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Urgent Care Centers and Workersâ Compensation Medical Cost Containment

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This is to certify that the doctoral study by

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2020

Abstract

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by

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MS, Walden University, 2011

BS, Averett University, 2009

Doctoral Study Submitted in Partial Fulfillment

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Abstract

In response to healthcare payment policy reforms, billions of dollars in healthcare provider charges are challenged annually. Following the implementation of the Virginia workers' compensation medical fee legislation, healthcare organizations experienced declining worker compensation medical fee schedule reimbursements and lack of profitability. Grounded in the adaptive cycle model, the purpose of this qualitative single case study was to explore strategies 2 urgent care center (UCC) leaders in Virginia used to increase profits after implementing the Virginia workers' compensation medical fee legislation. Data were collected via in-depth interviews and a review of company documents. Thematic analysis was used to analyze data. The findings revealed 4 organizational strategies: develop controls, increase organizational knowledge, measure organizational performance, and evaluate products and services. Urgent care center leaders who adopt these strategies could develop a strategic plan that improves their bottom line. Implications for positive social change include the potential for healthcare leaders to assist UCCs and other healthcare organizations in navigating healthcare policy reforms to create sustainable organizations. A sustainable organization can increase access to care and strengthen the U.S. healthcare delivery system for individuals, families, and communities.

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Dedication

I dedicate this doctoral study and the significance of achieving this milestone to the memory of my late father, Joshua Ewell Barbour, and my mother, Margaret Eleanor Barbour, who laid the foundation for my life. Thank you for letting me see that hard work is enough, when you can walk away and know you did your best, regardless of the outcome, the work is enough. To my loving husband, Karl Anthony Thompson, for whom I thank God for bringing you into my life, I dedicate this finished product to you, who has sat on the sofa for long hours behind me without saying a word, and when I felt like I was sinking, refused to allow me to sink into discouragement as the years passed. This study is for you!

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First, to God be the glory, as I walk in this victory. Thank you to everyone that supported this process and me directly or indirectly. As the page is turning, a special thank you for my husband, without your patience, encouragement, support and love I would not be closing this chapter. I offer my deepest gratitude to Dr. William Stokes, my doctoral chair, who has provided encouragement and tangible contributions toward my growth as an academic scholar during this journey. You have provided stellar support and I can finally agree; the journey does eventually take a turn downhill. Thank you to other committee members, Dr. Janet Booker, who provided support for the foundational knowledge that frames fundamental research principles and Dr. Diane Dusick, for the purposeful comments to aid in guiding scholarly understanding and maturation that was instrumental to successfully navigate the final stages of this journey.

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Section 1: Foundation of the Study

As the discourse surrounding efforts to control United States healthcare spending grows, remuneration to providers continues to fuel momentum for sweeping changes in the healthcare market. Schakel, Wu, and Jeurissen (2018) cited a difficult debate existed surrounding the growth of healthcare cost ultimately resting on efforts to control quantity and price. The extant literature focuses primarily on macro-environmental factors to control access to care, quality of treatment, and reimbursement for medical services. Burns and Pauly (2018) evaluated the influence of the Affordable Care Act (ACA, 2010) and its intended purpose to advance the healthcare system toward value-based healthcare services and determined that the system improvements may be slow to be realized. The ACA and other healthcare policies geared toward controlling medical spending may contribute to how leaders in healthcare environments develop organizational strategy in the future.

Background of the Problem

In response to healthcare payment reforms that reduce medical treatment reimbursement, leaders in healthcare organizations must develop strategies to maintain sustainability. Escalating healthcare costs has emerged as an essential component of discussions among consumers, payers, and policymakers. Quality, access, and remuneration may present as key components to the center of debate surrounding medical services provided and level of reimbursement for healthcare treatment. Exponential growth in urgent care centers (UCCs) may reflect a paradigm shift in healthcare leader strategies to build sustainable value in response to the changing healthcare landscape.

UCCs provide urgent and primary care treatment for injury and illness in the healthcare delivery system (Urgent Care Center, 2017). Fiscella and McDaniel (2018) indicated that primary care facilitates an integral entry point in the healthcare system. Iglehart (2012) argued that policymakers and payers have engaged in much debate for the increased utilization of primary care medical practices promoting improved accessibility, coordination of care, and controlling medical remuneration. According to Bindman, Blum, and Kronick (2013), the primary care provider is the nucleus coordinating and transitioning patients back into the community after inpatient treatment. As such, primary care fosters early detection, preventative medicine, and sustainable patient relationships during the healthcare life cycle.

The 2016 Virginia General Assembly passed legislation that promulgated a workers' compensation medical fee schedule. Noveiry, Varzaneh, and Yousem (2018) researched 22,236 diagnostic procedure codes and highlighted the significance of reimbursement influences on healthcare provider revenue streams from fee schedule adjustments imposed by the Centers for Medicare and Medicaid Services. Enactment of the Virginia fee schedule may encompass a significant ripple in the landscape of workers' compensation medical treatment reimbursement for UCCs.

Problem Statement

Loeppke et al. (2015) cited the integration of primary care in employer health and safety programs as an integral factor influencing the health of more than 130 million Americans in the United States and globally. In a study of healthcare remittance data for 2013-2015, an estimated $11 billion dollars in healthcare provider charges were

challenged annually attributed to enactment of healthcare policy reforms (Gottlieb, Shapiro, & Dunn, 2018). The general business problem is some UCCs experienced declining worker compensation medical fee schedule reimbursement (FSR) that resulted in increased expenses and loss of profits for the business. The specific business problem is that leaders of UCCs lack strategies to increase profits after the inception of FSR policy reform in the workers' compensation system.

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies that UCC leaders used to increase profits after the inception of a FSR system. The targeted population was two leaders from a UCC in Virginia who have implemented strategies to minimize increased expenses and loss of profits due to FSR policy reforms. To remain viable in today's healthcare industry, healthcare providers must balance practice management with quality care (Lear, Fleig-Palmer, Hodge, Fleig, & Arensdorf, 2016) Findings from this study may contribute to positive social change in the business models of urgent and primary healthcare service delivery. Primary care practitioner growth using sustainable business models may occur through increased insights into proven business strategies that maximize profit. Bitton (2018) determined that leaders in primary care provider settings must adopt strategies to adapt to environmental fluctuations in healthcare landscapes. As a result, the leaders in primary healthcare settings may be able to offer increased opportunity to influence access, quality, and remuneration of care provided in the United States healthcare delivery system.

Nature of the Study

I considered qualitative, quantitative, and mixed method research for this study. Quantitative and mixed methods were not appropriate for the study because I did not seek empirical results to prove or disprove statements about leaders' strategies. The approach to this study was to allow participants to talk about their experiences in developing organizational strategies. Qualitative research methods provide participants the opportunity to talk about their lived experiences, opinions, and interactions with the interviewer and promotes in-depth exploration into a phenomenon (Molina et al., 2018). Qualitative method has proven advantages in gaining insights into understanding how to adapt to healthcare policy changes (Kilgour, Kosny, Mckenzie, & Collie, 2015). I selected a qualitative research method to explore leaders of UCCs sustainability strategies.

I considered ethnography, narrative, phenomenological, and case study research designs for this study. Ethnography, narrative, and phenomenological designs support observing participants in the natural setting. Kawulich (2005) suggested that participant observation fosters learning through purposeful engagement by the researcher in the day-to-day activities of the subjects. Since the intent of the study was to explore organizational strategic decision-making and not to observe participant activities, I did not select ethnography, narrative, and phenomenological designs. The case study design promotes in-depth exploration of a phenomenon in the context of the environment and landscape. According to Berg, Rørtveit, Walby, and Aase (2017), case studies provide rich descriptive knowledge of a phenomenon and promote depth in understanding. I

selected the single case study design to explore the decisions of UCC leaders that influence the development of sustainability strategies.

Research Question

What strategies do leaders in UCCs use to increase profits after the inception of a FSR system?

Interview Questions

1. What strategies do you use to increase profits for healthcare services provided to injured workers?
2. How has the implementation of a FSR influenced the strategies you use to increase profits for healthcare services provided to injured workers?
3. How do you measure the success of your strategies to increase profits after the implementation of a FSR system?
4. What barriers have you faced to achieving increased profits after the implementation of a FSR system?
5. What critical information do leaders of UCCs need to develop effective strategies, which minimize barriers to increasing profits after the inception of a FSR system?
6. What additional information would you like to add pertaining to the strategies leaders use to increase profits after the inception of a FSR system?

Conceptual Framework

The adaptive cycle was the conceptual model used to explore the strategic choice influences of leaders in UCCs to increase profits after the implementation of a FSR system. Miles, Snow, Meyer, and Coleman (1978) put forward the adaptive cycle model

by extending the work of some organizational strategy theorists. For example, Chandler (1962) researched large American buisnesses and identified that strategy determined the purpose, market, and resources needed to achieve sustainable firm performance. Comparatively, Rumelt (1974) researched post World War II corporate enterprises and determined organizational diversification of strategies varied how firms achieved goals and performance. Miles et al. (1978) asserted that an organizational paradigm emerged aligning strategy, structure, and process to organizational performance.

The adaptive cycle encompasses four organizational typologies: defender, prospector, analyzer, or reactor that represents descriptive categorizations of organizational behaviors exhibited in response to changes in the environment (Miles et al., 1978). Researchers use the constructs of the adaptive cycle to identify organizational characteristics that illustrate how organizational strategies influence firm performance (Maniora, 2018). For example, Beekun and Ginn (1993) applied the adaptive cycle to investigate the success of hospital strategic decision-making and determined open system interchanges fostered exchange of ideas versus closed systems creating a controlled atmosphere void of collaboration with internal and external actors. Similarly, Maniora (2018) researched US firms and identified linkages between typology classifications of organizational business strategies and ethical behavior in informing stakeholders of firm performance. The adaptive cycle promotes the exploration of leaders in UCCs strategy, structure, and processes employed to adapt to the adoption of a FSR.

Operational Definitions

Organizational strategy: Organizational strategy is the development of goals and processes to achieve outcomes. Kouamé and Langley (2017) determined that organizational strategy represented the convergence of firm operational, managerial, and labor knowledge and practices toward achieving maximum productivity in work systems.

Urgent care center: An urgent care center is a specialty primary care facility that provides treatment that is unscheduled and may occur during extended hours. Alberti and Morris, 2017 indicated urgent care centers provide an innovative, alternative care mechanisim that lowers the high cost associated with emergency department visits.

Worker compensation: Defines employer responsibility for employee injuries occurring in and from workplace activities (Howard, 2016). The requirement to provide medical treatment for occupational injuries is an employer responsibility.

Worker compensation injuries: Worker compensation injuries include injuries determined to be causally related to employment (Kilgour, Kosny, McKenzie, & Collie, 2015). Employer responsibility is established when injuries are linked to employment.

Worker compensation system: The worker compensation system is a public program that regulates employer response to employee injuries and worker compensation regulatory requirements (Mallon, Grizzell, Holland, & Hodgson, 2015). Employer financial liability for injuries is determined by legislation.

Assumptions, Limitations, and Delimitations

Assumptions, limitations, and delimitations are reflective of the macro considerations identified in selecting this study topic, that is, the agenda for the intersections, interactions, and boundaries in completing the research (Yin, 2016).

Assumptions

The study included four assumptions. Zukerman and Korn (2014) described assumptions as a display of generalized knowledge about situations and information. The first assumption was that leaders in UCCs possessed knowledge and understanding of the purpose and intent of medical fee schedules. This underlying assumption emerged from the ongoing remuneration debates fueled by workers and nonworkers' compensation policy reforms. The second assumption was leaders in UCCs operate with expanded hours and provided services for work-related injuries, which are compensable under the workers' compensation act. The third assumption was that leaders in UCCs were willing to answer questions concerning practice processes and potential FSR implementation influences. The fourth assumption was that a qualitative case study was an appropriate methodology and design to explore leader strategy for organizational positioning within a dynamic market.

Limitations

Limitations represent conditions that may reduce the validity of research outcomes (Rubin & Rubin, 2012). This study was subject to two limitations. One limitation was the geographic area for participants. I interviewed leaders in a Virginia UCC organization, which limits generalizability of the results to all UCCs. Another

limitation of the study was my knowledge of the subject matter. I have 10 years reviewing medical bills that included bill submissions from the identified provider groups, and in my role as the medical fee schedule manager, am responsible for monitoring and maintaining the new FSR. I disclosed the nature of my employment to each participant. To eliminate respondent bias from occurring, I encouraged participants to be factual in the responses to the interview questions.

Delimitations

Delimitations are the study's scope and boundaries (Yin, 2016). I omitted UCCs' experiences occurring in other states in response to workers' compensation payment policy reforms even though such comparisons could provide insight into possible strategic changes developed within those jurisdictions. Further, structured interviews of leaders within a UCC were scheduled. No other staff members were included. My initial consideration included transformational leader strategic decision-making; however, because the focus of the study was concentrated in health policy influence on firm strategy and not human resource and organizational strategy, I rejected this framework and selected Miles and Snow's adaptive cycle model. A final delimitation was the geographic location and sample size. It may not be transferable to apply the findings of this study to other UCC settings.

Significance of the Study

Regulatory changes, market competition, and technological innovations may have far-reaching implications on the healthcare industry. Healthcare leaders develop strategies to guide the trajectory of their organizations. The goal of this study was to offer

healthcare leaders who face variability in the regulatory environment potential lessons to increase organizational profitability.

Contribution to Business Practice

The outcomes of this study may guide change in business leaders' strategic decision-making. This study is expected to reveal the adaptability and strategic decision-making of leaders in UCCs in developing organizational strategies to increase profits. The results of the study may help refine the business practices of healthcare organizations by increasing the body of knowledge evolving healthcare organization strategies and market positioning. Exploring the actions of leaders in healthcare organizations to identify the challenges affecting their business, improve their strategic decision making, and promote organizational sustainability may promote the effectiveness of these leaders in delivering care to patients and building sustainable healthcare business models.

Implications for Social Change

Soklaridis, Cassidy, Van Der Velde, Tompa, and Hogg-Johnson (2012) indicated 10 employer groups identified medical cost and effective medical treatment as key factors to be considered in maintaining a healthy workforce. Urgent care centers are emerging into a dynamic healthcare ecosystem that may be influenced by employer reimbursement mechanisms. Firms entering into existing interconnected systems must develop strategic positioning to leverage uncertainty (Bock & Johnson, 2017). Maniora (2018) applied the adaptive cycle model to unveil which firm types are more likely to experience sustainability challenges in response to changes in market systems. The exploration of UCC leader strategic decision-making in defining strategies to increase profits after the

implementation of the FSR in the workers' compensation ecosystem is expected to reveal opportunities to minimize sustainability challenges and strengthen organizational performance. The strength of healthcare organizations in the healthcare delivery system influence care provided to injured workers. A healthy workforce is integral to the economic strength of the nation's economy. Ultimately, the results of the study may contribute to positive social change by improving (a) strategic decision-making of healthcare providers, (b) effectiveness of the healthcare delivery system, and (c) the health of the nation's workforce in the face of ever-changing reimbursement mechanisms.

A Review of the Professional and Academic Literature

The purpose of this literature review was to identify relevant and salient research on the strategies of UCC leaders to increase profits after the inception of a FSR system. Jong and Dembe (2006) researched 96,183 office visits for work-related conditions and discovered only 25.6% of treatment occurred in primary care provider settings and concluded that a disproportionate number of visits occurred in emergency department or other emergent care provider settings. Conversely, Chokshi, Rugge, and Shah (2014) indicated that healthcare delivery models were shifting toward increased utilization of UCCs and retail clinics (RCs). To illustrate further UCC impact in the healthcare system, during 2004 to 2016, UCCs averaged 300 new locations annually and provided primary and nonemergency medical treatment (Le & Hsia, 2016). Growth in UCCs promoted immediate access to care during high demands for nonemerging medical treatment (Memmel & Spalsbury, 2017). This paradigm shift from emergency departments to

UCCs provided further support to explore leader organizational strategic decision-making in urgent care business models.

Organization of the Review

The review of professional literature included purposive key word searches of scholarly and peer-reviewed journal articles, books, and electronic communications. Search terms included *urgent care center, medical fee schedule, worker compensation injury, strategic decision-making, health policy influence, environmental influences, provider remuneration, medical cost containment, episodic care, firm strategy, and strategic choice.* Gentles, Charles, Nicholas, Ploeg, and McKibbon (2016) concluded systemic review methods promoted critical analysis and synthesis of literature. I searched Business and Management databases including Business Source Complete/Premier, ABI/INFORM Complete, EBSCOhost, and ProQuest. Additional online search engines included Google, Google Scholar, and Bing. Ulrich's Serials Analysis System online website provided the source to validate if articles were peer reviewed. The foundation for the literature review of this study was to present a comprehensive review of the phenomena evolving from the literature related to increasing profits in the face of policy changing reimbursement mechanisms. The constructs of the study provide pivotal underpinnings for the foundation of this literature review. The literature review includes support for alignments between the constructs of this study and the research problem.

I developed the review of the literature on organizational strategies within UCCs using three focus areas: critical analysis and synthesis of the conceptual framework,

analysis of literature surrounding the historical footprint for UCCs, and critical analysis and synthesis of the phenomena surrounding organizational strategies to increase profitability in the face of legislative mandates.

Strategy for Searching the Literature

The literature review includes 282 online scholarly sources of which 93% were peer reviewed. Of the total scholarly publications, 242 were published after 2014, and 88% were published and peer reviewed after 2013. The remaining sources not published prior to 2013 and not peer reviewed within 5 years were included for historical points of reference providing context to topic outcomes. Table 1 provides a summarization of the resources identified for the study and the review of the literature.

Table 1

Sources of Data for the Literature Review

Reference Type	Published Period I 2014	Published Period II <2014	Total Sources	Peer reviewed	Literature Review PR
Journals	230	32	262	91%	93%
Dissertations	3	0	3	N/A	N/A
Seminal books	8	8	16	N/A	N/A
Government	1	0	1	N/A	N/A

Government entities and nonprofit organizational information reviewed included the Virginia Workers' Compensation Commission and Urgent Care Association of America (UCAA) online websites that provided regulatory, certification, and accreditation processes for urgent care centers. The literature review includes a review of two textbooks that informed topics surrounding performing case study research and underpinnings for the conceptual framework. While the peer reviewed literature included

numerous publications on UCCs treating illness and injuries, there were few on UCCs and organizational strategic decision-making with respect to the treatment of workers' compensation injuries and illness. A larger number of literary sources were available on UCCs and treatment of episodic illness and injury.

