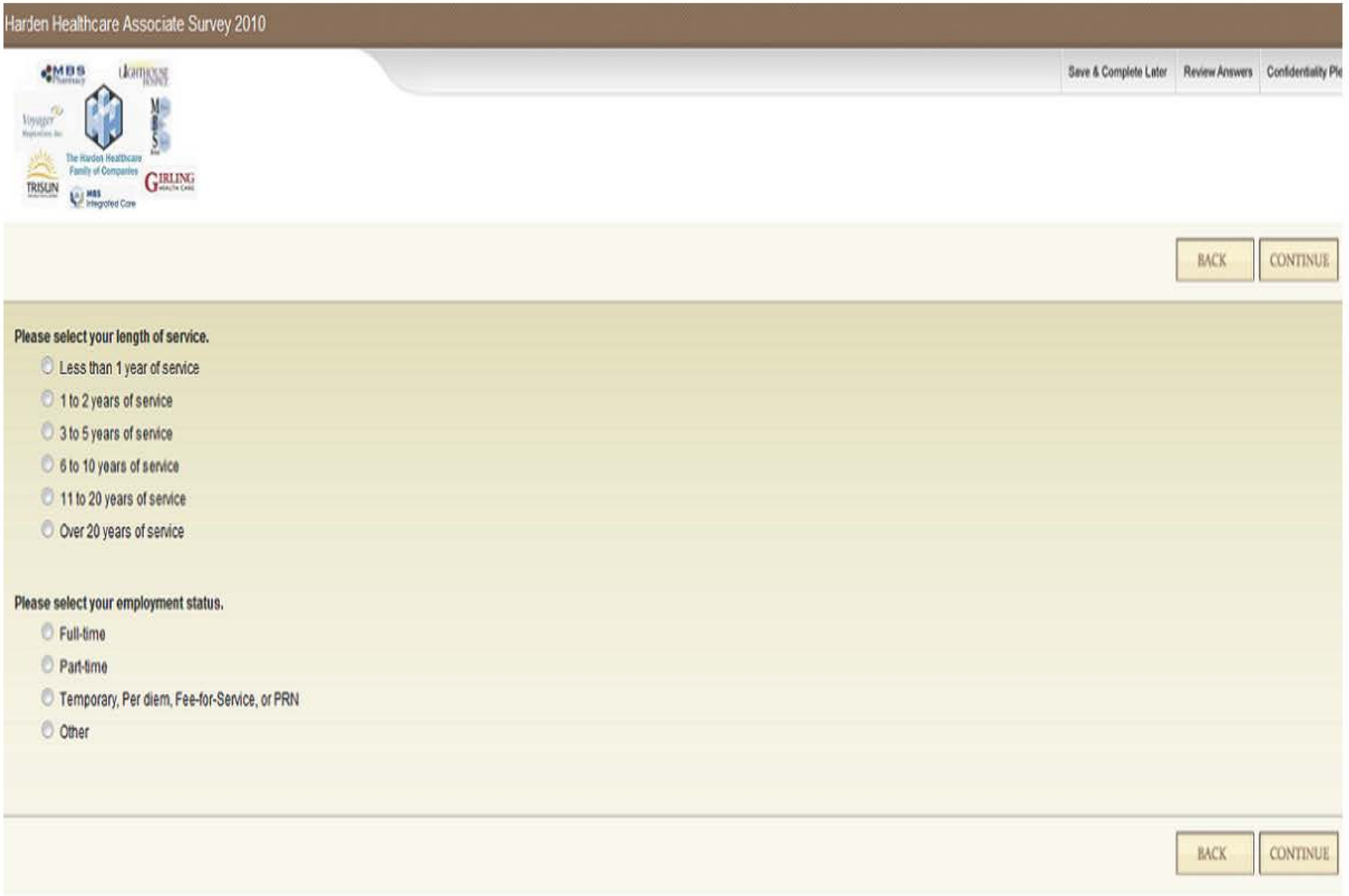
Appendix C

