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A Health Care Management Organization's Internal Controls Strategy for Managed Care

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Walden University
2020

Abstract

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MBA, Rosemont College, 2009

BBA, Temple University, 2007

Doctoral Study Submitted in Partial Fulfillment

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Abstract

A lack of effective operational internal controls among health management organization (HMO) leaders could lead to poor operational practices, mismanagement of the government's health care funds, increased health care spending, and a negative impact on patient health outcomes. Grounded in transformational leadership theory, the purpose of this qualitative, single case study was to explore successful internal control strategies used by leaders at a southeastern Pennsylvania HMO. Data were collected from semistructured interviews with 5 participants who held positions of director or above within the organization for at least 3 years, had institutional knowledge, and had responsibility for overseeing the organization's operations. Copious notes and transcribed interviews were analyzed using coding and word frequency to discern patterns and identify themes regarding HMO leaders' strategies. Four essential themes emerged from the analysis: (a) appropriate resources, (b) continuous audit and assessment, (c) communication, and (d) holistic approach to patient care. The findings support that HMO leaders who attain appropriate human and technical resources may efficiently and effectively maximize performance outcomes and cost savings. A key recommendation is that HMO leaders adopt a holistic management strategy that fosters collaborative relationships between leaders, managers, employees, and patients. The implications for positive social change include the potential to increase HMO leaders' understanding of corporate governance strategies that improve operational efficiencies and patient health care outcomes.

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Dedication

I dedicate this doctoral study to my family – the David, Stuart, La Roche, Franklyn, and Bailey families. They are the reason for my being. Without them, I would not have been here to complete this journey. I would like to especially mention my mother, Ellener La Roche. Mummy, I dedicate this study in honor of the sacrifices you made to ensure that I had the opportunity to go to school and achieve my academic pursuits. You taught me the principles of honesty, integrity, humility, and love of self and others. You are my hero.

Isabelle La Roche, you are more than a baby sister to me. You are the wind beneath my wings. I dedicate this study to you for your support, encouragement that willed me to press on even through the most difficult times, and for the many sleepless nights you sacrificed staying up with me while I worked.

I dedicate this study to my niece, Dominique David for loving, and supporting me beyond measure, and to my nephew, Brandon Paul, who at 10 years old, motivated me with his advice that only my best was good enough. I also dedicate this study to Sharon Stuart-Fraser, Chelsea, Sergei, and Peter Fraser for their immeasurable love and support.

Finally, I dedicate this study to my deceased grandmother, Uty Ma'am David-Morris. I know that you always wanted the best for your grandchildren. For pushing me to strive for excellence in all I do, Ma'am, I thank you and wish you were here to see the fruits of your labor of love. To God be the Glory.

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I acknowledge the unwavering support of my mother, Ellener La Roche. I acknowledge all of my siblings and family members, with specific mention of Uty Morris, Dexter David, Bert David, David La Roche, Vilma Bailey Hassan, and Isabelle La Roche for supporting me and believing that I could accomplish this goal in spite of the many challenges and adversities I faced along the way. I also acknowledge and thank my dearest friends, Denise Burke and Deryck Palmer, and my cousin, Sharon Stuart-Fraser for their motivation and support every step of the way.

I feel humbled and privileged to add this doctoral degree to my family's academic accomplishments and legacy, and to bear testimony to my family, friends, and colleagues that anything is possible with hard work, perseverance, and lots of sacrifice.

I will never take lightly this honor that has been bestowed on me. To God be the glory.