Critical Analysis and Synthesis of the Conceptual Framework

The conceptual framework binds the literature review. D'Andreamatteo, Ianni, Lega, and Sargiacomo (2015) concluded that a comprehensive literature review included identification of empirical and theoretical articles that highlighted the topical focus of the study. The adaptive cycle model provides the vehicle to explore leaders in UCCs strategy, structure, and process. Supporting and contrasting views identified in the literature for the organizational adaptive cycle model and indicators for firm performance were presented. Secondly, the purpose of this qualitative, single case study was to explore strategies that leaders in UCCs in Virginia use to increase profits after the inception of a FSR system. As such, I concentrated synthesis of studies that align with the conceptual elements identified in the research topic. An analysis and synthesis of the literature on the adaptive cycle model served as the means for exploring leader decision-making in developing UCC organizational strategies. A lens into leader identified product market domains and construct mechanisms laid the foundation for UCC categorization as defender, prospector, analyzer, or reactor type. Gila et al. (2015) determined that an integral component to elevate the research process included comprehensive approaches guided by established frameworks. Categorization of UCC type may parallel the positioning of organization market placement and inform leader strategy in the face of

environmental fluctuations. Organizational strategies adopted by leaders in UCCs may be an integral factor in defining firm sustainability and performance outcomes. However, prior to a detail exploration into the intersection of the conceptual model and the research topic, it was first important to frame the foundation for organizational strategy, structure, and process alignments with historical underpinnings of the adaptive cycle model.

Strategy. At the foundation of strategy formulation, are decisions regarding goals, collection, and analysis of information, final determinants, and implementation of activities. Within the field of organizational studies, Miles and Snow introduce the importance of how strategy coupled with leader use of strategy propels an organization forward in performance from the current to a future state. Burgelman et al. (2017) determined the strategy phenomena comingled activities and processes surrounding communications to adapt and develop frameworks for action. Leaders in UCCs may find it challenging to promote strategies that balance expansion activities, processes to improve organizational performance, and changes in medical treatment remuneration attributed to the establishment of maximum healthcare reimbursement schedules. Hautz, Seidl, and Whittington (2017) framed determinants underlying research for transparency and inclusion in identifying key dilemmas affecting strategy development. Stai, Karyotis, Bitsaki, and Papavassiliou (2017) determined evolutionary stable states (ESS) and user strategic decision-making for information diffusion within generalized networks aligned with changes in adaptations to user preference and decision-making over time. Zhang, Chen, and Li (2017) determined adaptations to competing strategies and dynamic mechanisms influence how user strategy evolves. A premise for the use of adaptive cycle

might include the classification of organizational activities that evolve how leaders in organizations identify, design, and implement strategies in response to internal and external challenges. Uhl-Bien and Arena (2018) determined organizational adaptability requires senior leaders in organizations to transcend beyond traditional roles of leading change to creating an environment in which the organization is poised to utilize its resources to infuse known facts with probable outcomes as a method to manage the chaos of dynamic landscapes promoting implementation of organizational strategy. Within the research of Miles and Snow, strategy effectually becomes the nucleus surrounded by other navigation tools such as organizational structure and process to guide expectations for the trajectory of organizational performance**.**

Structure. Researchers define organizational internal determinants such as management decision-making authority, firm financial strength, and innovation readiness as key considerations in determining an organization's structure. Sharpe, Mehta, Eisenberg, and Kruskal (2015) determined organizational financial strength was a pillar to successful strategic adoption and deployment via the use of available resources to fund strategic directives. Graham, Harvey and Puri (2015) and Busenbark, Wiseman, Arrfelt and Woo (2017) further illustrated that leader decision-making to delegate capital allocation functions provided further insights into researching potential successes and failures within an organizational structure. Brunner et al. (2017) and Tuncdogan, Boon, Mom, Van Den Bosch and Volberda (2017) framed the importance of developing effective teams to drive advances in innovation that yield better outcomes and promote firm performance. High cost, limitations in access, and consumer inconveniences

attributed to historical healthcare models may lay the foundation for further UCC growth strategies. Leaders in UCCs may be required to identify and exercise sound use of capital allocations and delegation of financial decision-making to position the organization to develop more effective innovation readiness strategies in response to changes in healthcare treatment complexity, legislation, provider alignment, and dynamics associated with a landscape of changing consumers and demand for services.

Processes. Boje, Baca-Greif, Intindola, and Elias (2017) determined it was integral to measure how well organizations digested information and created knowledge perpetuated by accepted or rejected decisions and activities as the organization navigates its current, future, and projected positioning within its landscape. The series of activities and methods in which the organization diffuses information, creates learning, and responds to fluctuations in its environment in order to achieve goals encircle adopted processes. A paradigm encompassing linkages between successes and failures in defining organizational process development and implementation to firm performance exists. Madanoglu, Kizildag, and Ozdemir (2018) presented arguments that organizations, which pro-actively developed comprehensive campaigns, geared toward engineering progressive sustainability processes exceeded organizations that developed minimal or marginal firm sustainability measures. Processes may depict organizational learning activities, information mapping of instruments, and working activities, which orchestrate management strategic choices toward promoting value attainment in organizations.

Adaptive cycle model. The adaptive cycle model extends the research on organization strategy by Chandler and Rumelt toward defining trends in organizational

behavior that drive firm performance. The adaptive cycle model, first proposed by Miles et al. in 1978, categorizes the strategies an organization adopts to adapt to changing environmental conditions. Miles et al. based the findings of a study of 84 firms and organizational strategies within college textbook publishing, electronics, food processing, and hospital industries to inform managerial choice and decision-making in dynamic environments. Miles et al. determined that organizational decision-making over time exhibited patterns of behavior defining how organizational response to environmental disruption evolves. At the core of organizational response are business level decisions designed to solve internal constraints influencing firm strategy, structure, and processes. The researchers identified a dynamic process (adaptive cycle) separates constraints leaders must continuously navigate into three categories: an entrepreneurial problem, an engineering problem, and an administrative problem.

Strategy is the core antecedent of the adaptive model. Porter (1985) defined strategy as a series of choices. Healthcare leader organizational strategy plays a critical role in firm performance. Fiscella and McDaniel (2018), O'Reilly et al. (2017), and Rosen et al. (2018) discovered linkages between effective teamwork and collaboration strategies to improved healthcare outcomes. Kash, Baek, Davis, Champagne-Langabeer, and Langabeer (2017) completed a review of hospital readmission rates and concluded hospital health information exchange strategies promoted improvement in population health from reduced readmissions. Hayes, Wolf, Labbé, Peterson, and Murray (2017) determined primary care organizational strategies surrounding practitioner communications with obese patients influenced efficacy of obesity treatment and

management protocols. Sturgeon (2017) argued that effective strategies involve efficient administrative use of resources. Nadeem, Abedin, Cerpa, and Chew (2018) identified innovation adoption promoted organizational level strategies surrounding resource management, business process reengineering, and competitive advantage.

With the nature and velocity of challenges influencing the healthcare landscape for some organizations, leaders must strive to align strategic decision-making to keep pace and manage current and future expectations amid competing priorities. UCC leaders might find it challenging to manage evolutions in reimbursement models, care delivery, and new entrants into the competitive landscape attributed to growth in number of UCC locations.

Entrepreneurial, engineering, and administrative problems. Leaders in healthcare organizations face internal and external challenges to defined organizational strategy. Krystallis, Demian, and Price (2015) identified an urgent need in the healthcare industry to adopt holistic strategies in response to dynamic environmental shifts and rapid implementation of advances in medical technology. Miles et al. (1978) indicated varying business level strategic decisions present in organizational responses attributed to managing products, services, and fluctuations in market share. Strategic decisions encapsulating the selection of the product and market domain in which a firm competes and allocates resources are reflective of the stage in the adaptive cycle in which the firm responds to entrepreneurial constraints. Bates, Sheikh, and Asch (2017) identified an emerging opportunity for firm sustainability in healthcare organizations highlighted strategies that prioritized linkages between innovation and firm performance. Mazzei,

Ketchen, and Shook (2016), Provasnek, Schmid, Geissler, and Steiner (2016), and Roundy, Harrison, Khavul, Pérez-Nordtvedt, and McGee (2017) identified innovation as a key indicator of effective organizational strategies in response to entrepreneurial problems.

In comparison to entrepreneurial constraints, there appears to be subtle dependencies exhibited to that of engineering constraints. The engineering problem encompasses strategic decision-making concerning the processes and mechanisms to deliver products and services to market. The processes and systems implemented by leaders in UCCs may postulate outcomes for firm performance. Miles et al. (1978) discovered that patterns emerged attributed to the strategies firms employed to secure technical systems to produce products and deliver goods. Organizations navigating this stage in the adaptive cycle to define systems and methods of product delivery exhibited alignment between critical activities and firm strategy. Ellner and Phillips (2017), Feldman (2017), Hirsch, Rosenkrantz, Bibb, Manchikanti, and Nicola (2016), Kravitz and Feldman (2017), and Rehm, Marquez, Spurrell-Huss, Hollingsworth, and Parsons (2017) researched influences of organizational capabilities in response to internal activities and constraints requiring coordination with external factors to promote sustainable innovation and implementation performance. As such, the engineering problem presents as the mechanism to implement strategic solutions to entrepreneurial challenges.

Processes and procedures defining how the organization intends to move toward accomplishing strategies in response to entrepreneurial and engineering challenges

present in administrative problems. The structure of the organization influences implementation of solutions to engineering and entrepreneurial challenges. Felin and Powell (2016) identified that organizational structures articulate a firm's ability to harness dynamic capabilities toward fashioning responses to identify, design, and seize opportunities promoting sustained performance. Provider remuneration, promotion of integrated models of care, and demands for efficiency in healthcare systems may represent determinants for UCC predictability toward implementing strategies in response to administrative problems. deGruy (2015) cited primary practice integration modeling for systems and resources created disturbances in clinical settings that are often unpredictable and difficult to navigate. Prybutok (2017) supported changes to a commonplace process delay in hospital emergency specialty care, which challenged organizational strategy for acceptable patient wait times. Miles et al. (1978) indicated that organizations exhibited patterns of adjustments in internal interdependencies in selecting mechanisms to implement strategies geared toward solving problems affecting product domain and delivery systems. The adaptive cycle encompasses varied firm strategies designed to respond to the constraints within competitive landscapes. The entrepreneurial problem relates organizational strategic orientation to product development and market placement. The engineering problem includes systemic requirements management deploy for production and distribution of defined products or services. The administrative problem represents the management of uncertainty, streamlining, and stabilizing process development, structure, control mechanisms, and strategies required to implement and control the product or service, technology, and potential future innovation. Miles et al.

suggested firms developed similar solutions to entrepreneurial, engineering, and administrative problems. As a result, similarities among varied organizational strategic behavior patterns mirrored one of four strategic types: prospector, defender, analyzer, and reactor.

Prospector, defender, analyzer, and reactor characteristics. The adaptive cycle model classifies organizational strategy using a subjective lens into one of four patterns of strategic decision-making. McCarthy, Collard, and Johnson (2017) indicated that every organization exhibited distinct characteristics, which frames how the organization responds to change based on its organizational model. Innovation and growth are key determinants reflective of the prospector firm. Prospectors view their market domain through a wide lens. Miles et al. (1978) indicated prospector firms' entrepreneurial problem encircled promoting the development and exploitation of new products, services, and technologies. Frambach, Fiss, and Ingenbleek (2016) and Tollin and Christensen (2017) further identified that a successful marketing strategy was a key determinant to firm performance. Viers et al. (2015) researched healthcare provider organizational strategies promoting telemedicine and mobile healthcare innovations fostering opportunity for radical change in healthcare delivery models attributed to declining provider reimbursement. This type of healthcare innovation may parallel the movement of growing UCC organizations in the healthcare delivery continuum. Each might catalog the influence of innovations disrupting the healthcare environment.

Prospector organizations may succeed in disruptive environments by being the first to implement initial products and services to its market domain. Kafchehi, Hasani,

and Gholami (2016) identified that firms strived to find unique methods to position their products and services in dynamic market domains and therefore are innovative oriented. However, constant innovation may require extensive resource utilization to seek out new products. Prospectors' engineering problem may stem from system adaptability to continuous innovation. There is insufficient time for repeat testing and refinement of processes or products to identify potential risk. Gokus (2015) proposed that prospector organizations measure fluctuations in market turbulence and competitive intensity in considering innovation strategies to minimize risk engaging in multiple product markets simultaneously. An administrative problem for prospectors might evolve in the absence of effective internal control mechanisms as it seeks to increase market presence. Bentley-Goode, Newton, and Thompson (2017) determined that accounting prospector firms exhibited weak internal control mechanisms and were not responsive to developing quality improvement campaigns to mediate weaknesses identified.

In comparison to prospector firms, defender types' purpose is to secure a stable product offering in its domain and exhibit narrow market focus. The expectation is that the organization will become the premier service provider for its market domain driven by internal strategy to specialize in its selected products and services. Miles et al. (1978) determined that defender organizations calibrate strategies promoting consistency in achieving high quality and efficiencies with selected products and product domain. The entrepreneurial problem takes form in its defense of its share of the market. Corwin, Parker, and Brown (2016) and Pearson, Tao, Kroeger and Peterman (2017) indicated UCCs' emergence in the healthcare landscape provided a viable response for specialized

services meeting market demand for immediate and emergent primary care for nonlife-threatening injury and illness previously provided in higher cost hospital emergency department settings. Maniora (2018) identified defenders were deliberate in harnessing adaptive capability by purposeful product selection and placement limiting the need to make major engineering adjustments. Miles et al. determined defender firms responded to administrative problems using a bureaucratic top down approach to managing operations with a focus on strategic decision-making guiding the organizational focus to achieve efficiency and devoting resources to refining its operations.

The prospector and defender firm organizational strategies present as polar opposites on the organizational strategic decision-making continuum. Bedford, Malmi, and Sandelin (2016) studied variances in prospector and defender management control and determined defender firm management control complements included strategic decision-making for critical performance variables and formalized process development or performance measurement; conversely, prospector firm control complements included structural evolutions in response to strategic uncertainties. Navissi and Sridharan (2017) identified wide variances in prospector and defender determinants in defining risk strategies and reliance upon market factors to establish cost structures as exhibited in the defenders adoption of target costing facilitating stable environments and defined profits versus prospectors declining adoption of target costing attributed to perceptions that flexible cost structures created flexibility to innovate and create resulting in potential for increased profits. Yu, Eshleman, and Soileau (2017) identified variances between defender and prospector firms' commitment to achieve performance projections,

retention of current assets, and meeting financial obligations as key determinants of firm sustainability and identification of critical weaknesses in auditing control mechanisms. Organizational product selection, distribution, and governance drive variances in strategic decision-making. Miles et al. (1978) posited that the pace in which the organization adopts innovation, degree of flexibility to produce products, and the general principles guiding daily operations represent key factors influencing organizational strategy.

Roles exhibited in prospector and defender types emphasize strong positioning toward innovation or stabilizing existing operations. Analyzer type organizations might express unique factors reflecting hybrid approaches to organizational strategy. The analyzer typology stresses equilibrium in organizational strategy decisions. Sorek and Benjamin (2016) determined in researching healthcare policy such as the ACA that mere focus on increasing the insured population was insufficient, equal attention should be allocated to ensure subsidies for financing premiums were prioritized. In comparison to enactment of the ACA, the Virginia General Assembly may have determined that an equilibrium state encapsulated the development of a workers' compensation medical fee schedule with due consideration to preserve provider remuneration for a given period of time was the most effective approach to reducing medical injury and illness cost. Miles at el (1978) posited analyzer firms exhibit organizational strategy medial to prospector and defender firms. Analyzers balance production efficiencies for current products against resource utilization in identifying innovations and market space. Analyzer organizations may exhibit a regimented view of the market, competition, methods, and techniques of operations to ensure a stable endogenous environment. The cautious state of the analyzer

firm requires dual operational strategic mechanisms. The entrepreneurial problem stems from its focus to maintain existing products and services using innovative methods. The engineering problem presents in conflicts, which may arise between organizational strategies to increase efficiency and resource demands for product and service development. The administrative problem exhibits in firm processes to balance being efficient and flexible to sustain its current market and grow competitively. Vallaster (2017) indicated analyzer firms innovated by refining current products, identifying efficiencies, and improvements.

Compared to prospector, defender, and analyzer types, reactor typologies exhibit the lesser strategic driven behavior. Ravenhorst and Huvser (2014) determined that reactor typologies lack defined strategic decision-making and are unstable. Miles et al. (1978) indicated reactor organizations lack a systemic strategy to respond to internal and external disturbances. Structure and process configurations are lacking. The omission of structure precludes identification of reactor type engineering, entrepreneurial, and administrative problems. Reactors develop responses aligning with leaders' perceptions of the environment.

The adaptive strategies may provide some indication of variances exhibited in firm performance among each typology. Prospector organizations present as highly adaptive while reactor organizations appear the least adaptable. Defender and analyzer firms reflect strategies between prospector and reactor extremes. Miles et al. (1978) presented arguments framing the characteristics, which organizations exhibit in response to environmental change agents. The characteristics are exemplary of leaders' strategic

decisions in defining business level strategies in response to dynamic landscapes. Sharpe (2015) determined that linkages emerged in healthcare firms with defined strategic decision-making determining sustainable organizational performance. Adaptive strategies may parallel linkages to firm sustainability and performance over time.

Comparison of views on organizational strategy classifications. In theory, organizational strategy research is a precursor to identify organizational behavioral characteristics, which harness and exploit capabilities and create value. Miles et al. (1978) Thurgood, Barrick, Smith, Courtright, and Thurgood (2018) demonstrated that businesses exist for a defined purpose and mechanisms exist to promote achievement of the purpose. Firm performance is an integral construct in organizational strategy research. Researchers in support of the adaptive cycle model found consistent evidence of alignments between organizational strategy and firm performance.