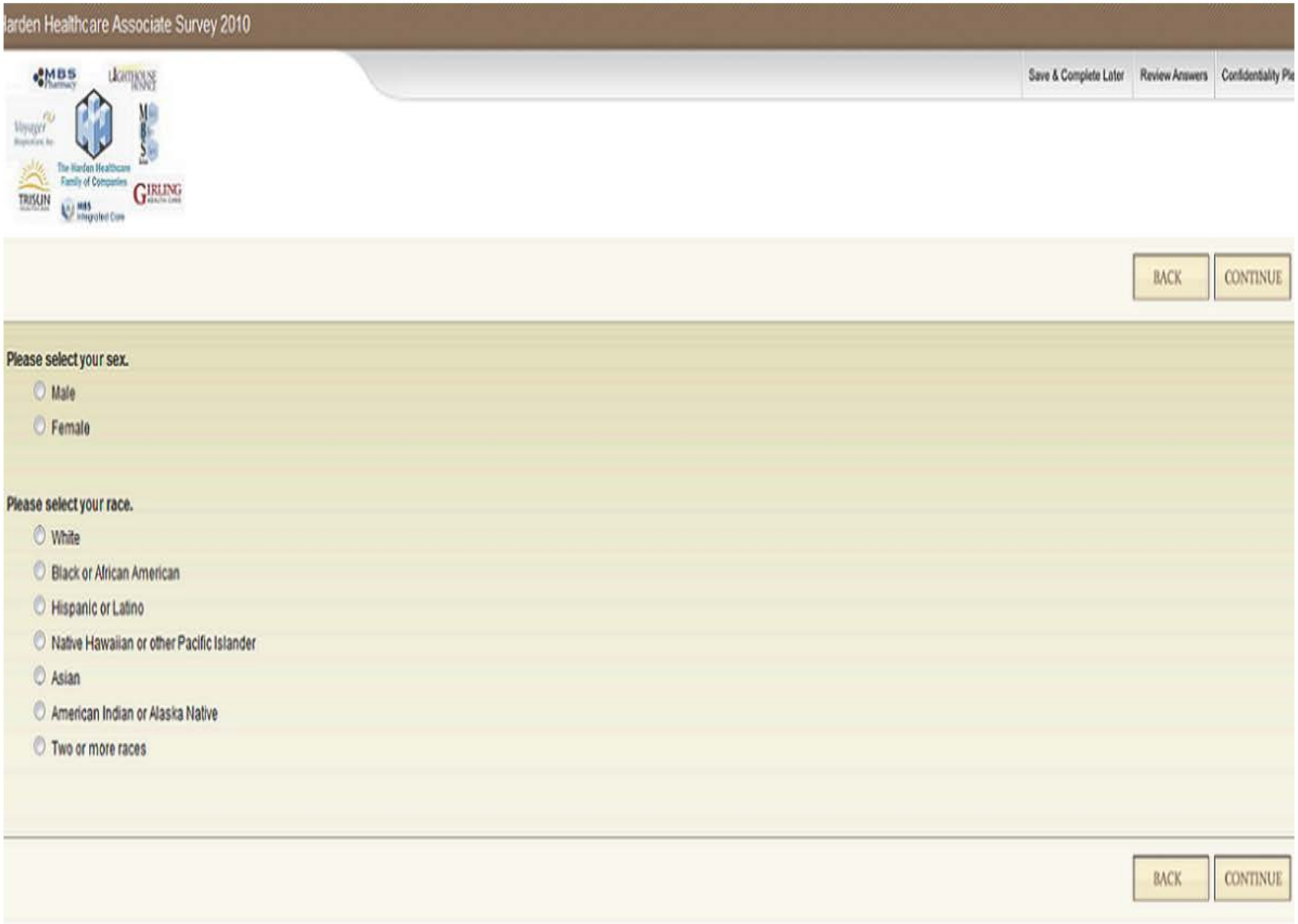
Sample of the Online Associate Satisfaction Survey