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Section 1: Foundation of the Study

The cost of health care delivery in the United States is greater than in any other country in the world and poses a serious threat to the country's economic position and its health care industry (Dieleman et al., 2016). The ineffective management of the government's health care funds by health management organizations (HMOs) is a key contributor to the rising cost of U.S. health care (Gruber, 2017; Herland, Khoshgoftaar, & Bauder, 2018). The Patient Protection and Affordable Care Act (PPACA), also known as Obamacare and the Affordable Care Act, was signed into United States legislation in 2010 (Kerkhoff, 2015). The triple aim of the PPACA is to mitigate the cost of health care, increase patients' access to care, and improve the quality of care administered to patients (Kerkhoff, 2015). One of the PPACA's strategies to mitigate the inefficient management of current health care funds was the development of accountable care organizations (ACOs) as an alternative to existing HMOs (Blumenthal, Abrams, & Nuzum, 2015). The entrance of ACOs in the health management industry put HMOs at risk. HMOs stand to lose a significant portion, if not all its market share to ACOs (Gaffney & McCormick, 2017). Conversely, the emergence of ACOs presents an opportunity for HMOs to develop internal control mechanisms to improve their processes by creating leaner, more efficient business practices, reduce health care costs, and provide better quality health care to its members (Marton, Yelowitz, & Talbert, 2014).

Based on the dilemma faced by HMOs, I conducted a qualitative single case study to explore what business solutions HMO leaders used to improve operational efficiencies, and reduce health care costs to maintain its competitive advantage in the face of ACOs'

emergence as an alternative in the health care management industry. I focused on internal controls because, when strategically applied, an organization's internal controls may affect efficiency, cost effectiveness, and quality improvement. The implications of this study are that the findings may help HMO leaders explore strategies to reduce costs and improve efficiencies, quality, and access to care.

Background of the Problem

The U.S. health care delivery system and its management are extremely complex and costly in nature. It is the fiduciary duty of HMOs to effectively manage health care funds, provide quality care for the individuals whose health care they manage, and comply with all applicable laws and regulation governing HMOs (Pozgar, 2016). Health care costs continue to be high, and it is projected that by 2025, 19.9% of the nation's gross domestic product (GDP) will be spent on health care (Keehan et al., 2017), and between 47-49% of the national health care costs will be funded by federal, state, and local government (Hartman, Martin, Lassman, & Caitlin, 2015; Keehan et al., 2016).

Obama (2016) found that ineffective management of health care funds significantly contributed to the rising cost of U.S. health care. As a result, HMOs are constantly challenged with improving their internal controls to meet both regulatory and market demands from multiple stakeholders, while trying to maintain market share amidst competition from existing HMOs and new entrants into the managed care industry (Chen & Goldman, 2016). Findings of this study may assist in the development of business strategies that add value and provide positive change for leaders in the HMO industry. These findings may include the development of innovative business processes,

risk mitigation strategies, operational cost reduction, and health care cost savings. This study may add positive social change to HMO-managed patients' access to health care, the improvement in the quality of care these patients receive, and the reallocation of unspent health care funds.

Problem Statement

Notwithstanding its complexity, the PPACA identified effective population health management as a key strategy of its triple aim objective: improved population health outcomes, improved patient experience, and reduced health care costs (Slaubaugh et al., 2016). The U.S. government spent $3.4 trillion on health care costs in 2016, and projected that in 2025, $2.7 trillion, or 47% of U.S. national health costs will be managed by health maintenance organizations (Hartman et al., 2015; Keehan et al., 2016). The general business problem is that traditional HMOs' ineffective organizational controls significantly contribute to inefficient management of health care funds and poor quality of patient care. The specific business problem is that HMO leaders lack internal control strategies to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage.

Purpose Statement

The purpose of this qualitative, single site case study was to explore what internal control strategies HMO leaders used to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose health care they managed. Five directors representing different departments with varying number of years' service within a southeastern Pennsylvania HMO, and whose key roles included

development, administration, and execution of the organization's goals and operational strategy participated in the study. Findings of this study may contribute to social change by presenting the participating organization or similar HMOs with an opportunity to reevaluate current operational processes and identify opportunities to improve organizational efficiencies that may reduce health care costs, and improve quality of care for the individuals whose healthcare they manage.