Hao and Song (2016) and Mandal and Bagchi (2016 indicated that key factors influencing firm performance exhibited during organizational alignments among strategy, structure, and processes. These mechanisms define the basis for the strategies organizations employ. Ravenhorst and Huyser (2014) researched the effectiveness of human service providers using a strategy classification system affirming the research of Miles and Snow as being an effective classification tool to measure organizational strategy. Sollosy, Guidice, and Parboteeah (2015) extended the adaptive cycle theory to include ambidexterity and illustrated that consistent firm performance within dynamic environments paralleled consistent approaches to developing strategies to solve entrepreneurial, engineering, and administrative problems. Shortell and Zajac (1990)

affirmed that researchers use of the adaptive cycle model as an effective means to research organizational strategic orientation via a study of 574 hospitals. Shortell et al. (1995) expounded upon the adaptive cycle model and developed a defender and prospector ordinal scale to measure hospitals' implementation of total quality improvement and management initiatives. Forte, Hoffman, Lamont, and Brockmann (2000) utilized the adaptive model incorporating influence from corporate structural changes between and within organizational forms in the measurement of firm performance. Hambrick (2003) insisted that there were various combinations of impacts for researchers and managers to assess in making business choices, to that end strategic classification systems such as Miles and Snow's adaptive cycle model provided one of the more effective instruments to assess firm strategy. Akman, Ozcan, and Hatipoglu (2015) utilized the adaptive cycle model to classify organizational strategies toward its prowess to innovate competitive advantage.

Conversely, Porter (1985) argued that a strategy paradigm existed in which the firm positioned itself strategically in its market through activies surrounding cost leadership, differentiation, and focus strategies. Within the generic strategy framework, firms market positioning parallels its efforts to adapt to environmental flux. Porter and Lee (2016) researched the strategic direction change in operational focus adopted by a Utah healthcare team to priorize its operations around improving value of service, measurement to achive value, and internal organizational adoption of Center of Medicare and Medicaid commitment to reward value based medical treatment. The role of healthcare providers in the U.S. healthcare delivery system has evolved from institutions

providing social welfare to the indigent funded by donations from the wealthy to complex organizations with business models that must promote quality care, educational, organizational, financial, regulatory, and social objectives. There is a fundamental need to manage healthcare data in order to make informed decisions. Internal and external forces continually alter leader strategy development in healthcare organizations. Demands from consumers, regulatory agencies, policymakers, and payers play a role in day-to-day operations of organizations. Disruptions in traditional forms of healthcare financing, delivery models, and quality metrics have heightened the need for leaders in healthcare organizations to develop firm strategies and employ innovative processes and standards in order to promote effective firm performance.

Population Health

The continuum of care in the U.S. healthcare system ranges from improving individual patient outcomes to improving healthcare outcomes for the nation's population. There are systemic challenges embedded in the U.S. healthcare system, which permeate throughout the healthcare landscape. Escalating healthcare cost, uninsured patient populations, and failures to improve overall quality of care provided may present in a stressed healthcare delivery system. Flores and Lin (2013) identified cultural, social, and economic stressors influenced healthcare landscapes. Individuals, employers, medical providers, and insurers are key stakeholders affected by access to care, quality of care, healthcare cost, and policy reforms.

The sustainability of the healthcare system in the United States has been a prominent subject area for research attributed to concerns with healthcare medical

treatment utilization patterns, cost, and provider populations. Giesbrecht et al. (2018) researched how access and efficacy of care options paralleled fluctuations between place and type of services provided. Brooks, Gorbenko, and Bosk (2017) determined quality improvement strategies in hospitals required continuous engagement and commitment from those stakeholders impacted by its services.

Analysis of Medical Treatment Utilization Patterns and Cost

The extant literature revealed relationships between healthcare treatment utilization and costs. For example, Losina et al. (2015) observed frequencies in the influence of total knee arthroplasty (TKA) on lifetime medical costs and determined that primary and secondary treatment associated with (TKA) resulted in 10% of lifetime medical costs. van Boven et al. (2016) argued that adherence to medication interventions were an integral factor relative to cost effectiveness. Adrion, Aucott, Lemke, and Weiner (2015) studied the influence of post treatment for Lyme disease management on increasing healthcare expenditures and concluded post treatment protocols exacerbated the total cost of care and resulted in a 66% increase in utilization of outpatient healthcare services. Peery et al. (2015) quantified the implications of gastrointestinal and liver disease on morbidity and mortality, in connection with overall medical cost factors. Taylor et al. (2017) examined veteran healthcare utilization and costs associated with traumatic brain injuries (TBI) and determined trends in veterans' healthcare expenses increased 20-25% annually and required additional fees associated with post TBI mental health services. Wiertsema et al. (2017) developed a Transmural Trauma Care Model (TTCM) to establish defined intake procedures, coordination of TTCM care for patients,

unique physical therapy care plans, and electronic communication for treatment outcomes to identify opportunities to promote efficiencies in trauma care. Brezinski, Dhillon, and Armstrong (2015) determined the cost for psoriasis care in the United States reached approximately 112 billion dollars during 2013. Variations in utilization and cost research suggest a heightened concern for the efficacy of the healthcare delivery in the U.S. health system. These concerns may influence utilization and cost in treating occupational injury, illness, and disease.

Healthcare Provider Policy Implications

There are varying influences at play in enactment of legislation influencing the healthcare landscape. Potrafke (2018) cited the influence of ideology at the state level as a mechanism driving enactment of economic policy. Political action associations and public demand for equitable healthcare services may influence policy makers' actions. The Patient Protection and Affordable Care Act exhibit a renewed focus on population preventative and wellness care. Fuchs (2018) cited ACA expanded insured populations; however, cost of care remained consistent. Sacks (2018) projected the state of Virginia would experience high 2019 insurance rate increases in response to health insurance marketplace demand. Gaynor, Mostashari, and Ginsburg (2017) argued the U.S. healthcare system had experienced negative influences as market forces encourage provider consolidations and reduced market competition reflective of declines in primary care practices. The expansion of insured consumers and demand for increased access to care may have precipitated increased variations in traditional primary care provider models.

Within the healthcare landscape, researchers explored indications that suggest leaders in healthcare organizations will experience difficulties navigating mechanisms targeting escalating healthcare cost and negatively influencing profitability. Numerous researchers (e.g., Burwell, 2015; Casalino, Erb, Joshi, & Shortell, 2015; Frech et al., 2015; Kaufman, Spivack, Stearns, Song, & O'Brien, 2017; Lewis, Tierney, Colla, & Shortell, 2017; Rose, Zaslavsky, & McWilliams, 2016; Shortell et al., 2015; Stuart et al., 2017; Trosman et al., 2017; Walker et al., 2017) discussed challenges attributed to expansion of accountable care organization (ACO) models and reform efforts to improve provider efficiency, value of healthcare services, and reduced healthcare cost for population health.

Researchers further determined that in pay-for-service contractual agreements or defined maximum reimbursement schedules, leaders in healthcare organizations must navigate a changing healthcare landscape that places increased focus on achieving the most effective medical care at the lowest cost. Obama (2016) argued that value-based payment mechanisms primarily linked to the affordable care act played a role in reformations occurring in private sector healthcare landscapes. Similar to the ACA, the Virginia Workers' Compensation Act code § 65.2-605 defines the maximum liability of employers for medical services provided for work-related injuries. Leaders in UCCs may require strategies to engage with injured employee populations. Under Code §65.2-603, employers are required to provide to injured employees a panel of three physicians selected by the employer. Leaders in UCCs treating occupational injuries may experience

similar challenges with policy reforms that parallel efforts to promote change in medical treatment cost for occupational injuries.

Analysis of Urgent Care Center Evolution

Although there are dynamic mechanisms influencing strategy, structure, and processes in healthcare landscapes, continuous concern presents for healthcare leaders in developing sustainability strategies attributed to fluctuations in consumer choice and healthcare financing. Lee, Lim, Chia, Ea, and Yap (2017) identified consumer expectation for convenience and delivery of healthcare services presented noteworthy concern for healthcare organizations. Makarem and Al-Amin (2014) determined organizational and market factors surrounding access to physicians, service differentiation, and the competitive landscape promoted changes in consumer choice for healthcare providers. The patient autonomy paradigm has permeated the healthcare landscape and continues to evolve provider selection and patient-provider relationships creating demand for collaborative healthcare protocols (Rubeis, Schochow, & Steger, 2018).

A transition in the healthcare industry attributed to the patient choice paradigm is proliferating through the healthcare landscape. Nan, Finkelstein, Kruk, and Rosenthal (2017) cited attributes such as perceptions of personal health and individual satisfaction with a health system differentiated healthcare utilization patterns. Boston-Fleischhauer, Rose, and Hartwig (2017) studied a single hospital system's strategy to achieve seamless care for multiple comorbid patient populations and determined coordination of healthcare across disparate systems aligned with preferences for continuity of care. Nicholas,

Fogarty, Boydell, and Christensen (2017) researched consumer preference and adoption of mobile mental healthcare (mHealth) and determined that although mHealth provided same or similar benefits to traditional mental health models, there was minimal mHealth utilization. Wright, Ulph, Dharni, and Payne (2017) researched consumer preference for newborn bloodspot screening results and determined that future parents' health literacy influenced types of screening and communication of screening results. McColl-Kennedy et al. (2017) researched the influence of consumer preference on healthcare provider practice and determined that consumer behavioral patterns were migrating from the provider as the sole authority guiding selected treatment toward a collaborative approach where the customer actively participates in identifying the most effective treatment protocol.

Consumer choice in selecting preferred services represent critical influences to services offered by healthcare providers. Healthcare treatment is intended to promote efficacy in public health and is a staple of healthcare. In the U.S., healthcare service utilization follows consumer choice patterns. Professional services provided by practitioners rest at the heart of the healthcare delivery system. Scott, Orav, Cutler, and Jha (2017) identified during 2003 to 2012 there was 13% growth in conversions from hospitals providing physician privileges to hospitals directly employing physicians. Richards, Smith, Graves, Buntin, and Resnick (2017) determined horizontal and vertical integrations altered physician numeration and services provided.

During the 1970's, urgent care emerged in the United States during the period in which emergency medical physicians identified a need for treatment protocols in

response to consumer demand for urgent care, which presented in emergency care environments. Parks, Hoegh, and Kuehl (2015) determined steady growth in emergency department (ED) utilization by uninsured and lower income patients stressed the healthcare system. Over utilization of life sustaining emergency healthcare services for treatment otherwise occurring in urgent care settings ushered in a demand for urgent primary care. Kaissi, Shay, and Roscoe (2016) identified urgent care centers emerged due to market demand for immediate care and accessibility options for episodic primary care. Shrank (2017) determined urgent care provider utilization aligns with consumer demand for convenience and time-sensitive medical treatment. The urgent care industry may have experienced increased expansion during the 1990s and 2000s primarily due to significant increases in the awareness of healthcare, the difficulty in receiving primary care, high emergency room utilization, and changes in consumer awareness and demands.

The initial construct of UCCs may provide indication of environmental influences and effects on strategic decision-making in response to consumer demand and market positioning in the healthcare landscape. Woodrum (2016) framed the growth in UCCs in terms of ownership and cost highlighting three models of care: hospital referrals to lower cost adjacent settings, physician owned after hour's clinics, and private investor groups owning freestanding urgent care operations. The relative nature of ownership might include indication for strategic decisions guiding firm performance. Alberti and Morris (2017) cited consumer health literacy as a key determinant driving utilization of urgent care centers. Consumer populations driven by cost may seek to utilize UCCs as a means to reduce out of pocket expenses. Similarly, consumers seeking immediate care may find

UCCs provide the most convenient access to healthcare treatment and services with reduced wait times. Memmel and Spalsbury (2017) further identified UCCs provided increased medical pathways and access to immediate care that is nonemergent. Dominick, Widmar, d'Acunto, and Acharya (2018) and Villaseñor and Krouse (2016) determined that the location of UCCs influenced consumer utilization patterns. Medical industry constructs surrounding trends in opioid addiction treatment, demand for alternative healthcare access points, and flexible care options plays a role in strategic placement of healthcare facilities and principles associated with providing emergency medical services (Widmer, Swanson, Zink, & Pines, 2017). Ashton (2017) attributed the increased growth in UCCs resulted from shortages and changing roles in primary care. Additionally, due to proliferation of investment capital attributed to private equity firms, UCC growth exploded and further discussions surrounding variances between service and ownership models is warranted.

Comparison of Urgent Care Models

Urgent care model segmentation is linked to the level of service provided. Comparisons of services offered include variations in hours of operation, practitioner credentials, and cost of services provided. Sturgeon (2017) argued a high percentage of UCC usage aligned with center advertisements highlighting lower cost service and convenience. Factors influencing convenience encompass accessibility options for patient walk-in service to obtain urgent minor injury and illness diagnosis and treatment (Urgent Care Centers, 2017). Brooks, Sammarco, Pancir, Chittams, and Wiltse (2017) researched influences for growth in retail clinics providing urgent care treatment and determined that

expansion of scope of practice increased access to minor injury and illness healthcare treatment. Shrank (2017) provided insight into the rise of consumerism in the healthcare landscape and trends toward the development of concierge healthcare care models. With the entrance of RCs, there is literature identifying lower healthcare cost implications; however, there was limited scholarly research articles further exploring the quality of care paradigm. While there are similarities that exist between retail and urgent care center characteristics, critical differences are exhibited in how each entity is defined, target population, scope of services, staffing models, and industry segmentation. Some urgent care center models are closely associated with traditional primary care providers in terms of staffing models, hours of operation, and episodic conditions treated. These sites provide a variety of primary healthcare treatment for common illnesses, minor trauma, and preventative medicine. RCs differ from traditional primary care models, located in retail spaces, and provide a limited scope of practice. Vertical integration between hospital systems and physician practice, insurance companies purchasing provider groups, mergers, and acquisitions among retail chains and healthcare providers are creating niche spaces for new entrants in the healthcare landscape (Frakt & Garthwaite, 2018). These moving parts are resurfacing the foundation for healthcare delivery in the U.S. healthcare system.

Patient First may be considered the primary urgent care center located in the Commonwealth of Virginia. According to a search of the Urgent Care Association of America website, Patient First operates 28 of the 31 certified UCCs in the state. Increased utilization of UCCs has fueled additional expansion to the area from other national UCC

chains such as Med Express and BetterMed. Chang, Brundage, Chokshi (2015) reported 1.2 billion visits occurred each year in ambulatory care settings. The services offered by UCCs include primary care in addition to more acute injury and illness conditions. Corwin, Parker, and Brown (2016) identified urgent care centers as a prime nonurgent site for treatment of Medicare beneficiaries. The dependents influencing the number of visits that may transition to retail and UCC settings may contribute to how leaders in UCCs develop future growth strategies. Leaders in UCC healthcare organizations might find it challenging to chart the trajectory for the organization, which meet immediate needs and future demands. It becomes essential for leaders in UCCs to identify and assess internal and external organizational structural influences toward engineering responses in a changing environment.

There may be cost differentials among services provided in UCCs. Urgent care providers closely resembling traditional primary care models may provide same or similar charges for services provided. Research frames reductions in lower service cost structures associated with UCCs as compared to services provided in emergency department settings. However, there is minimal scholarly research defining aggregate comparisons among traditional primary care after hour programs, UCCs, and RC pricing structures.

Role of UCC Treatment for Work-Related Injuries

In the United States, statistics indicate there are more than two million injuries or illness care episodes occurring in the work environment (U.S. Bureau of Labor Statistics, 2018). Injured workers, employers, insurers, policy makers, and healthcare providers

encompass major stakeholders that potentially interact when occupational injuries and illness present. Workers' compensation is an integral feature of the liability system, which provides wage replacement and medical benefits when an injured worker presents with a compensable injury or illness and requires medical treatment. Macro environmental influences provides a lens to UCC strategic decision-making, value proposition, and future sustainability attributed to participation in coordinating care for work-related injury and illness. Leaders in UCCs treating occupational injuries that occur under the jurisdiction of Virginia worker compensation regulations may find it integral to possess a working knowledge of the current and emerging legislation.

Health Policy Reform

The Virginia General Assembly is the legislative body that adopts or rejects legislation amending state code. At the state level, the governing body encompasses the House of Delegates and the Senate. Appointed by the legislative body, the Virginia Workers' Compensation Commission (formerly known as the Industrial Commission of Virginia), administers workers' compensation regulations established by the Virginia General Assembly. Virginia state code section 65.2-605 establishes employer liability for employee at-work injury medical cost. Legislation in this section defines maximum fee reimbursement for fee scheduled medical treatment. Worker compensation provisions influence organizational healthcare remuneration for occupational injuries. The healthcare policy reform encapsulates factors directly and indirectly related to overall population health. Economic dependencies may encircle quality and access to care that remains in post reform environments. Sommers, Gawande, and Baicker (2017) cited

complexities exist when factoring how population health reforms influence healthcare such as management of financial risk, access to care, chronic condition management, mortality, and types of coverage available to market participants.

Medical Providers

The FSR defines maximum fee reimbursement for seven provider categories. Categories of providers include physicians exclusive of surgeons, surgeons, type one teaching hospitals, hospitals, ambulatory surgical centers, other providers of outpatient medical services, and purveyors of miscellaneous items. The intersection between occupational injuries and UCCs occurs at the point in which the injured worker seeks unscheduled urgent medical attention in UCC environments. Pines et al. (2016) determined episodes of acute and unscheduled care included treatment for injuries and illnesses. Researchers have identified linkages between early medical interventions and successful return to work (RTW) and disability management programs.

