

Strategic Human Resource Management of Volunteers and the Link to Hospital Patient Satisfaction

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Abstract

This article uses strategic human resource management theory to consider the ways in which volunteers can potentially enhance hospital patient satisfaction. Results of a structural equation modeling analysis of multi-source data on 107 U.S. hospitals show positive associations between hospital strategy, volunteer management practices, volunteer workforce attributes, and patient satisfaction. Although no causality can be assumed, the results shed light on the volunteer–patient satisfaction relationship and have important implications for hospital leaders, volunteer administrators, and future research.

Keywords

volunteers, hospitals, strategic human resource management, high-commitment work practices, HCAHPS, patient satisfaction

Introduction

Hospitals increasingly focus their efforts on delivering high-quality patient care while reducing costs. A key aspect of hospital performance is patient satisfaction, and hospital volunteers can potentially enhance patient satisfaction. Brent Hotchkiss, Fottler, and

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Unruh (2009), for example, found that greater use of volunteers was related to higher patient satisfaction scores. However, this volunteer–patient satisfaction relationship is not well understood. Referring to prior research that suggests a relationship between volunteers and patient satisfaction, Brent Hotchkiss, Fottler, and Unruh (2014) note, “Future research further exploring the relationship between these variables and focusing on the development of this relationship could greatly benefit hospitals wishing to improve patient satisfaction” (p. 16). They call for a wide range of approaches to this task, including research from “Experts in the field of volunteerism, economics, and business” (p. 15).

We take up their call by examining the volunteer–patient satisfaction link through the lens of strategic human resource management theory, a perspective pervasive in business administration scholarship. Non-profit scholars have recently encouraged applying a strategic perspective to the study of volunteers. For example, Connors (2012) pointed out a high need for additional research “to demonstrate the value added and the significant impact of effective strategic volunteer engagement” (p. xviii). We believe such an approach holds great promise for understanding the potential of volunteer resource management.

Human Resource Management as Strategic Choice

Wright and McMahan (1992) define strategic human resource management as “the pattern of planned human resource deployments and activities intended to enable an organization to achieve its goals” (p. 298). Simply put, strategic human resource management highlights the strategic importance of purposeful human resource management, or HR (Delery & Doty, 1996). Within strategic human resource management, a key discussion is that of the relationship between an organization’s strategy and the way it manages its workers. In studying the employment practices of American steel mills, Arthur (1992) found a relationship between an organization’s strategy as either a cost leader or a differentiator and its HR practices. Cost leaders tended to utilize “cost-reduction” or “control” HR practices, whereas differentiators used “commitment-enhancing” HR practices more often. In a 1994 follow-up study, Arthur empirically demonstrated a link between strategy, HR, and outcomes. Steel mills with commitment-based HR systems experienced better outcomes than mills with cost-reduction-based HR systems. Strategic human resource management researchers have since expanded the list of consequences of “high-commitment” HR to include links to decreased turnover, increased productivity and sales growth, improved corporate financial performance and organizational climate, and greater organizational citizenship and helping behaviors among employees (e.g., Batt, 2002; Cappelli & Neumark, 2001; Chuang & Liao, 2010; Guthrie, 2001; Huselid, 1995).

Applying strategic human resource management theory to the volunteer–patient satisfaction link becomes a potentially useful tool for “focusing on the development of this relationship” (Brent Hotchkiss et al., 2014, p. 16). Does a hospital’s approach to volunteer resource management reflect larger organizational characteristics, and does volunteer management relate to volunteer and organizational outcomes? Figure 1

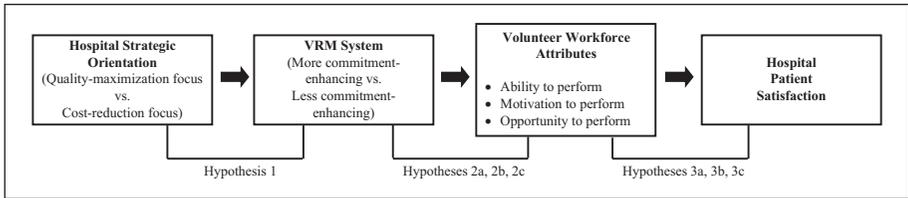


Figure 1. Conceptual model of the volunteer–patient satisfaction relationship.
 Note. VRM = Volunteer Resource Management.

depicts a framework for how these elements might work together and is based on conceptual and empirical models from strategic human resource management literature (e.g., Arthur, 1994). In the following section we theorize the nature of the relationships among the variables in the conceptual model presented in Figure 1.