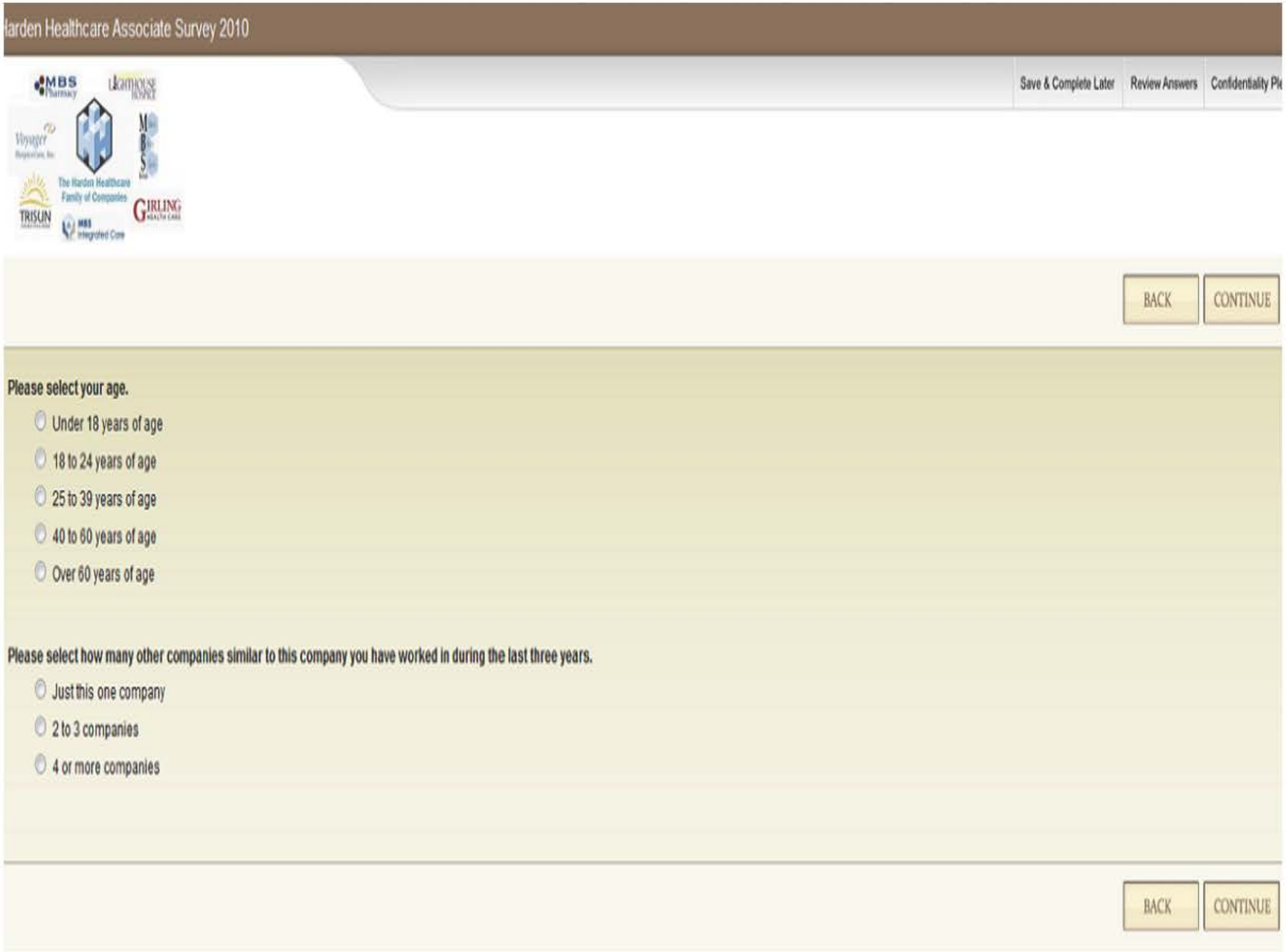


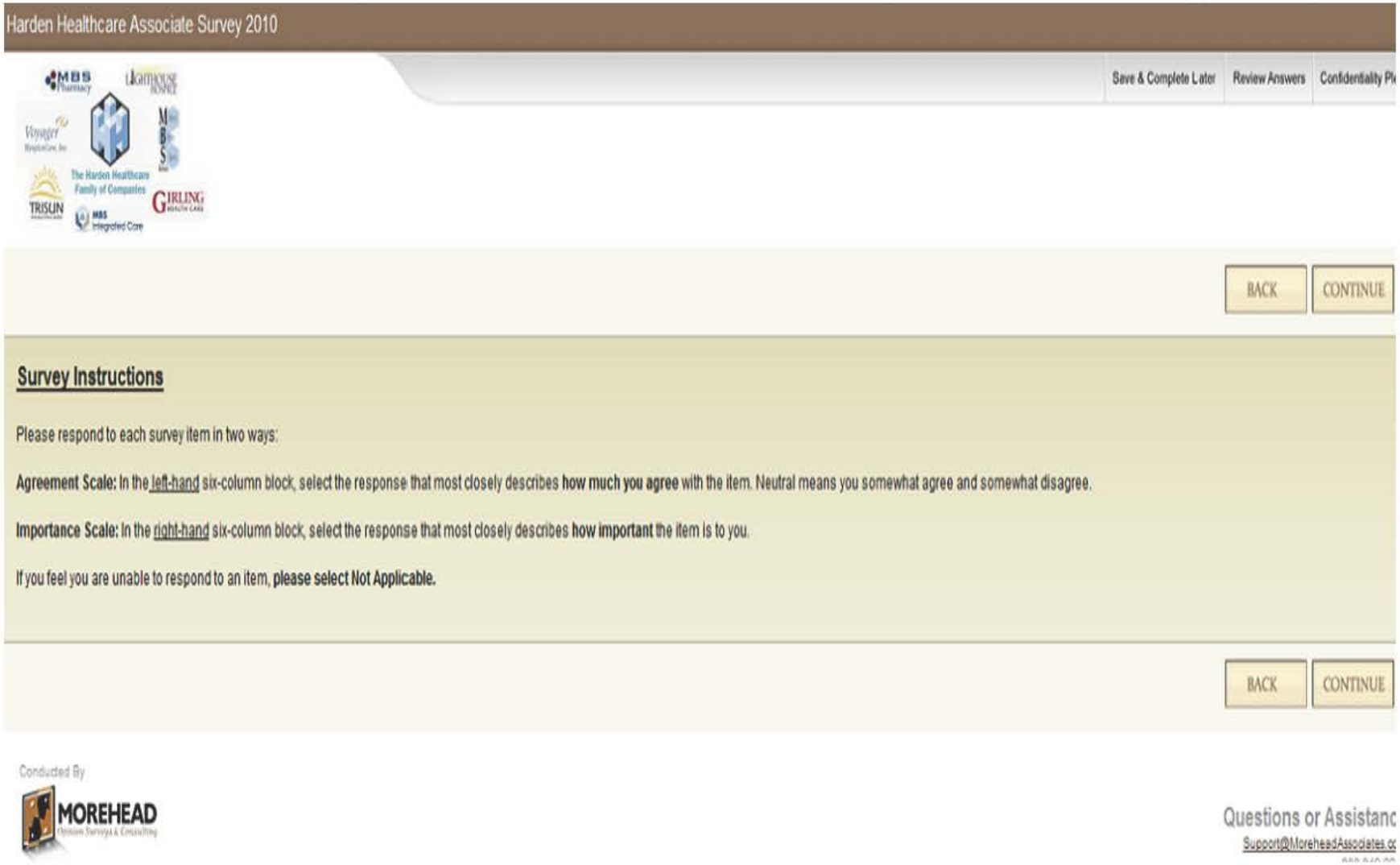

Harden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pledge
BACK
CONTINUE
Thank you for participating in this survey. Your responses will be combined with those of your coworkers and reported as group information. Survey results will be used to improve this organization.
Pledge of Confidentiality
Morehead Associates assures you of confidentiality. Your individual responses will never be identified or revealed. Results go directly to Morehead.
Navigating the Survey
Please use the navigation buttons (BACK, CONTINUE) and links provided within the survey. DO NOT USE your browser's BACK and FORWARD buttons/arrows. Make sure you scroll to the end of each section by using the scroll bar at the right before moving on. If you are unsure of how to respond to an item or question, please select Not Applicable.
Review Your Answers
At the top of most pages there is an option to Review Answers. This option will take you back through the survey, showing you the answers you have already filled in. You can revise your answers as you review, and you can review your answers at any time during the survey.
Save and Complete Later
If you're running short on time, click the CONTINUE button to save your answers and then click the Save and Complete Later option at the top of any survey page. You'll be given a password for returning; you'll need to write down your password and keep it secure. When you're ready to complete the survey, re-enter using the original survey address. In the area for Returning Visitors, enter your password where indicated, click CONTINUE SURVEY, and you will return to the last completed page of your survey with your answers saved.
BACK
CONTINUE
Conducted By
MOREHEAD
Questions or Assistance
Support@MoreheadAssociates.com