The landscape for healthcare services is dynamic. Selberg, Lumpkin, Fulmer, Chernof, and Blumenthal (2016) asserted effective healthcare delivery systems provided needed services to populations that seek to utilize services most frequently. Sepulveda (2013) cited upward trends in growth of urgent care and retail clinics were primarily driven by employer demand to control healthcare remuneration and promotion of worker production levels. Conversely, DeRigne, Stoddard-Dare, and Quinn (2016) determined injured workers were 3 times less likely to seek medical treatment, which resulted in extended unpaid time away from work. Inacio, Cafri, Funahashi, Maletis, and Paxton (2016) researched the influence of surgical outcomes of fractures and influence of

multiple patient encounters in a single provider setting and concluded interval monitoring of post-surgical healthcare encounters reduced subsequent surgical interventions. Blanchette, Rivard, Dionne, Hogg-Johnson, and Steenstra (2016) identified alignments between occupational injury expenditures and healthcare provider engagement at the onset of the injury. Eaton, Mohr, Gallarde, and Hodgson (2015) identified positive alignment between reductions in higher cost emergency department utilization with increased access to care for employees with workplace injuries when medical services were available in close proximity to the work site.

The influence of access to care and early interventions in injury and illness management have been linked to improved outcomes for workers, reducing incidents of continued follow-up care, and employer exposure to high cost medical treatment. Further research catalogs the influence of human resource allocation in urgent care centers as a primer to minimizing medical cost. Staffing modes for UCCs include higher concentration of mid-level providers. Xue, Ye, Brewer, and Spetz (2016) presented arguments that utilization of nurse practitioners improved access to care, utilization of healthcare services and cost, and expanded mid-level provider scope of practice authority to support affordable care initiatives. Anderson and Althausen (2016) indicated urgent care centers operated by orthopedic healthcare providers facilitated early detection and referral to specialty provider treatment, which often occurs at later intervals for occupational injuries and illness.

Work-Related Injury Management and Payment Methodologies

While the volume of occurrences provides UCCs increased opportunity to treat work-related injuries, workers' compensation injury and illness treatment occurs in a niche market. Leaders in UCCs may find there are greater competencies to complete administrative task associated with work injuries and illnesses. Cloeren et al. (2016) and Conlon et al. (2016) defined care characteristics for injured workers as highly specialized requiring healthcare provider knowledge of both state and federal mandates for treatment protocols and medical billing documentation.

Workers' compensation systems provide direction for reimbursement paid for injuries and illness, which are work-related. The mechanisms driving workers' compensation systems are highly dependent upon the employers risk management strategy for work-related injury, illness, and disease. Healthcare provider remuneration for work injury and illness treatment may present in the form of defined maximum fees established by medical fee schedules, managed care organization fee for service contract agreements, medical provider negotiated percentage off billed charge discounts, and full payment of provider charges. Medical fee schedules may reflect same or similar requirements for provider reimbursement as found in the Center for Medicare and Medicaid Services (CMS). Other jurisdictions may include state or regional requirements medical providers must navigate. Carey (2017) studied comparisons between CMS and commercial insurers reflecting systemic variation in reimbursement over time. There may present demand for increased knowledge of work compensation products, which may or may not align with healthcare provider business processes defined to treat UCC

workplace incidents. Lee, Abbey, Heim, and Abbey (2016) determined that there were varied healthcare reimbursement systems driving stakeholder strategic decision-making. Systemic influences to UCC practice may exhibit in variances experienced from private and public insurance options. Squires et al. (2016) identified medical provider profit fluctuated in response to healthcare reimbursement systems.

Legislators passed statutory reforms effective January 1, 2018 in response to concerns for the application and performance of employer medical reimbursement requirements of the Virginia workers' compensation system. Reimbursement methods established by workers' compensation systems may include fee-for-service (FFS) and discounted fee-for-service agreements. These agreements may promote a firm payment for healthcare services rendered by a given provider or provider group. Workers' compensation policy may influence FFS reimbursement systems. Policies governing workers' compensation medical reimbursement may require medical treatment be rendered in accordance with usual and customary medical practice without further delineation specific to the service and payment, or postulate defined fee schedules for medical treatment, and establish specific provider reimbursement payment levels.

Determinants for Organizational Profit Maximization

Identification of tangible resources to neutralize threats and produce firm performance and sustainable competitive advantage are exemplars of determinants promoting organizational profit maximization. In order to neutralize threats within the healthcare landscape, organizations must identify factors influencing firm strategy. Dixit (2016) and Ellner and Phillips (2017) identified healthcare landscapes require innovative

strategies to deliver quality care within a competitive environment. Baicker and Robbins (2015) concluded managed care would experience exponential growth in response to Medicare expansion initiatives creating a multiplicative influence on nonMedicare healthcare systems. With the significant changes resulting from policy reforms in healthcare delivery systems, there may be implications for leaders in healthcare organizations to provide healthcare treatment that is value focused and promote ideal patient outcomes. Urgent care centers provide specialty care that depicts consumer choice for access to healthcare service that is comprehensive, value based, and convenient. Implementation of systems that promote efficiency and reduce redundancy, process steps, and needless activity, may improve provider response time, patient experience, and minimize expenditures. For example, during the patient admittance process, minor changes may be required during the screening process for each patient encounter to ensure the organization does not incur financial losses from ineffective intake procedures. Considerations for staff competency, attention to detail, and an ever-changing clinical treatment environment may have a direct influence on firm performance in treating work-related injuries.

Summary and Transition

Section 1 included an introduction to the influence of healthcare policy and cost containment initiatives. I provided detailed explanations of the study that included summary of the background and identified problem affecting leaders in healthcare organizations, purpose of this research study, and the nature of the study that includes the research method and design. Further discussions highlighted the primary research

question and ten additional interview questions, and the conceptual framework based on organizational strategy theory. Additional topics include assumptions, limitations, and delimitations of the research study, significance of the study, implications for social change, contribution of this research study to business practice, and a review of the professional and academic literature.

The purpose of this qualitative case study was to explore the strategies that leaders in UCC organizations use to increase profits after the inception of a FSR system. This study may be instrumental in strategy development for leaders in healthcare organizations, policy makers, and employer groups. Leaders may utilize the information in this research study to improve strategic decision-making promoting profit maximization. Policy makers may utilize the research in this study to refine future legislation. Employer groups may use the research in this study to guide decision-making in forming contractual relationships with healthcare providers. Through a review of the literature, I discovered that organizational performance is linked to leaders' decision-making and leaders must identify strategies to respond to internal and external challenges in order to build profit maximizing business models.

Following Section 1, a description of the research method and research design was provided in Section 2. Other topics included in Section 2 were the details for the role of the researcher, population and sampling, data collection, data organization, and specific data analysis techniques to be used to complete the study. In Section 3, I discuss the research findings, application to professional practice, and the implications for social change along with recommendations for action and future studies.

Section 2: The Project

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies that UCC leaders used to increase profits after the inception of a FSR system. The targeted population was two leaders from a UCC in Virginia who have implemented strategies to minimize increased expenses and loss of profits due to FSR policy reforms. To remain viable in today's healthcare industry, healthcare providers must balance practice management with quality care (Lear, Fleig-Palmer, Hodge, Fleig, & Arensdorf, 2016) Findings from this study may contribute to positive social change in the business models of primary healthcare service delivery. Primary care practitioner growth using sustainable business models may occur through increased insights into proven business strategies that maximize profit. Bitton (2018) determined that leaders in primary care provider settings must adopt strategies to adapt to environmental fluctuations in healthcare landscapes. As a result, the leaders in primary healthcare settings may be able to offer increased opportunity to influence access, quality, and remuneration of care provided in the United States healthcare delivery system.

Role of the Researcher

The researcher functions as a data collection instrument performing data collection and assimilation from varied inputs. According to Buetow (2013), a researcher is a voyager, digger, cleaner, and facilitator culminating in a well-orchestrated presentation of information from the data collected. The researcher must adhere to ethical principles that guide each phase of the research process. Yip, Han, and Sng (2016) stated

that the efficacy of nonmedical research required the use of ethical standards and enlisted the principles outlined in the *Belmont Report* of 1978 to articulate parallels in acceptable research guidelines for nonmedical studies. The *Belmont Report* defined boundaries for autonomy, beneficence, and justice in acceptable treatment of participants and protocols for the research process. While the tenets of the report are prescriptive treatments for medical studies, the *Report* includes generalities that may apply to other research (Bromley, Mikesell, Jones, & Khodyakov, 2015). Davis (2015) stated that important contributions to generalized knowledge emanated from research and ethical standards must exist for participants. The importance of ethical research into business aspects of healthcare systems is monumental to informing knowledge within a dynamic healthcare environment. Probing for underlying values, beliefs, and assumptions are integral to understanding organizational behaviors (Hung, McQueen, & Hsu, 2017).

In the role of the researcher, it is integral to define potential relationships, which might exist among the researcher, study topic, and participants. Mason-Bish (2018) highlighted the importance of critically assessing one's own views of self, phenomenon, and participants to guard against potential bias or overreach in the role of researcher.

I have professional experience and knowledge of FSR influences on healthcare providers including UCCs. This knowledge and experience hails from two perspectives. My prior employment with a medical bill adjudication company that may have negotiated preferred provider contracts, recommended lower remuneration to a participant, and participation in a public data call in which aggregate data provided to the actuarial firm assisted in the development of the schedules. As the Virginia Medical Fee Schedule

Manager, I have primary responsibilities to manage and maintain the FSR and dispute resolution process.

Participant or researcher bias may exist attributed to prior knowledge and experience surrounding the selected topic. I completed purposeful steps to provide study participants assurances that any responses obtained were to be used for the sole purpose of conducting the research study proffering the engagement of open and frank participant responses. Each participant was provided written notification of informed consent to include confidentiality rights, process of collecting data, potential risks, and data analysis and retention. Additionally, I abided by the key principles in the *Belmont Report*, (a) justice, (b) respect of person, and (c) beneficence. Bracketing was employed to reduce personal bias. Newman and Tufford (2010) cited bracketing assisted in mitigating researcher pre-conceived notions regarding the study topic and the research process. I conducted a qualitative case study engaging care in notetaking, performing methodological triangulation, and categorically coding participant responses to open-ended questions during interviews. I coded responses from participant interviews, UCC value proposition analysis, and identified approaches to strategy extracted during the research process to underscore research outcomes.

Participants

Upon receiving approval to conduct research from Walden University's Internal Review Board (IRB), participants for the study were identified from an online public Virginia directory of urgent care centers. I used the directory of UCC providers to select a UCC with a business model that promotes healthcare treatment options to injured

workers. Strategies to maximize participation for the selected UCCs included outreach to each respective participant organization to secure confirmation for availability of personnel with strategic decision-making authority, and providing concise representation of the purpose and intent of the study. The participants included organizations, which have identified strategies they are using to maintain profits within an industry influenced by health policy reforms.

Qualitative research sampling is to be purposeful and promote exploration into a study topic. Benoot, Bilsen, and Hannes (2016) indicated that purposeful sampling promotes investigation into a topic providing new opportunities to discover, explore, and increase understanding. To ensure the selected participants might contribute to best practices, workers compensation medical treatment industry experience was an additional requirement for study participation. The sampling was reflective of the population including selection of relative participant experience to add to the body of knowledge for the study topic. Moustakas (1994) concluded purposeful sampling promoted an effective methodology to contribute to better understanding of the study topic. Rohrbeck and Kum (2018) identified that leaders and organizational innovation strategies were key influencers in organizations, which excelled in performance. A review of the demographics of selected organizations to identify participants in leadership roles occurred to gain access to participants meeting the study participation criteria. The initial engagement with participants included informal emails and phone calls to build rapport and establish defined schedules for in-depth interviews. Glegg (2018) cited rapport with participants' fostered opportunity to create safe and comfortable atmospheres promoting

the sharing of personal experiences and attitudes. Heath, Williamson, Williams, and Harcourt (2018) recognized that while traditional models of communication to perform research are still highly utilized, technological advances, such as Skype, telephone, and email promoted an alternative method to build rapport with research participants. Researcher steps taken to consider alternative methodologies may directly influence participation in the study. Moylan, Derr, and Lindhorst (2013) indicated researcher use of smart technology and electronic communication such as email and phone calls added efficiencies in completing studies. Carduff, Murray, and Kendall (2015) concluded use of email to complete research promoted an opportunity to reach participants outside the bounds and constraints of time and space. I conducted in-depth interviews upon confirmation of selected participant role and acceptance of the study parameters. Hudon, Chouinard, Diadiou, Lambert, and Bouliane (2015) utilized in-depth interviews of patients with chronic disease to explore patient and family perspectives on case management interventions on outcomes in primary healthcare. Namey, Guest, McKenna, and Chen (2016) considered in-depth interviews as one of the more common cost effective methods for evaluators.

Research Method and Design

Research Method

I selected a qualitative research method to explore strategies leaders use to increase profits after the inception of a FSR system. Greenhalgh and Papoutsi (2018) defined the importance in health services research to identify research methods applicable to open systems with dynamic environments requiring research models that promote

understanding and development of strategies to address influences surrounding uncertainty and emergent conditions. Qualitative research is a method to gain understanding of how responses are fashioned to a phenomenon through the examination of influences occurring in the setting as the researcher discovers them (Yin, 2016). Pope and Mays (1995) proposed qualitative research methods expanded the researcher's ability to study the phenomena surrounding complexities exhibited in health services research.

The goal of using qualitative research method is to explore the natural setting in which multifaceted complexities might influence health services landscapes (Leedy & Ormrod, 2005). Qualitative study provides the researcher pathways to explore questions of how and why. Vaughn et al. (2018) sought to characterize trends in low performance organizations using qualitative analysis. Sidek and Martin (2017) used qualitative analysis to explain how implementing change initiatives informed healthcare leaders of best practices and emphasized the emergence of two key attributes surrounding service quality and client satisfaction in the healthcare management literature. Kilgour, Kosny, McKenzie, and Collie (2015) performed qualitative analysis to unveil impact of why negative interchanges between the medical community and workers' compensation insurers influenced medical outcomes for injured workers. Wu et al. (2016) cited the underlying goal of qualitative study is to explore the study topic discovering themes, patterns, and linkages increasing understanding of complex interventions.

Alternatively, Coles et al. (2017) argued that quantitative research promoted assertions to uncover how and why quality improvement initiative in healthcare environments succeed or fail using four steps to establish causality and identify if a series

of events influenced outcomes. Barnham (2015) argued quantitative method included numbers, closed-ended interview questions, and percentages to test hypothesis. Stake (1995) argued quantitative researchers seek an explanation for a phenomenon, to discover knowledge, and are void of personal connection to the study.

Mixed method is a hybrid approach combining both qualitative and quantitative research objectives. Bentahar and Cameron (2015) argued there was opportunity to achieve dual objectives in selecting mixed method approaches. The pedagogy of scholarly research involves the art of successfully navigating one of three research methods. Of the three methods, quantitative methods evaluate and measure data numerically responding to questions surrounding how much or how many, qualitative method promotes opportunity for rich in-depth discovery of why and how, and mixed method co-joined qualitative and quantitative methods to illicit deep inquiry and creation of assertions to explain associations surrounding the phenomenon. Denzin (2012) stated the research question ultimately steered the selection for the method. Guided by the objective expressed in the overarching research question to explore UCC leader strategies and open-ended interview questions to espouse information concerning the phenomenon, I determined quantitative and mixed method traditions were not appropriate for this study.

Research Design

There are several qualitative research designs. I considered ethnography, narrative, phenomenological, and case study research designs. Ralph, Rapp (2017) and Zapata-Lancaster (2014) determined ethnography included participant field observations.

Moen (2006) and Polkinghorne (2006) concluded narrative designs frame descriptive stories of human activities. Blank, Harries, and Reynolds (2015) and Giandinoto and Edward (2015) utilized phenomenological designs to explore and observe meanings of lived experiences of varied participants as the phenomenon occurred over time. Narayanamurthy, Gurumurthy, Subramanian, and Moser (2018) utilized case study design to document readiness for lean capabilities phenomena in healthcare institutions The intent of the study was not to explore and present meaning of participant lived experiences as is exhibited in ethnography, narrative, and phenomenological research designs. Yin (2016) affirmed researchers used case study designs when the goal is to gain understanding of a complex issue or topic. I selected the case study to promote an inductive approach to obtain data surrounding the exploration of strategies leaders use to promote firm performance.

Population and Sampling

Bradshaw, Atkinson, and Doody (2017) determined sampling techniques were included as one of the foundational underpinnings to establishing rigor in qualitative research. Patton (2015) determined quality and appropriateness to the research design and question were key indicators reflective of appropriate sampling. I used a purposeful sampling approach to select participants from a list maintained in a database by the Urgent Care Association of America (UCAA) and American Academy of Urgent Care Medicine (AAUCM) accreditation organizations. Braithwaite et al. (2012), Hernandez, O'Connor, and Meese (2018), and Nicklin, Fortune, Ostenberg, O'Conner and McCauley (2017) suggested healthcare providers attaining accreditation were reflective of

professionals and institutions exhibiting dedication and commitment to meeting standards which embody a higher level of performance as established by the recognized accreditation organizations. Researchers using purposive sampling seek to be deliberate in their participant selection process. Benoot et al. (2016), Duan, Bhaumik, Palinkas, and Hoagwood (2015), and Patton (2015) determined that purposeful sampling provided information-rich data surrounding a phenomenon as selected participants meet predetermined criteria better suited to provide actual reflective and informative discovery for a research topic from participant experiences. I selected two participants from an established UCC who had attained organizational certification.

Additional considerations for sampling encompass the number of participants selected for the study. Data saturation is a methodological principle influencing sample size for qualitative research (Saunders et al., 2018). Constantinou, Georgiou, and Perdikogianni (2017), El Hussein, Jakubec, and Osuji (2015), and Fusch and Ness (2015) determined saturation occurs at the point further data collection and analysis become unnecessary. Squires and Dorsen (2018) framed the importance of the qualitative researcher maintaining the goal to attain data saturation from the onset of conducting the study throughout each stage of the process. Data saturation occurs when the researcher finds additional sampling does not provide new knowledge. Malterud, Siersma, and Guassora (2016) determined that an appropriate sample size in a qualitative study was any number yielding expansive and varied information in response to the research question. Boddy (2016) identified qualitative study interview sample size may be as small as a single case and yet still provide significant insight into a phenomenon. With

the goal of achieving data saturation at the forefront, I compared the information obtained from the interviews with the two leaders until no new strategies emerged.