Links Between Strategy, Volunteer Management, Volunteer Attributes, and Patient Satisfaction

Drawing on the work of Arthur (1992) and more recent studies (e.g., Takeuchi, 2009) that demonstrate a link between an organization’s strategy and its approach to managing employees, we hypothesize that a hospital’s volunteer resource management will reflect a leaning toward cost-reduction or toward quality-maximization. How might this link occur in practice? Arthur’s (1992) study revealed that organizations focusing on cost-reduction tended to create HR systems that emphasized minimizing labor costs through direct (e.g., relatively low wages and benefits) and indirect (e.g., narrowly defined jobs and intense supervision) cost containment. Conversely, organizations concentrating on quality-maximization viewed labor-related expenses as investments that enabled the production of high-quality goods and services. Such steel mills in Arthur’s (1992) study tended to use “commitment-enhancing” HR practices such as relatively high wages, broadly defined jobs, and increased training and development. Similarly, we propose that hospitals with a primarily high-quality strategic orientation will tend to use more frequently commitment-enhancing volunteer resource management. This relationship constitutes Hypothesis 1 in Figure 1. The complete list of volunteer management practices we considered is listed in Table 1.

Moving to the right in Figure 1, we draw on “black box” research in strategic human resource management to explore the relationship between volunteer management and volunteer worker attributes. Early strategic HR research (e.g., Huselid, 1995) demonstrated a link between HR practices and firm outcomes. However, the mediating mechanisms and processes (i.e., the variables comprising the then unknown “black box” between HR and outcomes) by which human resource management influenced organizational outcomes were not well understood. Recently, studies have highlighted these mediating mechanisms. A meta-analysis of strategic HR studies by Jiang, Lepak, Hu, and Baer (2012) describes a sequential process in

Table 1. Correlation Matrix for Study Variables.

	M	SD	1	2	3	4	5	6	7	8
1. Hospital size (ln)	5.24	0.89								
2. Volunteer hours (ln)	6.18	1.32	.58**							
3. Volunteer/staff ratio	0.70	3.18	-.34**	-.24**						
4. Hospital strategy	3.49	0.57	.12	.21*	.06	(.65)				
5. Volunteer HR	3.71	0.63	.24**	.47**	-.07	.26**	(.83)			
6. Ability to perform	3.78	0.68	-.13	.11	.12	.31**	.39**	(.87)		
7. Motivation to perform	4.11	0.65	-.09	.12	.15	.22*	.18*	.70**	(.78)	
8. Opportunity to perform	3.70	0.81	-.10	.13	.10	.15	.42**	.33**	.18*	(.76)
9. Patient satisfaction ratings	66.27	8.24	-.12	.23*	.13	.40**	.25*	.25**	.16	.30**

Note. Coefficients reported in the parentheses are the internal reliabilities.

* $p < .05$. ** $p < .01$.

which human resource management influences worker attitudes, which in turn influence organizational outcomes.

We apply this sequence to develop a model in which volunteer resource management practices relate to volunteer ability to perform job tasks, motivation to perform job tasks, and opportunities to perform job tasks. Commonly referred to in management scholarship as the ability–motivation–opportunity model, Blumberg and Pringle (1982) conceptualized worker performance as a three-dimensional model reflecting one's ability, willingness, and opportunity to perform job tasks. Ability to perform consists of a worker's knowledge, skills, competencies, and other human capital characteristics (Becker, 1975). Willingness to perform speaks to an employee's motivation to exert effort toward his or her work. And opportunity to perform describes whether the appropriate environmental conditions exist that enable workers to do their jobs well. The meta-analysis by Jiang et al. (2012) shows that HR practices influence all three, and we propose that volunteer management practices will also relate to each one. Specifically, greater use of commitment-enhancing volunteer resource management practices will be positively related to these volunteer attributes. These predictions constitute Hypotheses 2a, 2b, and 2c in Figure 1.