Nature of the Study

Quantitative, qualitative, and mixed methods designs are the three paradigms of research studies (Yin, 2017). I selected the qualitative research method because my study was exploratory in nature. Additionally, this study closely aligns with the change-oriented, political, and collaborative tenets of the advocacy and participatory worldview which predominantly ascribes to the use of the qualitative research method. Quantitative researchers use close-ended questions to test theories and statistical analysis to examine casual relationships among variables (Groeneveld, Tummers, Bronkhorst, Ashikali, & Van Thiel, 2015). Mixed method research uses a combination of quantitative and qualitative methodologies (Molina-Azorin, Tari, Pereira-Miliner, Lopez-Gamero, & Pertusa-Ortega, 2015). My study did not require the use of a hypothesis, or statistical analysis of variables, so I rejected the quantitative and mixed methods methodologies.

I considered using the ethnography, phenomenology, and case study research designs to explore how HMO leaders' use of internal controls impact their organization. Of the three designs, the case study was most appropriate for my study. Both the ethnographic research method, used to explore the meaning and explanation of

individuals' actions, and the phenomenological method, used to explore or understand the essence of participants' experiences to find the meaning for or characteristics of a phenomenon, could have been used for this study but were not chosen because a case study most closely aligned to my needs and presented the most complete and accurate portrayal of the issue or phenomenon being researched. The case study design allows the researcher to explore issues an in-depth, real-life setting and uses the case as the specific illustration (Johnson & Matthews, 2015; Keeffe & Andrews, 2015). I opted for a qualitative, exploratory case study and collected data from participant (a) interviews, (b) copious, comprehensive dictated notes, and (c) personal observation of the participants.

Research Question

The overarching question guiding this study was, what internal control strategies must HMO leaders develop to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage?

Interview Questions

Using the following questions, I explored how an HMO's use of internal controls, such as effective management and distribution of policies, procedures, and other contractual guidelines, reduced health care costs, mitigated risk, and ensured its sustainability in light of the PPACA's triple aim strategy and its introduction of ACOs as the new model for U.S. health care management.

1. What can HMOs do to develop or enhance its internal controls to satisfy the guidelines set forth by the PPACA and other state and/or federal guidelines?

1.1. How can internal controls affect organizational change and improve sustainability in the changing climate of health care management?

1.2. How do your internal control strategies mitigate patient risk, and influence the quality of care that patients you manage receive?

1.3. What strategies have you implemented to improve patients' access to care?

1.4. How has the introduction of ACOs impacted your organization's competitive advantage in the HMO industry, and what measures, if any, have your organization implemented to address this?

2. How does this organization address accountability for the distribution, acknowledgement, and adherence to internal control measures by the workforce?

2.1. How is the internal workforce initially made aware of changes to and/or the creation of internal controls such as policies, procedures, and other guidelines?

2.2. How does the organization qualitatively and/or quantitatively monitor and measure adherence to internal controls?

2.3. What mechanisms (internal or external) are used to manage the organization's internal controls and organizational guidelines?

2.4. What are the ethical and or legal implications, if any, of nonadherence to organizational internal control measures?

Conceptual Framework

In this study, I explored strategies that health care leaders used to implement effective internal controls at a southeastern Pennsylvania HMO. This study aligned with the advocacy and participatory worldview and was grounded in transformational leadership theory, which sociologist Burns (1978) developed in the late 1970s. Burns theorized that transformational leaders inspired and motivated positive change in their followers' attitude and expectation toward common goals. Burns also contended that transformational leaders were usually energetic and passionate visionaries who also believed in and participated in the objectives they imparted on their followers. Building upon Burns's theory, Bass (1985) contended that transformational leadership theory consisted of four main interrelating characteristics that fostered the achievement of organizational goals. These four concepts are idealized influence or charisma, inspirational motivation, intellectual stimulation, and individualized consideration (Bass, 1985). Burns's and Bass's transformational leadership theory aligned with this study because the model posited that transformational leaders served as role models for their workforce, positively influenced workforce participation and encouraged employee alignment in their administration and execution of internal controls strategies to maximize the organization's objectives and overall performance outcome. The transformational leadership theory provided the basis for my study's examination of what internal control strategies HMO leaders used to improve its operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose health care they managed.