The interview setting is a final consideration for the researcher. Oltmann (2016) identified contextual considerations such as participants' ability to access the geographical location and potential sensitivities participant may experience in providing responses to sensitive research questions were key factors to consider in the interview setting. Jamshed (2015) determined the setting of the interview must be conducive to elucidate optimal participant responses to interview questions. Pacho (2015) framed the importance of providing an interview setting that is convenient and comfortable for the participant to communicate responses freely to interview questions. I identified an appropriate interview setting the participants to ensure the selected location provided a comfortable and convenient setting promoting opportunity to obtain optimal responses to the research questions.

Ethical Research

The Walden University IRB process comprises strict procedural guidelines for participants care and ethical research. Ohayon, Cousins, Brown, Morello-Frosch, and Brody (2017) and Willis, Slade, and Prinsloo (2016) determined that IRBs were gatekeepers required to review and monitor research to ensure quality and high ethical standards holding the researcher accountable for the participants, research process, and final work product. The IRB approval number granted to conduct this study is 04-23-19-0185174.

Yin (2016) highlighted the importance of maintaining ethical perspectives in research attributed to the researcher discretionary choice paradigm prevalent in qualitative research. Patton (2015) determined ethical standards were pivotal in conducting interviews. Obtaining confirmed written consent from participants allows the researcher to exhibit material documentation of compliance to ethical standards. Ethical standards include participant protections. Nusbaum, Douglas, Damus, Orlow, and Estrella-Luna (2017) identified effective informed consent processes included clear communication to participants of the process, risks, benefits, and opportunity to continue or withdraw participation after being advised of the risk and benefits. Participants were advised their participation was contingent upon their willingness to participate and at any time may choose to withdraw from participating in the study by providing notification to the researcher verbally or in writing without any fear of reprisal. Lippe, Johnson, and Carter (2018) illustrated how during the process the researcher should seek to provide participant protections by using an identification coding system linking research data among identified concepts promoting anonymity for human participants.

Participants were provided a numerical identifier (P01, P02) to protect confidentiality. Lee and Stvilia (2017) emphasized the importance of establishing effective data management and curation activities throughout the research process to include controlling access, packaging, archival, and destruction of completed research. Gandy (2015) presented a data management plan that included a required 5-year period to elapse prior to destroying research data. The data was saved in document form and converted to electronic media using a USB device. The USB device will remain in a

locked container, in a secure location, for a period of 5 years, to ensure protections for the rights of participants. At the end of term, I will destroy the USB device. A final consideration for ethical research is remuneration of research study participants. Grady (2005) identified financial payment to participants may have unintended consequences obscuring intended purpose of informed consent to participate for monetary gain. As such, I did not provide reimbursement to participants. If requested, a summary of the completed study may be provided to the participants.

Data Collection Instruments

As the researcher, I was the primary data collection instrument in this study. Merriam and Tisdell (2015), Morgan, Moore, and Floyd (2017), Pope, Ziebland, and Mays (2000) concluded the primary data collection instrument in qualitative research was the researcher, exemplified in the continuous exposure from decisions made in defining the approach, influence once emerged during the data collection process, and analytical treatment once data collection is completed. Fusch and Ness (2015) and Roulston and Shelton (2015) determined interval interactions with the data provided continuous analysis and assessment by the researcher as the steps in the research process evolve to ensure personal bias is identified and restrained.

Yin (2016) concluded interviews and document archives represented methods to obtain data for case study research. In-depth interviews are a tool used to illicit knowledge or understanding through the engagement of purposeful discussion revealing insight through the verbal exchange. Arthur, Fisher, Stokley, Shoemaker, and Pozniak (2015) utilized in-depth interviews to determine how RC business models responded to

public demand for preventative healthcare treatment. Wong et al. (2017) found in-depth interviews provided an opportunity to explore interactions between primary care provider and the public in developing cost effective healthcare delivery systems. Yanar, Kosny, and Lifshen (2018) completed in-depth interviews with healthcare providers and case managers to identify gaps in healthcare providers' perceptions for return to work programs and reporting medical treatment to workers' compensation boards.

Similarly, review of documents promotes in-depth learning of actions taken at defined points in time through the review of text and reports. May et al. (2018) reviewed 108 historical report documents to identify and explore complexities of processes in healthcare implementations. Foley et al. (2017) analyzed public engagement planning report documents to inform how prospective strategies to manage expectations influence implementations for major system change initiatives. Yin (2016) supported review of archival documents to obtain research data.

Audio recordings of participant interviews is another tool used to re-evaluate participant responses as needed further improving contextual richness of data obtained during in-depth interviews. Falloon (2016) reported electronic devices facilitate the researcher's movement through data independent of space and time constraints. Alturki et al. (2018) and Bowers and Redsell (2017) used audio recordings to enhance the capture of information from medical providers in the interview setting.

Upon completion of data collection, a researcher must seek to enhance data credibility. Barlow, Scott, Thomson, Griffin, and Realpe (2017) indicated member checking was an effective tool to validate data obtained during interviews in the research

of aging members and medical decision-making for knee replacement was congruent to the researcher's perceptions. Birt, Scott, Cavers, Campbell, and Walter (2016) framed the importance of member checking to promote the researcher's assertions of participant interventions that enhance credibility for the phenomenon being studied. Rosenthal (2016) opined that member checking provided qualitative researchers a useful tool, which promotes study credibility. As such, I used member checking to enhance credibility of the study of strategies leaders use to increase profits after the inception of a FSR system.

There are guiding principles in completing scholarly research using case studies. Jónasdóttir, Hand, Misener, Polgar (2018) presented findings in support of case study method for occupational research and further determined researchers frequently omitted steps to bind case study contextual attributes to the finished study. Whitmore, Baxter, Kaasalainen, and Ploeg (2018) provided a detailed study protocol to inform new knowledge of nursing professionals' transition from graduate to practitioner. Yin (2016) defined attributes for a case study protocol, which included a project overview, descriptors for the purpose and intent of the study, and outline for data collection procedures. Appendix A includes the case study protocol that guided the trajectory for this study.

Data Collection Technique

Yin (2014) determined participant interviews were one of the more frequently used methods to obtain case study data. Polkinghorne (2005) and Wilson, Onwuegbuzie, and Manning (2016) indicated that interviewing was the most utilized data collection technique in qualitative research. I selected a qualitative research method to explore

strategies leaders use to increase profits after the inception of a FSR system. For this qualitative, single case study, one source of data was obtained from participant interviews.

As described in the case study protocol (see Appendix A), there were three stages encompassing the process of data collection from participant interviews for this study: data collection procedures, preparation for participant interviews, and interview with participants. During the data collection procedure, an initial email contact with identified participants occurred providing an overview of the study and informed consent documentation to develop rapport and obtain consent for further contact and participation in the study. In the preparation for the participant interview stage, contact with participants occurred confirming the site and providing responses to questions regarding the overview of the study and informed consent document. Upon receipt of the properly executed consent forms, the interview site was finalized and confirmed with the participant. An email with electronic meeting invite, identifying the meeting duration of approximately 45 minutes was forwarded to the participant to assist participant with time and place scheduling.

The interviews were conducted in a neutral location that was convenient and afford necessary privacy to maintain participant anonymity. I read aloud an introductory statement restating the purpose of the study and the contents of the informed consent form. I advised the participants regarding the time limit for the interview and requested if there were questions or concerns before the interview commenced. At the commencement of the interview period, I provided the participants with an opportunity to

withdraw from participating in the interview. The participant agreed to proceed. I advised the participants that the interview will commence and started the audio recording. During the interview, I made eye contact with the participants. I sought responses to open-ended questions. Guest, Namey, Taylor, Eley, and McKenna (2017), La Rocca and Hoholm (2017), Senot, Chandrasekaran, and Ward (2016) identified open-ended questions were effective in enabling researcher identification of broad contextual themes from participant interviews. Each participant was provided the same questions. At the conclusion of the interview, I thanked each participant for their cooperation and reiterated that I would follow-up with each participant to provide a synthesis of data obtained from the interview to ensure that I interpreted the correct meaning for the participants' responses.

The interview audio recordings enhanced the time spent with the data ensuring I interpreted the meaning of participant responses to the research questions. LeBaron, Jarzabkowski, Pratt and Fetzer (2017) determined audio recordings provided the qualitative researcher an additional tool assisting in the review and interpretation of interview data. Renz, Carrington and Badger (2018) posited combining manual and computerized data collection methods improved accuracy of data. Pacho (2015) highlighted use of audio recordings to augment information obtained during in-depth interviews.

Additionally, data were obtained through a review of company documents. Organizational documents such as firm performance projections, annual performance reports, and historical growth strategies provided additional information for the study. Yin (2016) suggested the collection of documents provided advantages in recalling

specific details surrounding events. Liang et al. (2018) compiled documents from three international organizations to promote better understanding of influenza preparedness. Baral and Pokharel (2016) analyzed S&P 500 company documents to measure sustainability strategies and attainment of goals.

There are advantages and disadvantages to the selected data collection techniques. One advantage of obtaining data from participant interviews is the researcher intersects the data at the point of origin and can seek clarifications or probe further into a given response to ensure understanding (van de Wiel, 2017). Opdenakker (2006) determined the synchronous communication occurring between the interviewer and the participant yielded advantage to discover nonverbal cues adding to the richness of data obtained from participant face-to-face interviews. Additionally, advantages of document review include ability to affirm validity of participant experiences and promote historical comparison and trends improving credibility of data. Opdenakker (2006) further cited a disadvantage to face-to-face interviews includes the researcher's role for dual dimensions of responsibility of understanding for both the interviewee in relation to the question and the researcher of the response to the question. Yin (2016) illustrated a disadvantage of interviews included the researcher inadvertently introducing bias into the study from poorly communicated interview questions resulting in inaccurate responses. George, Daniels, and Fioratou (2018) framed the importance of researcher reflexivity in eliminating the potential for researcher bias and data misrepresentation attributed to direct interaction with vulnerable populations and their views surrounding access to healthcare. Berger (2015) and Mason-Bish (2018) determined reflexivity was critical in

establishing an equilibrium state between researcher positioning power to that of the participants and study topic. Similar to interviews, there are disadvantages obtaining data from review of documents due to incomplete records or out-of-date information. Alturki et al. (2017) researched inconsistencies in healthcare clinical trial data resulted attributed to incomplete status labeling and determined international standards were not consistently met. Patton (2015) highlighted disadvantages in document review included access prohibitions to content relative to interview question responses.

The trustworthiness of qualitative data collection is integral to this study. A member checking process was included to enhance trustworthiness of data collected. Fusch et al. (2015) supported use of member checking to validate the researcher's interpretation of participant responses to interview questions. DeCino and Waalkes (2018) and Levitt et al. (2018) identified integrity of qualitative methods were enhanced by member checking. I provided participants a synthesis of their respective responses to the interview questions. The participants were asked to provide input affirming the interpreted response. The participants agreed that the synthesis represented the intended meaning for their respective responses to the interview questions; therefore, I accepted the data for use in the study.

Data Organization Technique

Frangella et al. (2018) determined codification in qualitative research systematically organized data obtained. Pope et al. (2000) further determined coding data improved organization techniques and provided a foundation for data analysis processes. A coding system that includes letter and numerical values was assigned to participant

responses to the interview questions. I assigned word and short phrases to represent participants' responses using Microsoft Excel spreadsheet software to preserve participant confidentiality. Slade, Philip, and Morris (2018) utilized spreadsheets to collect data on the role research plays in determining healthcare quality, safety, and consumerism. Participant names were un-identified and replaced with a number scheme beginning with P01. I used Microsoft Excel and Access to segment, group, and regroup the data into categories of strategies. The imported data were saved in the UCC Doctoral Study main file. I labeled the subfolders within the main Microsoft Access file that contains information from each participant P01 to P02. The query function in Microsoft Access was used to run thematic analysis queries using relational database rules to discover linkages among the approaches attributed to similarities and variances identified through discovery, insight, and interpretation of expressed responses regrouping segments further defining strategies. Lucyk, Tang, and Quan (2017) identified support for qualitative researchers to engage in rules driven processes toward defining relationships within and among data categories. Yin (2016) posits maintaining a chain of evidence preserves reliability for data collected. I will store digital data on a password-protected external storage device and nondigital data in a locked safe for 5 years.

Data Analysis

Data analysis is a critical component influencing the validity and reliability of a study. Yin (2016) determined qualitative researchers must analyze relevant evidence, present contrasting propositions, report significant findings, and draw from prior knowledge to perform a comprehensive data analysis. Denzin (1994) identified four

triangulation methods: data triangulation, analyst triangulation, theory triangulation, and methodological triangulation to achieve data saturation. Secondary research is not the primary source of data for this study. As a result, data triangulation is not appropriate for this study. Analyst triangulation incorporates multiple researchers in the data gathering and analysis processes and is not applicable, as there is one researcher. I did not select theory triangulation as theory triangulation employs using pre-determined hypotheses concerning outcomes and no hypothesis was defined. Methodological triangulation employs the use of multiple data sources or methodologies to enhance understanding. Forero et al. (2018) determined methodological triangulation in qualitative research comingled data with varied origins to produce profound information regarding a phenomenon. Carduff et al. (2018) used methodological triangulation of interviews with three different sources to identify data, complete thematic analysis, and compare and contrast findings among participants.

As the primary research instrument, in-depth interviews, open-ended questions, document review, audio recordings, transcriptions, and member checking are some tools I used to obtain data. Data analysis consists of carefully reviewing raw data identifying approaches that emerged in response to the research questions. Breland, Donalson, Dinh, and Maguen (2017) utilized thematic analysis to identify themes surrounding trauma and eating disorders. Yin (2016) defined the hierarchal activities in data analysis as examining of interview notes, transcription of audio recordings and related documents, organizing data into categories to eliminate unrelated or vague responses, grouping categorized data by assigning descriptive coding, reassembling coded data into themes,

interpreting meaning for themes emerging from the data, and presenting conclusions drawn from the research. Saunders et al. (2018) purported that data saturation concluded the researcher's final stage in the data analysis process.

Castleberry and Nolen (2018) and Frangella et al. (2018) employed the principles of Yin's five-step method to complete data analysis and enhance access and understanding of qualitative health services research. Donnelly, Brenchley, Crawford, and Letts (2013) based the structural underpinnings of data analysis to study specialty medicine integration into primary care focused health delivery models using Yin's five-step method. Likewise, I applied the principles of Yin's five-step data analysis method as detailed, in the data analysis process of the case study protocol (see Appendix A) to identify themes from collected data and answer the research question of what strategies leaders in UCCs use to increase profits after implementation of FSR. Hlady-Rispal (2016) researched the value construct in social entrepreneurship and determined thematic analyses become meaningful when compared to the conceptual framework. I used the adaptive cycle model to establish the contextual foundation for exploring participant responses to the central research question. The adaptive cycle model established the link between study findings and the literature review.

Reliability, Validity, Creditability, Confirmability, and Transferability

Reliability

Reliability is a term used to describe research methods that postulate rigor in the research process. Guba and Lincoln (1994) and Yin (2016) identified distinctions among research methods attributed to valuation of rigor assigned to the process and outcomes

when selecting one method over another. Researchers engaged in qualitative methods seek deeper insights and clarity of views as depicted in the framed research question beyond mathematical numeration of artifacts as prescribed in qualitative studies to gain intensive discovery of perspectives and experiences of the phenomenon. Qualitative researchers concentrate on dependability instead of reliability to illustrate authentic research (Forero et al., 2018; Marshall & Rossman, 2016). From the design phase to conclusion of findings, qualitative researchers introduce mechanisms purposed to ensure dependability. Yin (2016) indicated qualitative researchers might utilize case study protocols and databases to promote dependability. Burton, Peters, and Devers (2018) used a case study protocol to explore successes and failures of systemic interventions in the $100 million Child Health Insurance Program Reauthorization Act program. Farquhar, Kamei, and Vidyarthi (2018), Urisman, Garcia, and Harris (2018), and van de Pol et al. (2018) used Microsoft Excel as the repository to record and examine research data. Bradley et al. (2007) determined relationships and intersections in perspectives inform development of formal classification systems that describe characteristics surrounding a phenomenon. I established dependability of the research using the case study protocols: (a) a description of the project overview; (b) description of purpose and use; (c) description of data collection procedures for the study; (d) outline for the study and report content; (e) listing of defined case study interview questions; (f) summary of data analysis procedures and processes; and (g) description of the process to dependability, credibility, confirmability, and transferability of methods.

Validity

Bradshaw, Atkinson, and Doody (2017) argued qualitative researchers must systematically employ methods to present accurate representations and analysis of responses to the social phenomena researched. Morse, Barrett, and Mayan (2002) emphasized trustworthiness and transferability as pillars assuring rigor in qualitative studies. In comparison to the traditional quantitative emphasis on internal and external validity defining research quality, qualitative researchers are intentional in ensuring integrity through engagement of mechanisms and measures that enforce credibility, confirmability, and transferability (Marshall & Rossman, 2015 and Yin, 2016).

Credibility

Mandal (2018) determined credible research must demonstrate the researcher's critical thinking and consideration for the research process taken and presentation of knowledge surrounding the phenomena. Rodgers and Cowles (1993) determined credibility is fashioned from the onset with the researcher identifying and disclosing their role and potential connections to the phenomena being studied and further enhanced by identifying strategies for inquiry, research method, data collection, analysis and conclusions. These strategies are instrumental in defining researcher hierarchical events and changes creating an audit trail promoting trustworthiness of the interpretations of information collected from the participants during the study (Morse et al., 2002). de Klein and Van Leeuwen (2018) described the audit trail as a decision tree in establishing trustworthiness for the research steps taken to study the phenomenon using the qualitative method. Daniels et al. (2016), Leung (2015), Pomey, Clavel, Ghadiri, Karazivan, and

Fernandez (2015) indicated qualitative research provided opportunity to explore and potentially reshape thinking about primary care in healthcare systems aligning with explorations of experiences and impacts to healthcare awareness, interventions, and utilization. Noble and Smith (2015) and Nowell, Norris, White, and Moules (2017) outlined the importance of qualitative researchers incorporating strategies to ensure trustworthiness of findings. As such, I demonstrated credibility in the findings for the exploration into strategies leaders use to increase profits after the inception of a FSR system by exhibiting rich descriptive contextual underpinnings for the systemic process steps engaged to study the phenomenon.