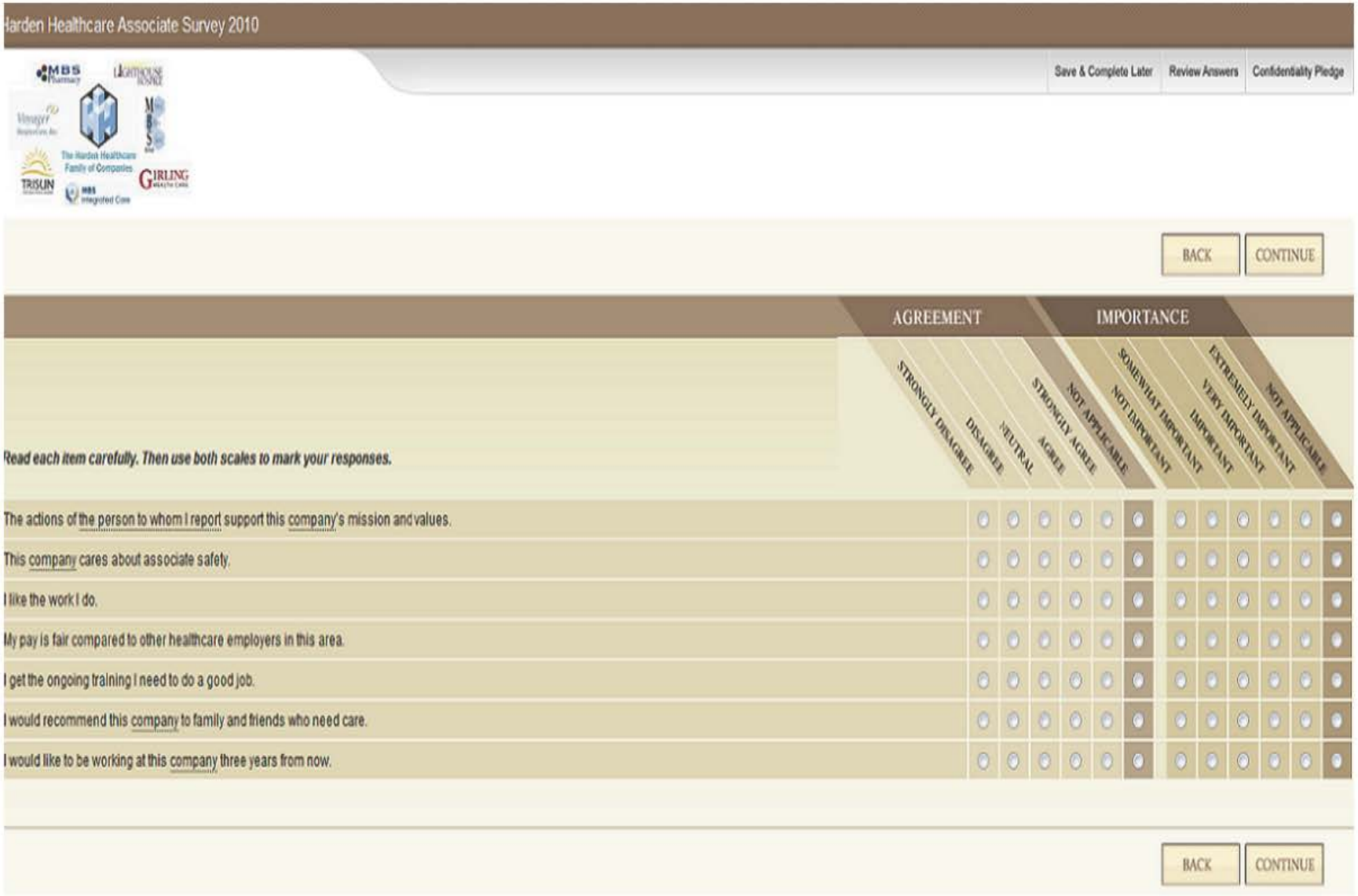

Harden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pledge
BACK
CONTINUE
The following items help ensure that survey results are reported in meaningful ways. To assure your confidentiality, your individual responses will be combined with those of others for reporting purposes. Your individual comments will never be identified.
Please select your position.
Vice President, President, CEO, CFO
Director of Operations, Director of Clinical Services, Alternative Director of Clinical Services, Branch or Region Manager, Clinical Supervisor, Branch Administrator, Agency Administrator, Alternative Agency Administrator, Clinical Consultant, Director of Psychosocial Services
Field Support Services Professional (IT Analyst, Payroll, HR, Accounting, Office Manager, Billing Department Manager, Administrative Support)
Austin Resource Center Support Services Professional (IT Analyst, Payroll, HR, Accounting, Office Manager, Billing Department Manager, Administrative Support)
Clinical, Dietary, or Social Work Consultant
Physician or Medical Director
Bereavement or Volunteer Coordinator
Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse
Occupational, Physical, or Speech Therapist or Assistant
Pharmacist
Chaplain
Licensed Social Worker
Branch Office/Facility Business Office, Administration
Therapy Technician, Pharmacy Technician, or Home Health Aides, Certified Nurse Aides, Patient Care Attendant, or Nursing Care Technician and Providers
Corporate Resource Center
Secretary, Receptionist, Clerk
Other Position
BACK
CONTINUE
Conducted By
MOREHEAD
Questions or Assistance