Operational Definitions

Definitions create a basis for understanding the key concepts of the doctoral study. The definitions herein focus primarily on health care related and management related terms. That said, some word meanings can be contextual.

Accountable care organization (ACO): An ACO consists of groups of doctors, hospitals, and other health care providers who voluntarily come together to form a managed care organization to accept reasonability for cost-savings programs and provide coordinated high quality to Medicaid and Medicare patients (Nyweide et al., 2015).

Cost containment: Cost containment in health care is the development of a budgetary and price-setting mechanism devised to reduce expenditure, and contain health care costs (Navarria, et al., 2015).

Health care delivery system: A health care delivery system, also referred to as health system, consists of all organizations, people, resources and actions whose primary intent is to deliver health care services to promote, restore or maintain health of targeted populations (Piña et al., 2015).

HMO: An HMO is an organized health care system that is accountable to the Centers for Medicare and Medicaid Services (CMS) for the financing and delivery of a broad range of comprehensive managed care for an enrolled population, and acts as a liaison with health care providers (hospitals, doctors, and the like) on a prepaid basis (CMS, 2017; Schlesinger & Gray, 2016). An HMO does not cover nonemergency or out-of-network services. (Claxton et al., 2015).

Internal control: Internal control is a risk assessment process designed to provide assurance in the achievement of an organization's objectives in operational effectiveness and efficiency, reliable financial reporting, and compliance with laws, regulations and policies (Chang, Yen, Chang, & Jan, 2014).

Organizational sustainability: Organizational sustainability refers to the alignment of a company's aims and organizational strategy with activities that demonstrates the inclusion of social, economic, and environmental concerns in its business operations and in its interactions with stakeholders that results in positive societal and environmental impact where the organization operates (Peterlin, Pearse, & Dimovski, 2015).

Transformational leadership: The transformational leadership style involves behaviors that empower, motivate, and challenge followers to maximize their potential (Turnnidge & Cote, 2018). Transformational leadership focuses on positive feedback and interpersonal relationships, while recognizing follower performance and contribution (Turnnidge & Cote, 2018).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are the perceived concepts or ideas that influence a researcher's data collection and interpretation processes (O'Brien, Harris, Beckman, Reed, & Cook, 2014). The researcher perceives his or her assumptions to be true, and these truths form the basis of the research study (Gordon & Paterson, 2013). Three assumptions impacted this study. The first assumption was that persons employed in leadership positions at the

organization for at least 3 years would be most suitable for the study because of their in-depth knowledge of the organization's goals, and operational processes. My second assumption was that the participants' responses to the interview questions would be transparent and honest and would provide accurate account of current business processes with regards to the development, implementation, and adherence to effective internal controls at this organization. My third assumption was that any documents and other archived artifacts collected from study participants would accurately reflect current standards of practices and historical occurrences at the organization.

Limitations

The limitations of a research study are external factors that define the boundaries of a study by identifying the study's potential weaknesses (Shapiro & Naughton, 2015). Three identifiable limitations existed for this study. The first limitation was that the study's geographic location may be too narrow to get a realistic picture of the HMOs across the country. Patient population, and regulatory or statutory guidelines that influence internal controls may differ from state to state. The second limitation was that employees with nonmanagerial roles would not participate in this study. Lack of feedback from the organization's nonmanagement workforce limited the study's scope because the perspectives and experiences of the workers are who are directly impacted by these internal control strategies are absent in this study. The third limitation was that the single case study's participants were leaders of one HMO. Other health care organizations may have provided different perspectives to this study since internal

control strategies and the effectiveness of the internal controls implemented may differ from one HMO to another.