Confirmability

Confirmability refers to the evidence exhibited that the research process encapsulates best practices and the findings reflect participant responses and not the personal bias of the researcher (Castleberry et al., 2018). Wu, Thompson, Aroian, McQuaid, and Deatrick (2016) underscored the importance of integrating multiple data sources to corroborate study data prior to generating conclusions. Kornhaber, Mclean, Betihavs, and Cleary (2018) demonstrated confirmability through a systemic process to obtain data and complete thematic analysis of individuals' experiences after encountering spinal cord injuries to present four key findings charting survivors' capacity for resilience. Kornhaber et al. (2018) further exemplified confirmability by describing how the study findings emerged from the data obtained from the survivors. As such, I provided in-depth description of the methodological process and steps taken to allow the trustworthiness of the research to be examined engaging data triangulation using multiple

data sources minimizing researcher bias and diagrams to demonstrate an audit trail for the research and findings of leaders in UCCs strategies to increase profits after implementation of FSR. As the current researcher, I documented any personal knowledge and experiences in journal notes to bracket potential views, beliefs, and bias during data collection and analysis.

Transferability

Healthcare systems are dynamic and, in some context, may present as volatile. As such, health service researchers must ensure research is transferable within complex landscapes (Greenhalgh & Papoutsi, 2018). Quantitative researchers assign generalizations to populations based on experimental findings surrounding a phenomenon whereas qualitative researchers attempt to demonstrate extensive contextual detail to allow the reader to determine if the environment or the phenomenon studied is similar, and findings applied to another environment (Hanssens, 2017). Saunders et al. (2018) affirmed data saturation is instrumental in determining transferability and is reached when participant data becomes duplicative resulting in redundant themes and trends and no new information. Data saturation affirms the researcher's approach has completed an exhaustive extraction to promote trustworthiness for interpretative views of data surrounding the phenomenon. I completed interviews with leaders in UCCs to gain an understanding of the phenomenon being studied and confirmed data saturation occurred. Guba and Lincoln (1994), Kaufmann and Denk (2011), and Thomas and Magilvy (2011) argued that the current researcher presented deep in-depth descriptions for the research process and the future researcher affirmed transferability of the study. I provided

comprehensive descriptors for the context and methods to promote future researchers' determination of the transferability of the study findings.

Summary and Transition

The purpose of this qualitative, single case, study was to explore the strategies leaders in UCCs use to increase profits after implementation of FSR. Section 2 provided the process to complete the study. The process included the identification of my role as a researcher, the participants, selected sample size, and a detailed description of the research method and design selected. Section 2 also includes description for the data collection instrument, data organization, analysis techniques and tools, ethical considerations, and reliability and validity of the research. As the researcher, I served as the primary research instrument.

The population for this qualitative research study included two leaders in a UCC in Virginia who have successfully developed strategies to increase profits after the implementation of a medical fee schedule. In addition to developing successful business strategies, these organizations' products and services included providing medical services to injured workers. After obtaining IRB approval to complete the study, purposeful sampling was employed, and interviews scheduled with the selected UCC leaders. At the conclusion of completing interviews and member checking, data analysis occurred and data saturation was attained.

I reviewed elements prescribing how the study would be reflective of reliable and valid research with a foundational lens toward demonstrating rigor in qualitative research framing underpinnings for dependability, credibility, confirmability, and transferability of

the study. Section 3 offers the final findings: the synthesis of the data obtained during the interviews, review of company documents, alignments between findings and conceptual framework, support for progressing business practice, and contribution to positive social change. I conclude Section 3 with personal reflections, conclusions, and recommendations for future research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative, single case study was to explore UCC leader strategies to increase profits after the inception of a FSR system. The participants included UCC senior executive and operational level leaders who offered multiple approaches to increase profitability: (a) develop controls to mitigate negative impacts, (b) increase organizational knowledge about negative impacts on margins, (c) measure the effectiveness of the controls and their impact on margins, and (d) evaluate the services offered and their placement in the market. The next section details the findings from the research study and leaders' strategies identified to increase profits after the inception of a FSR system.

Presentation of the Findings

The overarching research question guided the study in which I explored leader strategies to increase profits in a post reform environment. I completed in-depth interviews with two leaders from a UCC in Virginia who provided information to answer the research question and member checking to confirm interpretation of meaning for the responses. I reviewed company documents and other information available from the organization's website to corroborate data gathered from the interviews with the UCC leaders. The identified leaders, in their respective roles as Senior Vice President of Marketing and Director of Occupational Medicine, contributed UCC organizational knowledge for the study.

An interview protocol (see Appendix A) defined the steps taken to interview and record participants' responses. An informed consent form, provided to the participants, included declarations about the use of audio recordings and handwritten notes taken to capture the meaning of the responses. I used Microsoft Word to produce a synthesis of the responses and forwarded the document to the participants for member checking. The member checking procedure provided an opportunity for each participant to review and provide feedback to ensure that the synthesis accurately captured the intended meaning for each response provided. Fusch et al. (2015) determined that member checking procedures improved the accuracy of the researcher's interpretation of participants' responses. Each participant confirmed that the synthesis captured their intended meaning. Forero et al. (2018) affirmed that methodological triangulation promoted in-depth knowledge of a topic by combining multiple sources of data. Thus, the interviews were enhanced by a review of company documents and information available on the organization and UCC accreditation association's websites.

As the primary research instrument, I interacted further with the data by reviewing a visual representation of the participants' responses. McNaught and Lam (2010) indicated that word cloud content analysis promoted productive visual engagement with the data and elucidated preliminary knowledge via the display of prominent data elements. After compiling all responses, I used an online word cloud application (https://www.wordclouds.com/) to create the visual representation for the frequency of descriptive terms (see Figure 1). Ten terms appeared more frequently in the participants' responses to the interview questions: *employer, service, worker, claim,*

payer, *injury*, *schedule*, *compensation*, *strategy*, and *process*. The more frequently used terms correlated with the overarching research question for the study and with the approaches to leader strategies that emerged from the data analysis.

Figure 1. Word cloud depicting the most frequent words in the responses.

The UCC leader responses were reassembled. With the aid of Microsoft Word, Excel, and Access the data analysis was completed. I identified 39 UCC leader approaches to strategy that converged into four major leaders' approaches to strategy. The approaches aligned within the context of meaning for one of four key words (a) control, (b) knowledge, (c) measurement, and (d) products (see Table 2).

Table 2

Emergent Strategic Approaches

Approach Key Word Categorization	Frequency	%
Control	20	24.00
Knowledge	9	51.00
Measurement	4	10.00
Products	6	15.00
Total	39	100.00

Although the UCC leaders exhibited alignment in their responses for these four major approaches, there was variation among the participants' engagement within the strategic approach (see Figure 2). These findings correlated with previous researchers' views in the literature. Bitton (2018) determined that actors within healthcare landscapes experienced variances in perceptions for practice performance improvement across and within the same work environment. Chen and Li (2017) and Uhl-Bien and Arena (2018) affirmed that, during periods of chaos, effective senior leaders transcended their respective roles and priorities to coordinate knowledge and resources in the identification and development of organizational strategies in response to internal and external influences.

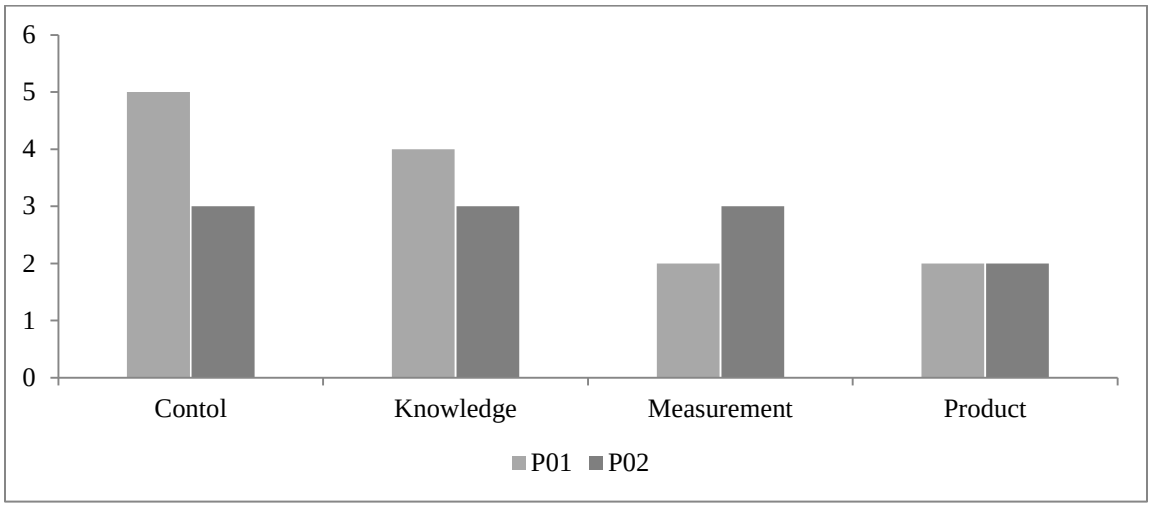

Figure 2. Leaders' strategic engagement analysis.

Within the framework of the adaptive cycle, Miles et al. (1978) argued firm strategic decision-making exhibited organizational behavioral characteristics aligning with prospector, analyzer, defender, or reactor typologies in response to entrepreneurial, engineering, and administrative problems. The approaches emerging from this study encompass strategies that the participants used to increase profits after the inception of the FSR system.

Strategy 1: Develop Controls

The first approach to emerge was the need for the UCC leaders to develop controls to minimize the negative influence on organizational capabilities to control (a) financial risks attributed to an aging accounts receivable (AR), (b) current processes and procedures limiting availability to acquire point of contact information, (c) existing market relationships influencing medical treatment remuneration, and (d) system efficiency and performance. According to P01,

> I think it is a big difference in what we face with regard to workers' compensation, forget the clinical side, it is the administrative side that is the problem, the clinical side is the easy part. Our decision is how do we proceed, where do we send the claim, and who do we contact to get information?

According to P02, "As the provider we must verify with the employer, that the injured worker presented and is seeking care. We are chasing down the employer in pursuit of trying to get the claim paid."

A review of the company's occupational injury medical cost containment summary report revealed the UCC leaders' strategic decision-making was concentrated in responding to operational uncertainty via development of controls to mitigate negative impacts attributed to providing medical treatment to injured workers. This revelation is indicative of UCC leader strategic decision-making to identify and deploy strategy, structure, process, people, and leadership decision-making that they used to solve the administrative problem. The UCC leaders' strategic decision-making encompassed different strategies used to develop controls to mitigate the negative impacts. Four controls (financial risks, process and procedures, market relationships, and systems) emerged from the data analysis characterizing UCC leader responses.

Financial risk. The first control encompassed the organizations' value obtained in exchange for services provided in the market. The UCC leaders' responses included considerations for decisions to identify and define strategies to mitigate negative impacts attributed to an aging AR. The participants identified variances in projected vs actual remuneration that directly influenced increasing profits and focused strategic decision-

making to identify, design, and implement strategies to mitigate negative impacts on margins. The UCC leaders framed the importance of remuneration for medical treatment provided to injured workers and impacts on financial budgets attributed to increases in staff. According to P02

> Implementation of the schedules changed the meaning of usual and customary fee reimbursement in a manner that disadvantages the provider. Payers require a discount off schedule values. If the medical services it provided to injured workers were paid in accordance with the fee schedule, a significant barrier to maintaining margins in treating work-related injuries would be minimized. A focus for us as a successful medical practice is to monitor margins.

P01 determined

> Implementation of the fee schedules has resulted in greater uncertainty for what payment is going to be received for the same service. Rather than the fee schedule becoming a tool of predictability, it is being used by payers as a tool of convenience to reduce payment for medical services. Controlling AR is priority and currently AR aging is over 240 days for medical services provided for work-related injuries.

The leaders' reflected upon decisions made to reduce AR aging and indicated the financial implications were not limited to variances in remuneration. The organization experienced increases in human resource allocations as there was a need identified to increase administrative staff to reduce escalation in unpaid claims. According to P01,

> It was important to use data reporting to track trends in AR. The fee schedule

> is producing 7% lower fee reimbursement and does not account for trend adjustment or cost of living. The organization hired additional operational staff, to keep up with the increased outbound calls to obtain payer contact information and collection efforts to reduce escalation of unpaid claims.

P02 indicated,

> AR tracking mechanisms were instituted using data analytics to identify connections between AR recovery efforts and administrative processes and procedures. Contract reimbursement language was compared to financial data reporting to identify inconsistencies in reimbursement.

A review of the company's AR summary report confirmed the leaders' decisions to adopt enhanced AR tracking to manage collection of outstanding employer remuneration. The AR summary report provided evidence of the UCC leaders' actions to identify the influence of an aging AR, hiring of additional staff for AR collection activities, and identifying variances in remuneration received for treatment provided to injured workers. This revelation aligned with findings in the literature. For example, Baicker (2017) cited managing financial risks as one of five core considerations for healthcare providers in response to healthcare reform. Within the adaptive cycle, organizational behavior includes the strategies leaders engage to reduce uncertainty and enable the organization to continue evolving (Miles et al., 1978).

Processes and procedures. The second control highlighted identification of gaps in administrative processes and procedures. The data framed the participants' comments for their defined processes and procedures. The UCC leaders identified inefficiencies in

obtaining the employer point of contact information process and claim intake procedures. According to P01,

> It is cost prohibitive to pursue a first point of entry (FPOE) medical service process at a rate of $200.00. It is not effective to use reimbursement for medical treatment to chase administrative dollars when a large portion of the medical rate is designated to care itself. What we found was very few employees know the workers' compensation representative.

P02 explained that

> Our claim intake process is injured worker goes to point of entry provider to seek care for a work injury. As the provider, we obtain the employer's contact information from the injured worker. Typically, the employee only knows their immediate supervisor.

The leaders identified strategies used to minimize inefficiencies attributed to FPOE medical service and claim intake. P01 substantiated the importance of strategic decision-making to adjust procedures. P01 stated that

> A strategy implemented in 2018 was to follow-up via phone call to employer the day after treatment to let the employer know that the employee was treated. Maintaining an employer profile that includes workers' compensation adjuster primary contact information was needed in order to create the database of information needed to complete the follow-up point of contact. It was determined to be more effective if information was secured at the point of service eliminating call back processes, at which time it was recovery efforts to obtain information vs

follow-up processes to contact the appropriate workers' compensation point of contact.

P01 indicated that UCC medical services provided to injured workers occurred in most cases at the onset of injury, with the UCC providing FPOE medical treatment. P02 pointed out that often claim intake processes revealed omissions for the employer's point of contact and validation that a compensable claim existed. P02 further stated, "the authorization for FPOE services included providing medical treatment based on the information provided by the injured worker and referred to this engagement as an honor system." Within the bounds of the honor system, P01 and P02 indicated that internal processes required mechanisms to validate information provided by the injured worker following initial treatment to include the process of establishing a database for the appropriate employer representative and next-day post treatment follow-up procedures.

A review of the company's occupational injury re–file claim intake form and claim intake policy summary revealed organizational administrative processes and procedures were implemented to collect employer information and workers' compensation point of contact prior to providing treatment to the injured worker. Comparatively, Dixit (2016) indicated that healthcare providers would be required to develop innovative strategies to maintain processes surrounding the delivery of products and services while navigating dynamic healthcare landscapes. According to Miles et al. (1978), organizations experience successes and failures, attributed to environmental change, in defining organizational strategies to align strategy, structure, and processes to

adapt and compete. The adaptive cycle exhibits how leader decision-making influences processes and procedures required to achieve firm performance strategies.

Market relationships. The third control encompassed interactions with market participants. The UCC leaders described interactions with market participants (employers, insurance carriers, third party administrators, and injured workers) and strategies identified to mitigate negative influences on margins. According to P02,

> The employer must file the first report of injury (FROI) to the workers' compensation insurance carrier and third-party administrators. We found in many cases the claim is rejected as denied due to no record of filing. Largely, there has only been one third-party administrator to hold our bills or have a recall process in place to reprocess a bill if the report of injury is received after a bill was denied.

P02 explained, "we have some 40% of visits where we do not have a pre-arrangement with employers." P01 and P02 highlighted the importance of marrying injured worker medical treatment to the employers' FROI and benefit assignment. P01 reflected upon additional considerations influencing leader decision-making and stated that

> There were difficulties experienced in engaging with third party entities and insurance carriers and I believe the employer was not engaged in the medical claim handling process. Direct participation with employer groups afforded a better opportunity for provider to employer interaction and facilitated the collection of key point of contact information leading up to and during the encounter with the injured worker.

According to P02,

> The decision to engage directly with the employers was an important step toward developing direct employer relationships for inclusion on employers' approved workers' compensation panel of providers. It was later determined that employers assigned claim handling and payment responsibilities to claims professionals within risk management companies.

P01 affirmed that medical providers must navigate multiple levels of intermediaries and highlighted that where possible; UCC leaders should pursue direct provider-to-employer interactions. P02 reflected upon decisions to focus organizational resources on processes to bring awareness to employers that medical services had been provided and resulted in outstanding AR. P01 and P02 stated that concerns that employers in many cases were distant from the actual claim process concerning the payment of medical treatment.

A review of the organization's provider-to-payer listing revealed organizational relationships with employers, insurance carriers, and third-party provider networks. The organization's website included frequently asked questions to assist injured workers in prerequisites for employer engagement prior to seeking medical treatment. The adaptive cycle purports firm performance and resiliency exudes from organizational adaptation and configurations in response to environmental disturbances (Miles et al., 1978). P01 further highlighted that the FPOE medical services increased interactions with injured workers and often transitioned to nonurgent primary care medical homes. This acclimation toward primary care medical homes is similar to the findings in the literature.

Loeppke et al. (2015) posited that primary healthcare often intermingled with employer occupational medical treatment programs.