The final set of relationships in Figure 1 deals with the impact of volunteer attributes on patient satisfaction. And again, we use the strategic human resource management process model offered by Jiang et al. (2012) to understand this relationship. Handy and Srinivasan (2004) found that hospital volunteers engage in a range of patient contact as well as administrative tasks, including visiting with patients and providing companionship to their families, fundraising, transporting patients, and serving on boards. Hospitals that utilize commitment-enhancing volunteer management practices could potentially be creating pathways for volunteers to directly and indirectly enhance the patient experience. A few hypothetical examples might make this relationship clearer—we offer one example for each of the three domains of ability, motivation, and opportunity to perform.

The practice of providing specific training for volunteers and paid staff on methods of working together to deliver high-quality patient services (the volunteer management practice) may provide volunteers with the skills needed to work alongside hospital paid staff synergistically (the ability to perform) in a way that adds value for patients and enhances their satisfaction (the organizational outcome).

Recruiting and hiring volunteers based on specific skill sets such as fundraising, and then placing them in appropriate roles such as annual fund drives where they can utilize those skills (the volunteer management practice), may position them to do work that they are excited about because they have experience and know they can do it well (the motivation to perform). If the work of these volunteers helps generate relatively higher resources, those resources can be used to enhance the patient experience (the organizational outcome).

The opportunity domain of worker performance is often discussed in relation to employment empowerment. Employees perform better when they feel empowered to do the tasks assigned to them (Blumberg & Pringle, 1982). If hospital volunteers are given periodic performance evaluations in which they are told the job tasks they are

doing very well and the areas that need improvement (the volunteer management practice), then they can adjust their work behaviors as needed, continuing to do those tasks they perform well and working to improve weaker areas (the opportunity to perform). This management-enabled, self-reflective sharpening of individual performance might then relate to patient satisfaction (the organizational outcome). Taken together, these examples illustrate our Hypotheses 3a, 3b, and 3c.

In this section, we have used a process model of strategic human resource management to develop understanding about the volunteer–patient satisfaction relationship. Next, we conduct an exploratory test of this model using data on 107 U.S. hospitals.

Data and Method

Sample

One primary and two secondary data sources were used for this analysis. For the primary data, between October and December 2010, two waves of paper and pencil questionnaires were mailed to volunteer directors at 496 hospitals in five U.S. states in the northeast and the south. We received 131 completed surveys, for a response rate of 26%; however, missing data reduced our final analytic sample to 107 hospitals. We obtained additional data for the hospitals in our sample from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and the American Hospital Association data viewer website (<http://www.ahadata-viewer.com/>).

Although our survey response rate is not unusually low compared with many strategic HR studies, it is lower than rates recommended by non-profit scholars (e.g., Hager, Wilson, Pollak, & Rooney, 2003). To address the threat of non-response bias, we tested for differences between hospitals that responded and those that did not respond to our survey. Using an approach similar to that of Takeuchi (2009), we conducted independent-sample *t* tests comparing the means for several hospital variables, including number of hospital admissions, beds available, operating expenses, and number of paid employees, for survey respondents and non-respondents. Data for these variables are from the American Hospital Association database. We found no statistically significant differences for any of those variables ($p < .05$). Although the threat of non-response bias is not totally resolved, we are confident that our subsequent analyses can produce acceptable results.

On average, the 107 hospitals that comprise our sample have been operating for 96 years ($SD = 47$), have 261 patient beds ($SD = 177$), utilized 341 volunteers over a 12-month period ($SD = 364$), and have 1,883 paid employees ($SD = 2,054$; for the number of paid employees, we used the natural log in analyses). The number of volunteers at each facility was reported by survey respondents, whereas American Hospital Association data were used to obtain information for the other hospital variables. Most of these organizations were rural or suburban hospitals ($n = 55$) or metropolitan or urban hospitals ($n = 48$). Correlations, means, standard deviations, and scale reliabilities are presented in Table 1.