Delimitations

Delimitations are the researcher's self-imposed limitations that clarify the study's focus and define its scope and boundaries (Yazan, 2015; Zou, Xu, Saniavan & Wang, 2018). Yazan (2015) further described delimitations as simplified assumptions that allowed the researcher to specify the phenomenon of interest and draw boundaries or fence in what was being researched. Frankel (2015) offered that researchers were responsible for exercising absolute clarity when determining and defining a study's delimitations. A study lacking clear delineation or delimitation can lead to questions about its validity under real-world circumstances.

A delimitation of this study was the limited scope of the study in terms of the sample size of the participants, the geographic and business parameters, and the expected feedback. I explored internal control strategies of HMOs in the United States with a focus on how these internal controls impacted health care delivery in southeastern Pennsylvania. The population of the study included five healthcare leaders involved in the financial, legal, operational, and administrative development processes at this organization. This ensured that interview responses provided data from leaders who directly influenced the organization's goal, mission, and strategies. Another delimitation was that the study excluded leaders with less than 3 years of service so that the respondents had historical knowledge of the company's processes and provided more accurate, dependent, and reliable responses. It is possible that leaders with fewer years of

service would provide a different perspective, but the accuracy of their responses could come under scrutiny.

Significance of the Study

"First, do no harm" is one of the cornerstones in medicine, yet the inefficient management of health care delivery has led to a disjointed health care system, poor care coordination and deficient patient treatment and engagement (Shen & Norris, 2016). The increasing cost of U.S. health care consumes a large amount of federal and corporate expenditures and poses a serious threat to the health care industry and the country's economic position (Woolf & Purnell, 2016). Neither the government nor the citizenry can ignore the unsustainable cost of U.S. health care, the diminishing quality of care to health care recipients, and the shifting needs of the health care population (Pauly, 2018).

Contribution to Business Practice

Few studies currently exist on the PPACA's impact on HMOs, and the strategies that HMOs use to attain the legislation's triple aim of reduced health care costs, improved population health outcomes, improved patient experience. The findings of this study may be of value to the practice of business because the implementation of effective internal control strategies could lead to improvements in how HMOs manage the delivery of health care services, contribute to the reduction of the unsustainable costs of U.S. health care, and fill a gap in knowledge regarding effective organizational practices in HMOs. This study may also present an opportunity for HMOs to explore whether, with the implementation of improved internal controls, traditional HMOs can still be viable contributors to health care delivery management (Marton et al., 2014).

Implications for Social Change

The implication for positive social change may include the development of innovative strategies and organizational best practices that may effectively operationalize business management processes in the managed care and other industries. The gaps identified in this study may provide the baseline for further academic research, and for the exploration and development of improved health care management models for similar type HMOs to improve operational efficiencies, reduce operational costs, and maintain competitive advantage, in the health care management industry. The effective management, distribution, and adherence to internal controls in health care organizations may also significantly reduce health care costs for both patients and U.S. health care spending. The possibility exists for the reallocation of unspent government funds to other government-funded programs, such as housing and education, to better serve the U.S. population, thus providing an improvement in the quality of life for a greater number of the American citizenry.

A Review of the Professional and Academic Literature

The review of professional and academic literature, commonly called a literature review, is a critical component of scholarly research. Schulenkorf, Sherry, and Rowe (2016) posited that conducting a literature review allowed a researcher to conduct comprehensive, critical analysis of the past contributions of a topic, identify biases and knowledge gaps, and propose topics for future research. Schulenkorf et al. further stated that a literature review created opportunities for researchers to explain results of prior research and clarify alternative views of past research in the field of study. Akl et al.

(2017) and O'Mara-Eves, Thomas, McNaught, Miwa, and Ananiadou (2015) both indicated that conducting literature reviews mitigated unintentional duplication of existing studies and made additional contributions to existing literature.