Similarly, Rubeis, Schochow, and Steger (2018) determined that provider-patient relationships evolved beyond homeostasis states attributed to changes experienced in consumer demand. P01 and P02 provided insights into the assignment of payment for medical treatment functions to third party administrators and carriers contributed to difficulties in achieving acceptable AR margins between reimbursed and unreimbursed injured worker medical treatment. P02 cited the importance of reviewing alignment among provider contract language, reimbursement received, and medical treatment provided. P01 indicated that third-party administrators and carriers used statutory regulations for employer provider panels to harness the injured workers' access to employer-approved medical providers. P01 indicated that engagement in the panel process required medical provider acceptance of preferred provider contract provisions. P02 indicated that an integrated strategy to minimize negative AR impacts included negotiating more favorable contract terms.

Systems. The fourth control framed strategies to enhance technical systems to mitigate negative impacts attributed to claim intake and record of benefit assignment variances. According to P01,

> Information provided during claim intake regarding an injury is accepted, as provided by the injured worker during the point of first contact and we provide the necessary treatment. Additionally, many services are provided after hours when there is no one available to verify injured workers' benefit assignment

eligibility.

P02 explained that

> Treatment provided to injured workers is based on the honor system. It is not uncommon to have an injured worker present for treatment with only their immediate supervisor contact information assessable during claim intake. Currently, we do not deny treatment; we accept that information concerning benefit assignment for the injury provided is correct.

The UCC leaders described the identified system mechanisms to minimize inaccuracies in claim intake and benefit assignment impacts on margins. P01 indicated, "our electronic medical record (EMR) system allows for enhanced tracking for treatment and payment for medical service."

P02 stated that

> The EMR system included scalable capabilities and contributed to its organizational agility. We built in a claim submission delay. Medical claims are held for one week to allow the FROI to be processed. Employers, where there is not an established relationship, an auto-generated letter concerning treatment is provided to begin validating the claim information obtained during FPOE.

A review of the claims process for FPOE summary document revealed the organizational strategy to delay the initial claim submission for one week was instituted to minimize denials due to delays in first notice of loss reporting. Additionally, the summary included a procedural process to generate payment notices of billed statements to injured workers for unpaid medical treatment. This revelation confirmed the

organization adopted system enhancements to generate reports and automated past due account letter campaigns to the respective employer groups to minimize AR aging. This systemic control focus is consistent with the findings of Bates, Sheikh, and Asch (2017) who researched the influence of healthcare providers adopting medical innovations in order to improve internal care processes and determined that these actions increased opportunities to promote effective medical decision-making and improved firm performance. Within the adaptive cycle strategic model, the creation of systemic enhancements highlighted organizational characteristics toward framing solutions that influence firm performance (Miles et al., 1978).

Summary. The UCC leaders perceived it was important to develop control strategies. Strategic decision-making for four controls (financial risks, processes and procedures, market relationships, and systems) framed the participants' actions to respond to negative margin impacts after the implementation of the FSR. Analogously, Bedford, Malmi, and Sandelin (2016) researched the influence of management control (MC) packages and determined that organizational performance is positively influenced when the individual MC components complement each other and are a fit for the environment.

From the findings, it appears that the UCC leader participants exhibited minimal reliance upon an external systemic solution to overcome negative fee schedule impacts, which aligns with researchers in the literature. The perceptions of the participants align with the views of Powell (2016), who further explained that identification, design, and development of internal controls for organizational capabilities encompassed structural

adaptations toward engineering improved firm performance. Conversely, the UCC organizational behavior exhibited diverged from the firms in the findings of Bentley-Goode, Newton, and Thompson (2017) who determined firm typologies with weak internal controls struggled with developing effective performance improvement campaigns.

According to Miles et al. (1978), within the adaptive cycle, (a) firms exhibiting prospector strategies innovate new products and are amicable to high risk, (b) analyzer firms replicate at reduces rates existing innovations in the environment and accept calculated risk, (c) defenders exhibit a narrow focus on existing products with seldom need to innovate and experience minimal risk, and (d) reactors develop responses to environmental threats as encountered to mitigate risk. The UCC leaders identified the risks influencing the organization's margins after the implementation of the FSR and developed strategies to mitigate the risk. The strategy to develop controls in response to financial risk, processes and procedures, market relationships, and systems depicts organizational prowess as described by Miles et al. (1978) for the adaptive cycle attributed to strategic responses developed to solve the administrative problem.

Strategy 2: Increase Organizational Knowledge

The second approach to emerge from the data analysis was the need for the UCC leaders to increase organizational knowledge concerning negative effects on margins attributed to external environmental influences beyond its control and existing internal environmental constraints prohibiting effective prescriptive responses to minimize negative effects on margins. According to P01,

> The participants' responses included, a lack of workers' compensation system knowledge increased misconceptions concerning the workers' compensation system. As a FPOE, our services are standard. Implementation of the fee schedule has resulted in greater uncertainty for what payment is going to be received for the same service, as it appeared as if payers are cherry picking when and when not to use the fee schedule. Specific areas that required information to identify internal solutions included reducing administrative bottlenecks, time lapse among first report of injury, assignment of medical service benefit, and payment for medical services provided to the injured worker. In other words, we needed to identify the additional information to make any necessary internal changes.

P02 indicated that

> There was no assistance in obtaining FROI's from the employer. Providers of healthcare must gain understanding of the mechanics within the workers compensation system to identify solutions needed to address lack of payer accountability and how to address administrative lag time issues from the point of medical provider intake to claim acceptance and payment.

A review of the occupational injury medical cost containment summary report revealed that the UCC leaders' strategic decision-making included identification of knowledge management area strategies (KMAs) to improve the organization's use of resources in response to negative effects on margins attributed to the implementation of the FSR system. Additionally, the organization's website included a claim re-file form to facilitate the collection of employer and claim status information prior to treatment.

These revelations provided evidence of the UCC leaders' strategic decision-making to explore and exploit KMAs to increase organizational knowledge. The UCC leaders' responses aligned within two KMAs (external environment and internal environment).

External environment. The first KMA used to increase organizational knowledge included assessing the external environment. The UCC leaders described the workers' compensation systemic changes attributed to the implementation of the FSR resulted in fundamental questions surrounding workers' compensation remuneration. The UCC leaders explained an identified misconception was that the FSR would minimize barriers to achieving projected firm performance benchmarks attributed to increased predictability for payer remuneration. According to P01,

> There were two key issues: medical claims being paid, and medical claim payments being paid correctly. In many cases, payment was significantly lesser than charged or no payment issued. Implementation of the medical fee schedule afforded employers an additional level for payment comparison. The employer or claims administrators are utilizing the fee schedule as a tool to justify lowered or zero payments.

As stated by P02," FSR should be the reimbursement, no payer will agree to only allow application of the medical fee schedule solely as the determinant for payment."

P01 cited the implementation of the fee schedule resulted in increased uncertainty as payer remuneration levels were not equivalent to the stated fee schedule values. P02 further expressed payers "cherry-picked" reimbursement mechanisms by selecting the lesser of FSR or other remuneration amounts. P01 largely attributed the "cherry-picked"

paradigm underscored the existence of stipulations embedded in the provider-to-payer contracts. P02 described additional misconceptions surrounded employer defined claim handling processes. P02 expressed the importance of understanding employer engagement in the claim to benefit continuum and subsequent influence on the FPOE and downstream medical treatment provided to injured workers. P02 confirmed knowledge gained using an external environmental view revealed vital factors in determining required internal procedural enhancements and systemic innovations.

A review of the medical cost containment summary exhibited engagement with self-insured associations to gain knowledge surrounding the claim to benefit continuum and cataloged payer claim denials. Additionally, a review of the workers' compensation conference attendance rosters for 2018 and 2019 confirmed the participants' organization engaged in opportunities to increase organizational knowledge surrounding the workers' compensation system via attendance at post schedule implementation sessions. According to P02, "We determined it was an effective measure to engage with workers' compensation stakeholders, employers, third party administrators, and the Commission to gain increased understanding of the workers' compensation system." The participants' views encircling strategies to increase organizational knowledge aligns with the findings in the literature. Fiscella and McDaniel (2018) researched transformations in the U.S. primary care systems and determined increased information was pivotal to identifying holistic system changes, human resource preparedness to change, prioritizing change focus, and quantifying value of changes in order to experience sustainability. Krystallis, Demian, and Price (2015) researched the concept of future proofing asset management in

a study of 13 senior managers and determined organizational models that participated in opportunities to increase knowledge experienced success in adapting to unforeseen external environmental shifts.

Internal environment. The second KMA to increase organizational knowledge included an evaluation of experiences within the internal environment. The UCC leaders described strategies to review internal data to frame workers' compensation system influences on internal operations. According to P02

> The FPOE provider receives the lowest claim reimbursement, but bears biggest burden in obtaining information to process the claim and obtain FROIs filed in order to secure timely payment of claim. Leaders must have a process in place to locate and mitigate black hole claims from occurring.

P02 further defined black hole claims as those claims in which treatment was provided and there was not a clear identification of the employer or if there was an acceptable workers' compensation claim for benefit.

P01 indicated that

> The inconsistent application of the fee schedule occurred in comparing bill to bill but also among multiple medical service lines provided within a single bill. If other reimbursement models provided the lowest reimbursement, the fee schedule would not be used and the lowest model affording payment used.

P01 and P02 determined reviewing internal data revealed inherent workers' compensation system influences beyond their control. P01 further described that

> There are variances in reimbursement intervals between FPOE and downstream medical services that are provided. Payers should not have the ability to selectively apply the schedules. The downstream medical provider enters the treatment paradigm in most cases after the administrative smoke clears and the claim processes are in full swing, resulting in less an impact from denials due to claim status.

P02 indicated,

> We determined it to be important to maintain awareness of providing injured worker required medical services. In other words, the injured workers' demographics, injury classification, and employers' workers' compensation specialist must be engaged early on.

A review of the data analysis and issues summary assessing fee schedule experience revealed use of internal data analysis to identify trends in profits attributed to providing medical services to the injured worker population. The organization's data analysis included comparisons of outstanding AR collections between injured worker medical treatment reimbursement and nonworkers' compensation medical services. These revelations confirmed the participants' utilized internal data to identify micro-level workers' compensation system influences. The participants' responses highlighted that the imperative knowledge gained using its internal data influenced strategic decision-making for resource allocations and aligned with researchers' findings in the literature. Hayes, Wolf, Labbé, Peterson, and Murray (2017) researched primary care providers' management of obesity patients and determined that failure to assess continuous behavior

training within the internal environment resulted in inefficiency in practice collaboration, providing patient care, and management of chronic conditions. Similarly, Sturgeon (2017) opined effective strategies involved a call to action to effect organizational adaptation in response to internal organizational assessments.

Summary. The UCC leaders exhibited strategic decision-making to increase organizational knowledge. Knowledge management areas included acquiring new external and internal information. The strategy to increase organizational knowledge aligns with the views of Cloeren et al. (2016), who expressed the importance of healthcare providers increasing organizational knowledge in response to policy reforms to navigate systemic evolutions. Miles et al. (1978) suggested that the adaptive cycle catalogued trends in leader decision-making to adapt to internal and external environmental disturbances toward developing strategies in response to entrepreneurial problems. The participants determined increasing organizational knowledge of the internal and external environment was pivotal to develop responses to disturbances within the workers' compensation market attributed to the implementation of the FSR. The adaptive cycle purports prospector firms seek to identify opportunities to influence environmental change, defenders disregard developments, analyzers seek to gain knowledge in order to imitate what is proven, and reactors remain dormant until the next environmental shift occurs (Miles et al., 1978).

Strategy 3: Measure Organizational Performance

The third approach to emerge was the need for the UCC leaders to develop strategies to measure the organization's performance in response to environmental

disturbances attributed to the implementation of the FSR. The participants' responses included considerations for measuring the end-results of past strategic decisions for contract terms influencing remuneration and margins realized between the costs to deliver medical service to injured workers vs remuneration received for medical services provided. According to P02,

> There were differences in remuneration observed. Aging in terms of the number of days outstanding, total amount outstanding, and total services provided to injured workers are key benchmarks. Successful medical practice is closely tied to its margins. It was important to clearly define employer engagement in required claim intake steps and procedures.

As expressed by P01,

> Comparing the performance of workers' compensation to commercial payers to determine if there are trends that can be identified for the type of service provided was one consideration, in order to improve predictability for reimbursement. Our practice treats approximately 40,000 employees a year. At the time of a visit, payments are not collected from the employee. Our data analysis reflected a 7 million-dollar AR arrearage. This accounts for on average 100 injured workers per day. For many of the visits, we find that the employee is not working for the employer provided at the FPOE. Our goal is to increase the number of direct payer-to-provider contracts to allow for increased validation of injured worker FPOE obtained data.

Two organizational performance categories (contracts and margins) encapsulated the participants' responses characterizing identified tools to measure organizational performance in responding to the engineering problem. According to P02 "in our effort to provide patient care to injured workers, on average, the claim adjudication time period is from 160 to 180 days."

A review of the medical cost containment summary revealed the UCC leaders implemented strategies to measure progress toward increasing provider-to-employer contracted visits and reducing the claim to final adjudication life cycle. The participants' views aligned with Burgelman et al. (2017), who asserted that combining related organizational strategies encompassing activities and processes resulted in a strategic framework for organizational response to environmental evolutions. The revelation provided evidence of the participants' strategic decision-making to measure contract remuneration rates and average profit margins for medical services provided to injured workers.

Contractual influence. The UCC leaders identified deficiencies in remuneration attributed to treating injured workers and determined the contracts influenced organizational performance. As indicated by P01,

> We prefer where possible to establish direct contractual relationships with employers that does not include third party administrators or other entities. We determined this to be more advantages for the provider in predicting ability to maintain or increase margins.

P01 described the importance of assessing provider contracts to identify trends in reimbursement. P01 stated that two prominent concerns associated with provider agreements included “identification of the origin for errors associated with incorrect reimbursement and complete denial of payment.” According to P02,

> Provider engagement in networks versus direct provider-to-employer contracts required a comprehensive review of contractual terms defining reimbursements in exchange for products and services provided. While payers require a discount off the FSR, as an FPOE provider, it is important to be selective in finalizing contract terms.

A review of the claims process for FPOE revealed that the UCC leaders’ decision-making to measure contractual influence highlighted that less than 50% of medical claims were filed electronically due to the absence of a payer contract assignment. Comparatively, Squires et al. (2016) completed an analysis to measure the influence of reimbursement between CMS and commercial payers and asserted that over time providers would experience variations in reimbursement levels. Similarly, Lee et al. (2016) studied healthcare reimbursement processes and determined that seemingly simple omissions in contract structural elements created increased complexity for medical providers to obtain remuneration within reimbursement systems.

Margin impacts. The leaders reflected upon the identification of a barrier to increasing its organizational profits encompassed achieving acceptable margins. According to P01,

> Reimbursement for medical services provided to injured workers do not follow defined fee schedule reimbursement. In comparing what we receive to commercial payers, there is a significant difference. If we are not paid, we can pinpoint the reason; however, it is not the same for workers compensation. Many times, we are held to communication breakdowns between the employer and claim adjuster, with both denying requests for payment.

According to P02,

> The medical services we provide to injured workers are pretty defined. Our experience is that we do not have an issue with the fee schedule itself. If the fee schedule values were received, then there would be a measure of predictability.

P01 described the process of comparative analysis performed to evaluate the rate and frequency of reimbursement received for noninjured worker treatment.

The participants explained that the analysis revealed 98% of services provided for noninjured worker treatment resulted in the completion of adjudication for payment within 30 days versus the completion of 69% of injured worker treatment medical claim adjudication occurring within 120 days. A review of the AR summary report revealed the variance in days to receipt of reimbursement indicated by the UCC leaders. Additionally, there was evidence that the leaders identified further variations within a single payer reimbursement methodology for similar medical services provided influencing margins. The views of the participants aligned with Squires et al. (2016) who posited linkages existed between healthcare treatment reimbursement and the success or failure of organizational strategies to increase profits.

Summary. The UCC leaders identified and developed strategies to stabilize its operations via the measurement of organizational performance metrics. The organizational performance measurement strategies align with scholarly views that successful organizational performance requires iterative review processes to stabilize its operations within the context of the changing environment. Forte, Hoffman, Lamont, and Brockmann (2000) researched the influence of establishing effective organizational structures aligning with environmental fluctuations and identified linkages to improved organizational performance. Shortell and Zajac (1990) cataloged the use of experience tracking as a strategy and determined that firms can assess how well the organization performed over time. The participants identified organizational performance measurements for contractual influence and margin impacts as pivotal influences to evaluate over time as FSR experience increases. According to Miles et al. (1978), prospector firms seek to be flexible over efficiency, defenders incorporate and place emphasis on stability strategies, analyzers adopt proven strategies, and reactors fail to implement preventative strategies in response to engineering problems.

Strategy 4: Evaluate Products and Services

The final approach to emerge from the data analysis was the need for the UCC leaders to evaluate continued placement of services in the market. The participants' responses aligned in expressing confidence in the organizations defined core medical services. According to P02,

> Our core services are providing primary care and we offer urgent care during and after normal business hours. It is also during this time that we experience

> difficulty in completing enhanced claim intake procedures, as the employers' workers' compensation point-of-contact is generally not accessible after hours to provide the required approvals.

P01 indicated that

> The healthcare services provided after hours are where we see the larger affect from incorrect or nonpayment of treatment. It is continued access to these services that we are assessing in relation to impact on margins.

P01 and P02 determined that relationships among injured workers, employers, insurers, and other third parties directly influenced margins for its core services. P02 determined that

> The injured worker population presents as one consumer group of UCC core services. While we continue to provide services based on the honor system, the impact to our operations from providing medical services to injured workers and administrative efforts to acquire workers' compensation point of contact from the employer, third party adminstrator, and insurance carrier influence medical services and is being evaluated.

A review of the participants' organization website revealed descriptors that supported the identified core medical services provided to the injured worker population. I used the online directory for the participant UCC accreditation association to obtain a listing of comparable UCC organizations in order to confirm core services engagement within the market (Table 3).