Variables

Organization strategy has typically been assessed in strategic human resource management studies through either the paragraph method or multi-item scales, with the latter being more widely accepted (Takeuchi, 2009). Thus, we used scales, with four items to measure a quality-maximization strategic orientation, and three items to measure a cost-reduction strategic orientation. All items are listed in the appendix.

To gauge the degree to which an organization's HR practices reflect a commitment-enhancing human resource management system, strategic HR scholars typically compose a list of HR practices and then have respondents indicate the extent to which their organization implements each practice. We composed a listing of 23 volunteer resource management practices by reviewing the volunteer management literature. No single list of "best practices" exists, and the lists we retrieved included a different number of, overlap in, and variation across, practices. We settled on 23 practices from four oft-cited publications: Brudney (1999), Ellis (2010), Hager and Brudney (2004), and the UPS Foundation (2002). The way the practices were worded in our questionnaire reflects a commitment-based approach to volunteer management for all 23 items. Thus, we measure higher ratings of usage as indicating a high-commitment volunteer resource management, whereas lower ratings indicate lower levels of commitment. Table 2 lists the volunteer management practices as well as examples of what the administration of each practice might resemble under a commitment-enhancing versus cost-reduction approach.

We used established scales from previously published research to measure worker ability, motivation, and opportunity to perform job tasks (ability: five items; Youndt, Subramaniam, & Snell, 2004; motivation: three items; Park, Mitsuhashi, Fey, & Björkman, 2003; and autonomy: three items; Hackman, Oldham, Janson, & Purdy, 1975). Because these scales were not originally designed for volunteer workers, we modified the wording to reflect volunteers. The motivation measure addresses volunteers' motivations to perform their assigned job tasks, not the motives for volunteering or continuing to volunteer.

Patient satisfaction was measured using an average of two HCAHPS items. HCAHPS is a survey instrument that measures hospital inpatients' experiences and perceptions of medical care quality (<http://www.hcahpsonline.org/home.aspx>). The first reports the percentage of patients who gave the hospital a quality rating of 9 or 10 on a scale from 0 (*lowest*) to 10 (*highest*). For this item, a score of 0 corresponds to a rating of "worst hospital possible" and 10 corresponds to a rating of "best hospital possible." The second reports the percentage of patients who reported they would definitely recommend the hospital to others. About 90% of all acute care hospitals in the United States are represented in the HCAHPS survey findings annually (Giordano, Elliott, Goldstein, Lehrman, & Spencer, 2009).

In the analysis, we controlled for hospital size, the total annual volunteer hours worked, and the ratio of volunteer workers to paid staff. Such variables have been shown to be important in past volunteer analyses (e.g., Hager & Brudney, 2004, 2011) and in human resources research (e.g., Guthrie, 2001; Huselid, 1995). We measured hospital size in terms of number of beds.

Table 2. Twenty-Three VRM Practices, and Examples of Low-Commitment and High-Commitment Approaches to Volunteer Management.

VRM practice	Low-commitment approach to VRM	High-commitment approach to VRM
Written statement of philosophy regarding volunteer involvement	No written philosophy	Formal, written philosophy widely available to volunteers and paid staff
Written position descriptions for volunteer roles	No written volunteer position descriptions	Detailed written volunteer position descriptions
Written policies and procedures for paid staff working with volunteers	No written policies and procedures for paid staff working with volunteers	Formal written policies for paid staff
Periodic needs assessment to determine how volunteers should be involved to address the mission	No periodic needs assessments	Deliberate and strategic needs assessment performed periodically
Liability coverage or insurance protection for volunteers	No coverage	Some form of coverage
Reimbursement for work-related expenses of volunteers	None	Full reimbursement
Multiple media outlets (Internet, direct mail, volunteer recruiting fairs, etc.) used to recruit volunteers	Limited outreach and recruiting activities	Extensive outreach and recruiting activities, using multiple media
Volunteers are sought out based on having skills that match position requirements	Skills-match is a low priority when selecting volunteers for hire	Skills-match is crucial in volunteer recruitment
Formal volunteer screening and selection process (including position applications, interviews, background checks, reference checks, etc.)	Informal, unstructured screening, and selection process	Deliberate, structured screening and selection procedures
Orientation for new volunteers	No official new-volunteer orientation	Formal, structured orientation
Ongoing training and professional development for volunteers	Little or no ongoing training and development	Extensive training and development opportunities
Training for paid staff in working with volunteers	No training for paid staff working with volunteers	Formal training for paid staff
Paid staff new hires are told about why and how volunteers are involved in the organizations work	Volunteer involvement information not provided during paid staff new-hire orientation	Newly-hired paid staff are briefed on the role and involvement of volunteers