Harden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Ple
The Harden Healthcare Family of Companies
BACK
CONTINUE
Please select your length of service.
Less than 1 year of service
1 to 2 years of service
3 to 5 years of service
6 to 10 years of service
11 to 20 years of service
Over 20 years of service
Please select your employment status.
Full-time
Part-time
Temporary, Per diem, Fee-for-Service, or PRN
Other
BACK
CONTINUE


arden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pl
The Harden Healthcare Family of Companies
BACK
CONTINUE
Please select your sex.
Male
Female
Please select your race.
White
Black or African American
Hispanic or Latino
Native Hawaiian or other Pacific Islander
Asian
American Indian or Alaska Native
Two or more races
BACK
CONTINUE


arden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pl
The Harden Healthcare Family of Companies
BACK
CONTINUE
Please select your age.
Under 18 years of age
18 to 24 years of age
25 to 39 years of age
40 to 60 years of age
Over 60 years of age
Please select how many other companies similar to this company you have worked in during the last three years.
Just this one company
2 to 3 companies
4 or more companies
BACK
CONTINUE


Harden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pl
The Harden Healthcare Family of Companies
BACK
CONTINUE
Survey Instructions
Please respond to each survey item in two ways:
Agreement Scale: In the left-hand six-column block, select the response that most closely describes how much you agree with the item. Neutral means you somewhat agree and somewhat disagree.
Importance Scale: In the right-hand six-column block, select the response that most closely describes how important the item is to you.
If you feel you are unable to respond to an item, please select Not Applicable.
BACK
CONTINUE
Conducted By
MOREHEAD
Questions or Assistanc
Support@MoreheadAssociates.c


Harden Healthcare Associate Survey 2010
Save & Complete Later
Review Answers
Confidentiality Pledge
BACK
CONTINUE
AGREEMENT
IMPORTANCE
STRONGLY DISAGREE
DISAGREE
NEUTRAL
AGREE
STRONGLY AGREE
NOT APPLICABLE
NOT IMPORTANT
SOMEWHAT IMPORTANT
IMPORTANT
VERY IMPORTANT
EXTREMELY IMPORTANT
NOT APPLICABLE
Read each item carefully. Then use both scales to mark your responses.
The actions of the person to whom I report support this company's mission and values.
This company cares about associate safety.
I like the work I do.
My pay is fair compared to other healthcare employers in this area.
I get the ongoing training I need to do a good job.
I would recommend this company to family and friends who need care.
I would like to be working at this company three years from now.
BACK
CONTINUE

Appendix D

Associate Satisfaction Survey Items With Coding and Variables

Product	Health care database	Validity & reliability statistics	Scale	Web vsn	Voice vsn	Paper vsn	Billing l vsn	No. of qstns	Time to take	Training & support	Action plan tool	User-friendly reports	Result production time	On-site days
Gallup	1.21 million subjects	X	5-pt	X	X	X	X	12	5 min	X	X	0	3 wks	1
Health Stream	222 thousand subjects, 166 organizations	X	4-pt	X	X	X	X	40	5 min	0	0	0	4–6 wks	1
HR Solutions	X	Limited	5-pt	X	0	X	X	80	40 min	0	X	X	1–2 wks	12
Morehead	300 organizations	X	5-pt	X	X	X	X	51	15–20 min	X	X	X	5 days–Exec; 3–6 wks manager rollup	1
My InnerView	6,300 facilities	?	4-pt	X for LT and AL only	0	X	X	21	NA	Webinars available on request only	0	?	48 hrs–several wks ?	0
Press Ganey	350,000 subjects; 398 organizations	X	4-pt	X	O	X	X	67	20 min	0	X	0	4 wks	9

Appendix E

2009 Human Research Course Completion Report From the CITI Program

CITI Collaborative Institutional Training Initiative

Human Research Curriculum Completion Report
Printed on Sunday, January 18, 2009

Learner: Kimberly Lee-Layton (username: KimberlyLayton)
Institution: Texas State University - San Marcos
Contact Information Email: klayton@hardenhealthcare.com
Social and Behavioral Research Students:

Stage 1. Basic Course Passed on 01/18/09 (Ref # 2319079)

Required Modules	Date Completed
Introduction	01/18/09
History and Ethical Principles - SBR	12/06/08
Defining Research with Human Subjects - SBR	12/06/08
The Regulations and The Social and Behavioral Sciences - SBR	01/18/09
Assessing Risk in Social and Behavioral Sciences - SBR	01/18/09
Informed Consent - SBR	01/18/09
Privacy and Confidentiality - SBR	01/18/09
Texas State University - San Marcos	01/18/09

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

Return

Appendix F

2012 Human Research Course Completion Report From the CITI Program

CITI Collaborative Institutional Training Initiative

Dreeben School of Education Curriculum Completion Report
Printed on 2/19/2012

Learner: Kimberly Lee-Layton (username: KimberlyLayton)
Institution: University of the Incarnate Word
Contact Information 600 Clark Cove
Buda, Texas 78610 United States
Department: Organizational Leadership
Phone: 512-826-0786
Email: klayton@hardenhealthcare.com