The goal of this literature review was to provide a comprehensive analysis and synthesis of the body of literature on leadership in managed care organizations. Although there is a plethora of research studies on transformational leadership in health care, there is a paucity in professional and academic literature on how managed care and traditional health care management organizations achieve the triple aim requirements of the PPACA. The objective of this case study was to bridge that gap by exploring what internal control strategies health care leaders of an HMO in southeastern Pennsylvania employed to improve the organization's operational efficiencies, reduce its health care costs, and improve the quality of care for the individuals whose health care they manage. My study also focused on how these health care leaders used transformational leadership to motivate their workforce to obtain these organizational objectives. Although the focus on the study was on health care organizations in the United States, reviewing literature on health care organizations in the United Kingdom and Canada added depth to the study.

This literature review consists of (a) an outline of my literature search strategy; (b) a discussion of the transformational leadership conceptual framework that frames this study; (c) a review of literature in seven major areas including an overview of three major health care systems, key trends in U.S. health care system, internal controls in organizations, leadership, systems thinking, continuous quality improvement,

organizational culture and organizational change; and (d) a summary of the main themes covered, including gaps identified in the research and opportunities for further research.

I developed a literature search strategy to gather peer-reviewed, scholarly literature pertinent to my study and related topics. I researched several search engines and databases for peer-reviewed articles. These databases included Walden University Library, Academic Search Complete, Business Source Complete, Emerald Management Journals, ProQuest Central, SAGE Premier, ProQuest, Science Direct, Questia, Google Scholar, and the standard Google search engine. I focused my search on peer-reviewed articles published within the last 5 years. In limited instances, I expanded my search to articles beyond the 5-year period and included seminal contributions pertinent to my topic. I also set up a search alert on Google Scholar that fed me newly added journal articles containing the key search words pertinent to the study. The key search words included combinations of *internal controls, health care management organizations, accountable care organizations, leadership strategies, transformational leadership, organizational change, PPACA's triple aim, health care costs, access to health care, improving the quality of health care,* and *management of HMOs*. The study yielded a body of evidence that comprised of 236 references of which 87% were peer reviewed.

Transformational Leadership

Transformational leadership, a relationship-based leadership concept, is a component of the new leadership paradigm. The concept of transformational leadership is that this style of leadership promotes pro-organizational employee behavior beyond expectation and self-interest, motivates positive change in followers, generates creativity

and productivity, and transforms individual goals to common group goals (Bass, 1985; Prasad & Junni, 2016; Turnnidge & Cote, 2018). The theory of transformational leadership focuses on the morality and motivation of both leader and follower, and contributes to mental model convergence in teams (Chughtai & Balanchet, 2017). The transformational leadership theory also allows transformational leaders to examine their organization's internal and external environment, strategize the organization's strategic and task objectives, and deliver performance feedback to their followers (Freeborough & Patterson; 2015).

Burns expanded his transformational leadership theory in the late 1970s when he posited that leaders would achieve improved overall follower performance if they exercised consideration for their followers' higher ideals and moral values (Burns, 1978). Bass (1985) expanded on Burns's theory placing greater emphasis on transformational leadership in more organizational situations. Bass's transformational leadership theory established idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration as the four dimensions or conceptual characteristics of transformational leadership (Prasad & Junni, 2016).

Bass (1985) focused on three leadership styles on the continuum of leadership – laissez-faire, transactional, and transformational leadership. Bass contended that the laissez-faire leader lay on the right end of the leadership continuum. Laissez-faire leaders, according to Bass, abdicated their responsibility by taking a hands-off approach, avoided decision making, gave little or no feedback to followers, and avoided decision-making. Antonakis, House, and Simonton (2017) described laissez faire leadership as a corrective

and ineffective style of leadership. Transactional leaders, in the middle of the continuum, follow a top-down, task-oriented management style and deal with followers based on a contingent reward system (Burns, 1978). Transactional leaders reward followers with things of value for tasks performed. Transactional leaders also practice management by exception, which involves corrective criticisms, negative feedback, and negative reinforcement (Bass, 1985). Transformational leadership lay on the left of the leadership continuum. Transformational leaders exhibited a hands-on approach and motivated followers to align their personal goals to group goals, increase productivity, and achieve outcomes beyond expectations (Freeborough & Patterson, 2015; Prasad & Junni, 2016). Two main differences between Burns's and Bass's concept of transformational leadership were that (a) while Burns positioned that leaders were either transactional or transformational, Bass argued that leaders displayed both transactional and leadership styles (Bass, 1985), and (b) whereas Burns concentrated his attention to transformational leadership on a macro-organizational level, Bass concentrated on the micro-organizational level of transformational leadership (Bass, 1985).