(continued)

Table 2. (continued)

VRM practice	Low-commitment approach to VRM	High-commitment approach to VRM
Volunteer administrator professional development activities	Administrator not provided funding for professional development	Volunteer administrator given allowance to join relevant professional associations, subscribe to journals or publications, or attend conferences
Designated administrator responsible for overseeing the management of volunteers agency-wide (for example, Director of Volunteers)	No dedicated volunteer administrator	Dedicated volunteer administrator
Volunteer administrator is involved in top-level organizational planning	Not included	Key player in organizational strategic planning
Supervision of volunteers	High degree of direct supervision; volunteers are managed "to task"	Low degree of direct supervision; volunteers are allowed to manage themselves
Every volunteer has a designated supervisor (could be one supervisor for multiple volunteers)	No	Yes
Formal conflict resolution or grievance procedures for volunteers	No formalized grievance procedures	Formal, institutionalized, and codified conflict resolution procedure
Volunteers are provided information about organizational issues and events	Not regularly	Volunteers receive regular updates
Newsletter for volunteers	None	Yes
Rewards and activities for recognizing volunteers and their contributions	Limited rewards and recognition activities	Consistent rewards structure for volunteers, and regular recognition activities
Rewards and activities for paid staff recognizing their support for volunteers	Limited rewards and recognition activities for paid staff working with volunteers	Consistent rewards structure and recognition activities for paid staff working with volunteers

Note. VRM = Volunteer Resource Management.

Analytic Approach

We used structural equation modeling (SEM) in LISREL 8.72 (Jöreskog & Sörbom, 2005) to test measurement and structural models, and gauged model fit with chi-square (χ^2), root mean square error of approximation (RMSEA), the comparative fit index (CFI), and standardized root mean square residual (SRMR; Kline, 2005). SEM is advantageous over traditional ordinary least squares regression in several aspects, such as allowing for improved construct validity of the variables of interest, providing more accurate parameter estimates, and allowing researchers to test a complicated model with multiple paths simultaneously and compare hypothesized models against alternatives (Wolf & Brown, 2013). We tested mediation by checking statistical significance of path coefficients of a mediational pathway (Kenny, Kashy, & Bolger, 1998).

To reduce the number of item parameters included in our model, we constructed item parcels for organizational strategy (originally 7 items) and volunteer management practices (originally 23 items) using procedures recommended by Hall, Snell, and Foust (1999). Item parcels refer to subsets of survey scale items summed or averaged to form composites (in our case, averaged item responses). The seven items representing quality-maximization and cost-minimization organizational strategies were parceled to form two analytic variables—the quality-maximization and cost-minimization strategic orientations. For volunteer management practices, items representing conceptually distinct categories of practices (for example, training and development or recognition and rewards) were composed into six separate item parcels.

Results

A five-factor measurement model (organizational strategy, volunteer management practices, volunteer human capital, motivation, and autonomy) fit the data well, $\chi^2(142) = 201.50, p < .01$; RMSEA = .06; CFI = .97; SRMR = .07, and all factor loadings were significant, suggesting convergent validity of the measures (Anderson & Gerbing, 1988). In addition, the five-factor measurement model fit the data much better than a model collapsing all items to one factor, $\Delta\chi^2(10) = 646.71, p < .01$; RMSEA = .19; CFI = .80; SRMR = .16, suggesting the discriminant validity of the measures.