Dreeben School of Education:

Stage 2. Refresher Course Passed on 02/19/12 (Ref # 7502170)

Required Modules	Date Completed	Score
SBR 101 REFRESHER MODULE 1 - History and Ethics	02/16/12	5/5 (100%)
SBR 101 REFRESHER MODULE 2 - Regulatory Overview	02/16/12	5/5 (100%)
SBR 101 REFRESHER MODULE 3 - Risk, Informed Consent, and Privacy and Confidentiality	02/16/12	4/5 (80%)
SBR 101 REFRESHER MODULE 4 - Vulnerable Subjects	02/16/12	4/4 (100%)
SBR 101 REFRESHER MODULE 5 - Education, International, and Internet Research	02/19/12	4/5 (80%)
How to Complete The CITI Refresher Course and Receive the Completion Report	02/19/12	no quiz
SBR 201 Introduction	02/19/12	no quiz
Undue Influence	02/19/12	1/1 (100%)
Research Activities Eligible for Exemption	02/19/12	1/1 (100%)
Privacy vs Confidentiality in Social & Behavioral Research	02/19/12	1/1 (100%)
Assessing Risk in Social & Behavioral Research	02/19/12	1/1 (100%)
Completing the SBR 201 Refresher Course	02/19/12	no quiz
Defining Research with Human Subjects	02/19/12	1/1 (100%)
University of the Incarnate Word	02/19/12	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education

Appendix G

Approval Letter From the University of the Incarnate Word Institutional Review Board

4/30/2012

Kimberly Ann Lee-Layton
600 Clark Cove
Buda, Texas 78610

Dear Ms. Lee-Layton:

Your request to conduct the study titled *Correlating Employee Involvement, Coworker Relations, and Leadership with Associate Commitment in Select Health Care Companies* is approved as an expedited study. Your IRB number is 12-04-005 and was approved on 4/20/2012. Attached is a copy of your scanned IRB. The file includes the application with IRB number and the stamped IRB consent form. Please use copies of these stamped documents when you communicate with or consent your subjects. Electronic surveys or electronic consent forms, or other material delivered electronically to subjects must have the IRB approval number inserted into the survey or documents before they are used.

Please keep in mind these additional IRB requirements:

- This approval is for one year from the date of the IRB approval.
- Request for continuing review must be completed for projects extending past one year. Use the **IRB Continuation/Completion form**.
- Prompt reporting to the UIW IRB of any proposed changes to the approved research activity.
- Any change in proposal procedures must be promptly reported to the UIW IRB prior to implementing any changes except when necessary to eliminate apparent immediate hazards to the subjects. Use the **Protocol Revision and Amendment form**.
- Prompt reporting to the UIW IRB of any unanticipated problems involving risks to subjects or others.
- IRBs are filed by their number. Please refer to this number when communicating about the IRB.

Suspension or termination of approval may be done if there is evidence of any serious or continuing noncompliance with Federal Regulations or any aberrations from the original application.

Congratulations and best wishes for successful completion of your research. If you need any assistance, please contact the UIW IRB representative for your college/school. You will be receiving a copy of this letter in the mail at the address indicated on the IRB application.

Sincerely,

Dr. Helen Smith

Dr. Helen Smith
Chair, University of the Incarnate Word IRB

Appendix H

Letter to Potential Focus Group Participants

LETTER TO POTENTIAL SUBJECTS FOR A STUDY ABOUT EMPLOYEE INVOLVEMENT, COWORKER RELATIONS, PERCEPTIONS OF LEADERSHIP AND ASSOCIATE COMMITMENT
University of the Incarnate Word

Dear Prospective Participant:

I am Kimberly (Kim) Layton, a doctoral student at the University of the Incarnate Word working towards a doctorate degree in education with a concentration in organizational leadership.

You are being asked to take part in a research study of employee involvement, coworker relations, perceptions of leadership, associate commitment, and teams with a healthcare organization.

I am hoping to learn more about the relationships between employment involvement, coworker relations, perceptions of leadership, and associate commitment within the healthcare organizational environment through this study. I am conducting this study through an open-ended, voluntary focus group setting.

You are being asked to take part in this study as a group member because you have a perception about the work environment characteristics in which I am interested. You have perceptions about the work team setting in which might bring more insight related to recent associate satisfaction survey data.

If you decide to take part, I will describe the open-ended group interview process to you including how long the interview will take.

The main inconvenience to you will be the time required to participate, which will be one hour. You will participate as a member of a group from your work unit.

The main benefit from participating in this open-ended group interview will be contributing to the improvement of training for leaders and associates as well as in the improvement of the work environment to better meet the needs of work units and to contribute to bettering the delivery of patient care. You will also benefit from contributing to the betterment of your work area and to the organization.