Table 3

Accredited UCC Core Services Comparison

Core Service	Frequency	%
Extended hours	5	100%
365 Days of the week	4	80%
Walk-in	5	100%
Radiology on-site	5	100%
Lab on-site	5	100%
Primary care	3	60%
Urgent care	5	100%
Occupational health	4	80%
Integrated system	3	60%
RTW access at POS	2	40%
Light duty programs	1	20%
PE requirements	4	80%
Drug test protocols	3	60%
Specialist referral	1	20%

The comparison revealed that the UCC leaders' strategic decision-making provided core products and services (urgent care, extended hours, walk in access, onsite services) that were conducive to the consumer demand from injured worker populations. The participants described the core services available in the market resulted in the FPOE continuum. Lee et al. (2017) determined that consumer demand influences organizational decision-making in providing products and services provided to market participants. The comparison highlighted that 62% of the identified UCCs' core services aligned with the participants' organization. Furthermore, there was evidence that specialized workers' compensation medical treatment such as return to work (RTW), light-duty programs, physical examinations (PE), drug testing, and referrals to specialists varied across UCCs.

The participants' responses reflected that developing controls resulted from organizational impacts experienced providing its core services. P01 indicated, "The fee schedule is only in its second year. Specific areas are required for more legislative attention included reducing administrative bottlenecks and forcing third party administrators and insurers to make timely decisions." According to P02, "While there has been some improvement for pro-active processes put in place to begin reviewing claim processing after 7 days, there is still significant work that remains as evidenced by the data." P01 stated, "Increased organizational knowledge was critical to determine the viability to continue providing its core services." P02 indicated "Ongoing engagement in workers' compensation associations brought awareness to issues for medical providers in treating injured workers." The leaders of the participant organization exhibited a high confidence level for the organization's products and services positioned in the market.

Summary. The UCC leaders' strategic decision-making does not reflect fluctuations in product and service offerings within the organization's market space and confirms the high level of confidence in the services provided to injured workers. The participants identified that strategic decision-making to provide its core services to the injured worker population required continuous review over time and was reliant upon future FSR system experiences. The leaders' decision-making culminated in strategies surrounding organizational capabilities and resource allocations to support the infrastructure and market presence of the core services. This strategic focus exemplifies the influence of products and services as the independent antecedent allowing for reverse

engineering of solutions to increase profits as influences change in response to the implementation of the FSR and is depicted in Figure 3.

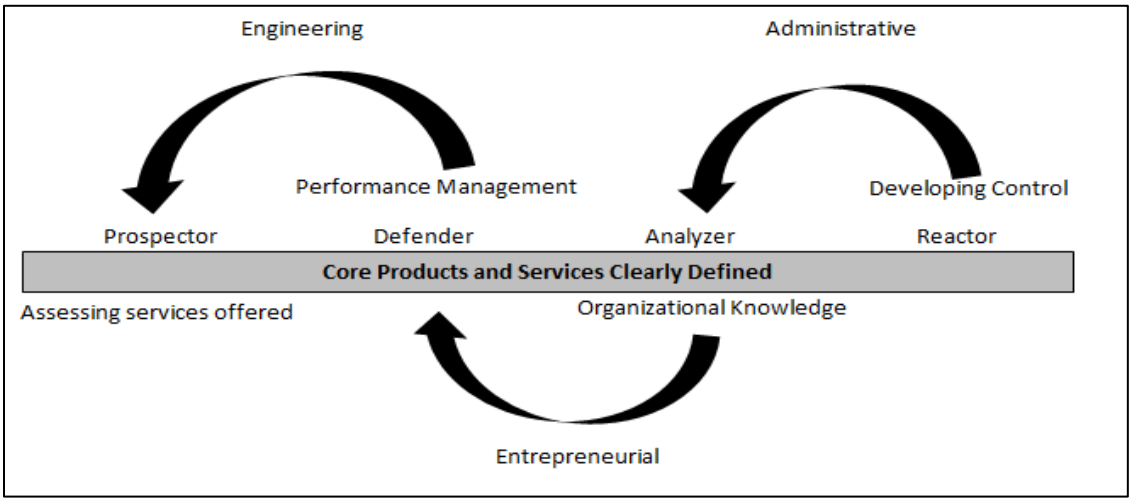

Figure 3. Adaptive cycle and impact of confidence level.

According to the adaptive cycle model, Miles et al. (1978) determined organizations emit defined characteristics aligning with one of four strategic types (prospector, defender, analyzer, and reactor) as predictors of how the organization responds to environmental change. Within the adaptive cycle, organizational behaviors exhibited in response to environmental influences align within the strategic typologies and frames predictability for successes or failures in strategies to engage organizational capabilities to solve administrative, entrepreneurial, and engineering problems. While the participants' organization behavior did not signal adaptations in defining market presence, there were clear signals that the organization exhibited similar characteristics of reactor, analyzer, defender, and prospector in adapting strategic focus and capabilities to the changing healthcare landscape attributed to the implementation of the FSR

Applications to Professional Practice

One of the findings of the literature review was that minimal research had been completed on how UCC organizational strategy is influenced in providing treatment for workers' compensation injuries and illness. The purpose of this single case study was to explore strategies that leaders used to increase profits after the implementation of the FSR system. The findings of the study expand upon the body of knowledge surrounding this phenomenon. According to Mandal and Bagchi (2016), organizational financial performance is reliant upon leaders understanding of interrelationships that exist between knowledge management and strategic decision-making.

The approaches emerging from the study encompass discoveries into how the participants developed strategies to increase profits in a post reform environment. These discoveries might be useful to healthcare providers contemplating providing medical treatment to injured workers. Specifically, the findings could present a viable strategic risk management framework for any healthcare provider who is struggling with administrative processes, procedural inefficiencies, and an aging AR attributed to healthcare policy reforms.

Identifying internal controls to minimize negative impacts to achieving increased profits may help business leaders ensure strategic decision-making is aligned with organizational capabilities to develop effective responses to changes in the environment. Increasing organizational knowledge necessary to develop responses to changes within the workers' compensation system may improve business leaders understanding of the environment and improve the organization's ability to identify environmental shifts in

order to adapt. Measuring organizational performance provides business leaders opportunity to promote strategies to establish best practices in performance and attaining acceptable margins in providing healthcare services influenced by policy reform. Evaluating products and services offered in the market, may improve business leaders' ability to embed firm controls in attaining value for services provided.

These core services provided by UCCs present as an optimal source of care for injured workers attributed to the alignment with consumer demand for flexible scheduling and extended hours. This was a qualitative single case study; therefore, the study findings may not be generalizable to the entire population of UCCs in the United States, as would be more likely for a quantitative study with larger sample size. For example, in Virginia, the analysis revealed that some UCCs' products and services in the workers' compensation healthcare market varied; however, five core services appeared more frequently within the UCCs. However, the findings can be useful to healthcare providers in North Carolina, West Virginia, Tennessee, Maryland, and Washington, DC, as the legislative mandate requires out-of-state provider treatment compliance under Virginia's statutory regulations. These are the border states to Virginia; additionally, there is the opportunity that providers near the Virginia border may provide treatment to injured workers that requires compliance to Virginia workers' compensation legislative mandates.

Implications for Social Change

Urgent care centers have emerged as an integral contributor to medical treatment for the injured worker population attributed to its positioning in the healthcare market,

providing flexible access points for medical care. The potential engagement for medical services provided by UCCs increases as growth in the number of sites occurs in mainstream healthcare landscapes. Le and Hsia (2016) indicated UCC charted exponential growth records averaging 300 new centers annually. Despite the growth in numbers of UCCs as a provider of lower-cost healthcare services, there are influences attributed to the enactment of policy reform that may increase the financial risk for center operations. The financial strength of healthcare organizations may directly influence quality and access to healthcare services. Lear, Fleig-Palmer, Hodge, Fleig, and Arensdorf (2016) described the need for healthcare providers to develop strategies to address an evolving healthcare landscape to continue as a viable option in providing healthcare services.

In this study, two UCC leaders provided information through interviews and company documents surrounding considerations for the strategic decision-making they employed to provide healthcare services to the injured worker population. The approaches emanating from the study encapsulated strategies that resulted from a systematic review and analysis of information gathered from two leaders within an organization navigating healthcare policy reform. The strategies (develop controls, increase organizational knowledge, measure organizational performance, and evaluate products and services) encompass the experiences of the leaders regarding organizational response to a dynamic healthcare landscape. The results of this study might provide healthcare providers strategies they can adopt within their strategic frameworks to increase profits.

According to Miles et al. (1978), the strategies organizations deployed provided predictions for organizational agility to transcend challenges toward refinements that improve the current state and promote future firm performance. With increased profits, business leaders might develop innovative healthcare treatment protocols further improving the quality of care provided to the nation's population of injured workers. The findings from this study may foster positive social change for any organization that uses these strategies to identify linkages between product and services placement and strategic decision-making in response to policy changes influencing markets. Kornhaber, Mclean, Betihavs, and Cleary (2018) determined in researching healthcare treatment experiences that engaging effective support strategies improving overall confidence might systematically embed resilience in activities performed. Leader strategic decision-making has been a feature deployed within healthcare organizations to effect positive social change as a part of some advancement in both the clinical as well as administrative healthcare settings.

Recommendations for Action

The purpose of this qualitative single case study was to identify strategies that leaders use to increase profits after the implementation of a FSR system. The findings of this study may provoke leaders of healthcare organizations engaging in providing healthcare treatment, influenced by healthcare policy reforms, to evaluate their organizational strategic frameworks, and identify opportunities to gain new understanding that promotes future firm performance. The following summations reflect

recommendations for action espoused from the analysis of the participants' perceptions of strategies to increase profits after the implementation of the FSR system.

The first recommendation is that UCC leaders must develop controls to mitigate adverse impacts on organizational capabilities. The findings of the study supported UCC leader strategic development for structural adaptations in the form of strategic frameworks to deploy organizational capabilities to control financial risk, processes and procedures, market relationships, and systems. Burwell (2015) observed that healthcare leader strategies were required to navigate ACO challenges that placed constraints on entrants in the healthcare system.

The second recommendation requires UCC leaders to increase organizational knowledge surrounding the workers' compensation system in order to navigate systemic evolutions in the internal and external environment. Madanoglu, Kizildag, and Ozdemir (2018) described the development of comprehensive strategic frameworks and inclusion of informed decision-making engineered firm sustainability in comparison to minimal or marginal successes realized from loosely defined processes. The study participants determined that pursuit of new organizational knowledge assisted in identification, design, and development of strategic frameworks to adapt to changes in the market.

The third recommendation requires leaders to establish routine performance measurement processes promoting continuous evaluation of organizational performance. Lee (2016) described the importance of tracking progress trends to identify successes and failures over time. The UCC participant leaders determined that measuring the influence

of contractual relationships and fluctuations in margin impacts provided critical information to identify trends in providing medical treatment to injured workers.

The fourth recommendation directs leaders to evaluate products and services offered in the workers' compensation market as a separate component within the organization's strategic framework. Leaders must understand how developed controls, organizational knowledge, measuring performance fluctuations influence the development of strategies surrounding the products and services placed in their market space. The participants identified that within the workers' compensation market space, UCC services primarily resulted from its core service engagement of providing urgent care treatment for injury and illness absent the high cost associated with emergency room medical treatment. However, strategies were required to manage disruptions in the environment. Comparatively, Viers et al. (2015) presented support for radical changes in healthcare treatment attributed to influences of telemedicine and mobile healthcare treatment options in healthcare promoting medical providers' swift adoption of new medical technological innovations to adjust to the demands for lower cost structures.

Finally, distribution of these findings, from this specific case, might be suitable for inclusion in leader strategic development training materials. Additionally, healthcare certification and accreditation associations may find it useful to provide members case exemplars for strategic frameworks to address financial challenges that may affect achieving or maintaining association accreditation or certification standards. This study may be conducive to workers' compensation insurance, and healthcare trade journals to provide context as a case example for strategic frameworks to address real business risk

exposure components associated with healthcare markets. Lastly, each year, on average, 500 stakeholders attend the Virginia Workers' Compensation Commission education conference (VEC). In the medical fee schedule manager role, a critical component requires contributions to the education and outreach content for the VEC conference. During this conference and other medical society presentations, I will utilize the findings from this case study in conference presentations to educate stakeholders within the Virginia workers' compensation system.

Recommendations for Further Research

The results of this study included an exploration into strategies that leaders use to increase profits after the implementation of a FSR system. The study included four underlying assumptions: (a) that leaders possessed knowledge and understanding for medical fee schedules, (b) UCC operations included providing work-related medical treatment and increased access to care, (c) leaders in UCCs were willing to participate in the study, and (d) a qualitative study was appropriate to obtain answers to the research question.

The findings of the study supported that leaders possessed knowledge and understanding of the medical fee schedules, confirmed that UCC operations provided medical treatment to injured workers, provided extended hours promoting access to care, and the qualitative methodology did espouse answers to the research question. The assumption that UCC organizational leadership would be willing to participate in the study resulted in an additional limitation. The number of participants meeting the participant organization requirements was 25. Of the 25 UCC organizations, only one

UCC organization agreed to participate in the study. During the participant selection process, four of the UCC organizations deferred responses regarding participation to corporate counsel, of which some did not respond. This experience encompassing the engagement of corporate counsel was unforeseen and generated questions that might present as a topic for future research to identify trends in variations for UCC organizational structures and evolutions in practice management.

There were limitations inherent to the design of this study. The participants in this study were limited to accredited UCCs in Virginia. Further research expanding the population and participant criteria to include all UCCs, is recommended. Further research may provide additional information healthcare leaders, who provide services to injured worker populations, can utilize to improve strategies to increase profits.

A consideration for future research could include expanding the participant populations to incorporate other medical providers and geographical locations. Expansion of the participant populations beyond the geographical region may elucidate identification of uniqueness or similarities of information obtained in order to corroborate, dispel, or extend the findings in this study.

Reflections

My current role as the Medical Fee Schedule Manager and past experience as Medical Bill Review Manager contributed to my knowledge of the study topic. This prior engagement meant there was an opportunity for preconceived ideas and personal biases to infiltrate the research study. However, the instruction and personal preparations before obtaining approval to conduct the study included learning how to identify and deploy

bias-mitigating processes and procedures using a strategic framework. The strategic framework included using the case study protocol that guided each stage of the research study including selecting the participants. The participants provided frank dialogue for their contribution to the study. This contribution was invaluable to the process. The use of member checking promoted the process to validate the interpretations of the participants' responses and void my own personal experiences and biases.

Completing this doctoral study has been a rewarding experience and provided invaluable lessons. The findings from the study highlighted some of the challenges UCC leaders experienced and strategic decision-making to operationalize identified solutions to solve administrative, entrepreneurial, and engineering problems attributed to the environmental fluctuations after the implementation of the FSR. Finally, during this doctoral journey, I have learned new knowledge regarding healthcare provider engagement in the workers' compensation system through data obtained from the experiences identified by the participants. This new knowledge has provided an expanded lens into the workers' compensation system from the perspective of the healthcare provider and fostered a renewed spirit to ensure equitable treatment for all participants in my role in the public service sector.

Conclusion

Leader strategies are imperative to increasing organizational profit. The overarching research question for this single case study was as follows: What strategies do leaders of UCCs need to increase profits after the implementation of a FSR system? Face-to-face interviews were conducted with two UCC leaders to gather data to answer

the overarching research question and methodological triangulation using company documents and information available via public websites was utilized to validate the data obtained. The study findings provided four major approaches surrounding strategies leaders use to include (a) develop controls, (b) increase organizational knowledge, (c) measure organizational performance, and (d) evaluate products and services offered in the workers' compensation market to promote increased profits after the implementation of a FSR system. These identified strategies are reflective of the UCC leaders' strategic decision-making to increase profits after the implementation of the FSR.

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Appendix A: Case Study Protocol

Research Question: What strategies do leaders in UCCs use to increase profits after the inception of a FSR system?

A. Interview Questions

1. What strategies do you use to increase profits for healthcare services provided to injured workers?
2. How has the implementation of a FSR influenced the strategies you use to increase profits for healthcare services provided to injured workers?
3. How do you measure the success of your strategies to increase profits after the implementation of a FSR system?
4. What barriers have you faced to achieving increased profits after the implementation of a FSR system?
5. What critical information do leaders of UCCs need to develop effective strategies which minimize barriers to increasing profits after the inception of a FSR system?
6. What additional information would you like to add pertaining to the strategies leaders use to increase profits after the inception of a FSR system?

B. Conceptual Model

Miles and Snow (1985) Adaptive Cycle

C. Protocol Purpose and Use

1. Researcher used the protocol to guide the research process to include identification of participants, data collection, analysis, consideration of

findings, and final preparation for conclusion.

2. The protocol was used to ensure dependability and quality of the case study processes and conclusion.

D. Data Collection Procedures

1. Data was collected from in-depth interviews and review of documents with leaders in UCCs that are responsible for developing strategies to increase profits after the implementation of medical fee schedules.
2. Participants (2) were selected from a single UCC organization in the targeted population.
3. Initial email contact for introductions and present an overview of the study to develop rapport with participants.

E. Preparation for Participant Interviews

1. Sites for interviews was finalized and communicated to participants.
2. Participant informed consent forms were forwarded for review and acceptance.
3. Researcher acknowledged the returned informed consent form. An electronic meeting invite was forwarded to each participant.

F. Interview with Participants

1. Introductions and provide brief summary.
2. Reviewed informed consent form and inquire if participant agrees to complete the interview.
3. Discussed privacy and confidentiality measures for the study.

4. Advised participant that the audio recording device would be turned on and asked if participant had additional questions.
5. Introduced participant code, data, and time.
6. Presented each question to participant until all 6 questions were answered.
7. Asked follow-up questions to obtain further details.
8. Concluded the interview and informed the participant of member checking procedures as follows:
    a. I synthesized responses to each research question.
    b. I provided a copy of the synthesis to the participant
    c. I requested the participant acknowledge the synthesized response and if there was additional information the participants would like included in the final summary of the interview responses.

       Input journal entry notes for personal experiences, knowledge, and perceptions surfaced after completion of interviews.

G. Data Analysis Protocol

1. I became emerged in the data by reviewing member checked responses and review of documents obtained.
2. I documented emerging concepts and key words in reviewing the data.
3. The data was indexed according to the identified key word.
4. Approaches were charted using headings and subheadings.
5. I analyzed characteristics and relationships for the charted approaches and interpreted meaning of the data set.