The mediating model also fit the data well, $\chi^2(238) = 439.48, p < .01$; RMSEA = .08; CFI = .91. As presented in Figure 2, organizational strategy was positively related to the use of commitment-enhancing volunteer management practices ($\beta = .33, p < .01$) after controlling for the effect of hospital size ($\beta = -.18, p > .05$), total volunteer hours ($\beta = .62, p < .01$), and the ratio of volunteers to paid employees ($\beta = .02, p > .05$). Thus, Hypothesis 1 is supported.

A high-commitment volunteer resource management system is also positively related to volunteer ability to perform ($\beta = .46, p < .01$), volunteer motivation to perform ($\beta = .18, p < .05$), and volunteer opportunity to perform ($\beta = .55, p < .01$). Thus, Hypotheses 2a, 2b, and 2c are supported.

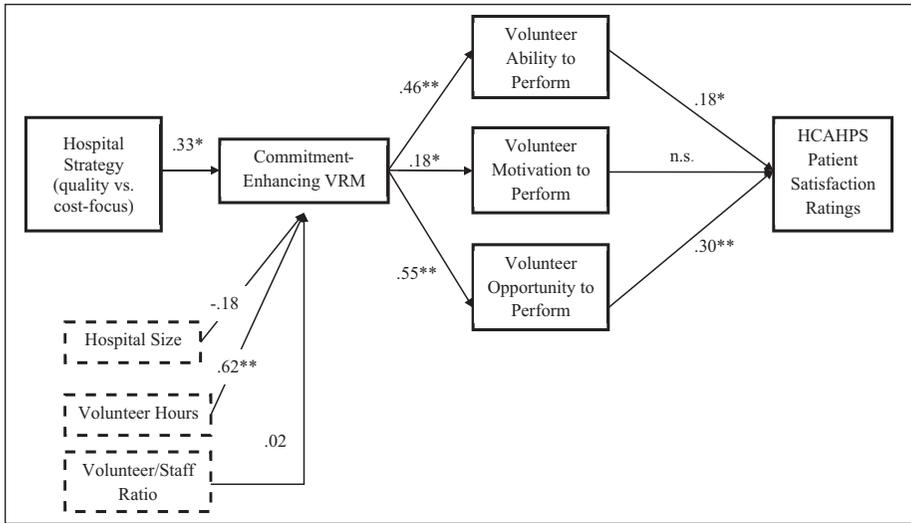


Figure 2. Structural equation model of the relationship between hospital strategy, volunteer resource management practices, volunteer attributes, and patient satisfaction.

Note. $n = 107$. VRM = Volunteer Resource Management; HCAHPS = Hospital Consumer Assessment of Healthcare Providers and System; n.s. = not statistically significant.

* $p < .05$. ** $p < .01$.

We found volunteer ability to perform and opportunity to perform to be positively and significantly related to patient satisfaction ($\beta = .18, p < .05$ and $\beta = .30, p < .01$, respectively); however, volunteer motivation to perform was not. Hypotheses 3a and 3c, but not 3b, are supported.

Discussion and Conclusion

In this Research Note, we used strategic human resource management theory to explore the volunteer–hospital patient satisfaction relationship. We found associations between hospital strategy, volunteer resource management, volunteer attributes, and patient satisfaction. Although causality cannot be assumed, our results are a preliminary step toward providing the “quantitative research” Brent Hotchkiss et al. (2009) call for to further “explore the relationships that exist between volunteerism and quality deliverables” (p. 16).

Starting from the middle of the model (at volunteer management practices) and moving to the right, our findings suggest that volunteer management and hospital outcomes are positively associated, suggesting the value in further research to determine whether volunteer resource management matters in producing better hospital outcomes. Although a positive volunteer–patient satisfaction relationship has been an anecdotal “mantra” of hospital volunteer departments, little quantitative evidence heretofore has been produced to demonstrate a link between volunteer resource management and outcomes.