Refreshments will be provided after the participation in the group interview.

Everything I learn about you will be confidential and no identifying information will be recorded. The information gathered in the study will be gained from the work unit group. This information will be trended with other group interview data in the study. If I publish this study, no personal identifying information will be utilized.

Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time.

If you choose not to participate at any time, you will not affect your current or future employment at this organization nor any current or future relationship with the University of the Incarnate Word.

If you have questions now, feel free to ask me. If you have additional questions later or you wish to report a problem that may be related to this study, contact me at klayton@hardenhealthcare.com or 512-634-4964 or 512-826-0786.

The University of the Incarnate Word committee that reviews research on human subjects, the Institutional Review Board, will answer any questions about your rights as a research subject (210-829-2759 – Dean of Graduate Studies and Research).

You will be given a copy of this letter and the informed consent form to keep.

You will be asked to sign an informed consent form which will indicate that you (1) consent to take part in this research study, and (2) that you have read and understand the information given above, and (3) that the information above was explained to you. This will occur before the group interview starts.

Thank you in advance for your cooperation and support.

Sincerely,

Kimberly (Kim) Layton
512-634-4964 (Work)
512-826-0786 (Cell)
klayton@hardenhealthcare.com

Appendix I

Focus Group Interview Informed Consent Form

SUBJECT CONSENT TO TAKE PART IN A STUDY ABOUT EMPLOYEE INVOLVEMENT, COWORKER RELATIONS, PERCEPTIONS OF LEADERSHIP AND ASSOCIATE COMMITMENT

University of the Incarnate Word

I am Kimberly (Kim) Layton, a doctoral student at the University of the Incarnate Word working towards a doctorate degree in education with a concentration in organizational leadership.

You are being asked to take part in a research study of employee involvement, coworker relations, perceptions of leadership, associate commitment, and teams with a healthcare organization.

I am hoping to learn more about the relationships between employment involvement, coworker relations, perceptions of leadership, and associate commitment within the healthcare organizational environment through this study. I am conducting this study through an open-ended, voluntary focus group setting.

You are being asked to take part in this study as a group member because you have a perception about the work environment characteristics in which I am interested. You have perceptions about the work team setting in which might bring more insight related to recent associate satisfaction survey data.

If you decide to take part, I will describe the open-ended group interview process to you including how long the interview will take.

The main inconvenience to you will be the time required to participate, which will be one hour. You will participate as a member of a group from your work unit.

The main benefit from participating in this open-ended group interview will be contributing to the improvement of training for leaders and associates as well as in the improvement of the work environment to better meet the needs of work units and to contribute to bettering the delivery of patient care. You will also benefit from contributing to the betterment of your work area and to the organization.

Refreshments will be provided after the participation in the group interview.

Everything I learn about you will be confidential and no identifying information will be recorded. The information gathered in the study will be gained from the work unit group. This information will be trended with other group interview data in the study. If I publish this study, no personal identifying information will be utilized.

All data will be kept in a locked and secured location and will be destroyed upon completion of the study not to exceed five years.

Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time.

If you choose not to participate at any time, you will not affect your current or future employment at this organization nor any current or future relationship with the University of the Incarnate Word.

If you have questions now, feel free to ask me. If you have additional questions later or you wish to report a problem that may be related to this study, contact me at klayton@hardenhealthcare.com or 512-634-4964 or 512-826-0786.

The University of the Incarnate Word committee that reviews research on human subjects, the Institutional Review Board, will answer any questions about your rights as a research subject (210-829-2759 – Dean of Graduate Studies and Research).

You will be given a copy of this form to keep.

Your signature indicates that you (1) consent to take part in this research study, and (2) that you have read and understand the information given above, and (3) that the information above was explained to you.

_____	_____
Signature of Subject	Signature of Witness
_____	_____
Signature of Investigator	Date and Time

Appendix J

Qualitative Focus Group Interview Questions

Primary Questions:

1. How does the work unit work together to accomplish their goals?
2. What enhances workplace satisfaction?
3. What enhances the teaming experience?
4. What facilitates teaming?

Secondary Questions:

5. How is trust developed?
6. Describe the work environment.
7. Describe the leadership style related to the work environment.
8. How does the team work through conflict?
9. How are you individually involved in making decisions?
10. How do you receive recognition?
11. How is accountability practiced on the team?
12. How are goals identified?
13. How do you know who does what?
14. How do you know when to move forward with a task or project?
15. How is feedback provided?
16. Describe the relationship you have with your supervisor.