The left side of our model—the organizational strategy–volunteer management utilization link—is also instructive. As Arthur (1992, 1994) noted, HR practices reflect an organization’s strategic orientation. We find evidence for this relationship with regard to hospitals. Does the finding that strategy is related to volunteer resource management mean that hospitals that have a cost-reduction orientation should just accept as fact a relatively lower-commitment approach to volunteer management? Our results suggest that organizational strategies may create cultural and operational dynamics that “pull” or “push” volunteer resource management in certain directions. However, any organizational pull toward less active volunteer management need not be the final word. Knowledge of the potential benefits of high-commitment volunteer resource management highlights the need for volunteer directors in resource-limited organizations to place greater emphasis on enacting such systems. Possible low-cost commitment-enhancing volunteer management strategies include the use of verbal recognitions, or the creation of a policy manual for volunteers and employees, to help them understand their respective roles.

One departure between our results and the strategic human resource management literature was our finding that volunteer motivation to perform was not positively associated with organizational outcomes (in this case, patient satisfaction). Considering our hypothetical staffing example proposed above concerning how motivation to perform might function, the process of fully exploiting the volunteer management–motivation–patient satisfaction relationship is a multi-pronged one in which volunteers not only need to be recruited strategically but also assigned purposefully to jobs. Perhaps some links in this hypothetical example are missing among the hospitals in our sample. We look forward to investigating motivation to perform and its possible relationship to patient satisfaction.

Our study has several limitations. Our sample was cross-sectional and limited to hospitals in five states in the northeastern and southern United States. Although our study is partially guarded against common-method bias by the use of data from three different sources (primary data, plus HCAHPS and American Hospital Association data sets), we asked volunteer directors to report the attributes of their volunteer workforces as opposed to obtaining those data from the volunteers themselves. Finally, our model leaves out a number of plausible explanations for a link between hospital strategic orientation and HCAHPS patient satisfaction scores, including employee performance and facility-specific characteristics (e.g., state-of-the-art buildings and equipment). Future research should develop more sophisticated models of the volunteer–patient satisfaction link and continue to fill-in the “black box” between volunteer management and organizational outcomes.

Volunteer administrators often lament that their efforts are underappreciated or go unnoticed. In the face of a changing health care system and an increasing concern with patient outcomes, our findings provide preliminary evidence that commitment-enhancing volunteer resource management is linked to patient satisfaction. If future research should support this narrative, it will become increasingly easy to justify investing organizational resources in volunteer administration and the volunteer workforce.

Appendix

Hospital Strategy

“The following statements refer to your hospital in general. Please indicate your level of agreement with each statement.” (1-5 scaling)

Quality-maximizing orientation

- My hospital seeks to provide the highest quality patient care, even if it means higher costs for the hospital and its patients.
- My hospital prides itself on delivering higher patient satisfaction than other hospitals.
- My hospital provides its paid employees above-industry-average wages and benefits.
- My hospital prides itself on having modern and technologically advanced medical facilities and equipment, even if it means spending more money.

Cost-reduction orientation

- Keeping operating costs and employee costs to a minimum is very important to my hospital.
- My hospital provides patients the care they need, but doesn't go out of its way to be an industry leader, especially if that means spending extra money.
- My hospital does not have a wealth of money and resources, so upgrades to buildings and medical equipment sometimes lag behind other hospitals.

Volunteer Ability, Motivation, and Opportunity to Perform

“The following has to do with your overall assessment of the performance and workplace behaviors of your volunteer workforce, in general. When answering, think of your volunteer workforce as a whole. Do not base your response on one, or a small portion, of your volunteers. Please indicate how often your volunteers exhibit the following workplace behaviors.” (1-5 scaling)

“OUR VOLUNTEERS . . . ”

Ability to perform

- Are highly skilled
- Are widely considered the best in our industry
- Are creative and bright
- Are experts in their particular jobs and functions
- Develop new ideas and knowledge

Motivation to perform

- Are always behaving in ways that help our hospital's performance
- Are always contributing in positive ways to the hospital's performance
- Are a highly motivated group of volunteers, compared with other hospitals

Opportunity to perform

- My hospital's volunteer jobs are arranged to give volunteers the chance to use their personal judgment in carrying out their work.
- My hospital's volunteer jobs allow volunteers to take part in making decisions that affect their work.
- My hospital's volunteer jobs give volunteers considerable opportunity for independence and freedom in how they do their work.

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