In 1995, Avolio, Bass, and Jung expanded the examination of transformational leadership with the development of a leadership tool of measure called the Multifactor Leadership Questionnaire (MLQ) (Avolio & Bass, 2004). The MLQ tool allowed organizations to determine a leader's style of leadership (transformational, transactional, or laissez-faire) based on other colleagues' and followers' perception of the leader's behavior and characteristics (Girma, 2016). Avolio and Bass (2004) enhanced the MLQ tool in 2004 and renamed it the (MLQ-5x).

The modern-day health care delivery system is ever evolving and becoming more competitive. In order to maintain their organization's sustainability and viability, HMO leaders must be able to adapt to change and transformation in this industry (Appelbaum, Degbe, MacDonald, & Nguyen-Quang, 2015). HMO leaders must establish ways to monitor and improve their organization's internal control processes to meet regulatory and contractual obligations, and to achieve organizational sustainability, financial profitability, and customer satisfaction (Emami & Doolen, 2015). Rosenberg and Ferlie (2016) argued that strategic planning, employee engagement, continued learning, and organizational growth can improve organizational sustainability and profitability. Freeborough and Patterson (2015) described transformational leaders as critical stakeholders in organizational development and social progress because they use their motivation and delegation skills to bring out core values in their followers and maximize the follower's human potential. Transformational leadership also allowed transformational leaders to examine their organization's internal and external environment, strategize the organization's strategic and task objectives, and deliver performance feedback to their followers (Antonakis et al., 2017).

There has been significant research within the past 5 years, including the following studies outlines below, that explored the use of transformational leadership in the health care industry. Vatankhah et al. (2017) conducted a cross-sectional, quantitative study among participants from educational and medical centers in Iran to examine the effect of transformational leadership on the productivity of employees in teaching hospitals. Vatankhah et al. found that transformational leadership practices were both

beneficial to the employees and the organization as it helped to increase productivity. Lin, MacLennan et al. (2015) examined the influence of transformational leadership style on the quality of 651 Taiwanese nurses' working lives, organizational commitment, and job satisfaction. Participants were asked to rate their perceptions of transformational nursing leadership styles and mental health outcomes at their organization, and to identify organisational factors that could improve the quality of nurses' working lives. The findings proved that transformational leadership significantly contributed to supervisor support and the nurses' job satisfaction and general well-being.

Cheng, Bartram, Karimi, and Leggat (2016) used Bass's MLQ 5X to collect data from a cross-sectional study of 201 first-line nurse managers to examine the role transformational leadership played in developing social identity, team climate, staff turnover, staff burnout, and the quality of care provided to patients. Cheng et al. found that when used through the psychological mechanism of social identification, transformational leadership had a positive impact on employee outcomes, and the perceived quality of care that patients received. Salas-Vallina et al. (2017) examined the relationship between transformational leadership, organizational learning capabilities, and happiness at work. Salas-Vallina et al. developed a confirmatory factor analysis scale to measure happiness at work and used this new measure to examine survey responses from 167 medical staff. The results of the study showed that transformational leaders could use the organization's learning conditions to predict and enhance the level of happiness at work (Salas-Vallina et al., 2017).

Although many studies such as the four mentioned above, empirically support the positive relationship between transformational leadership, employee development, and organizational performance, some scholars criticize the effectiveness of transformational leadership (Berkovich, 2016). Berkovich examined Menon's and Van Knippenberg and Sitkin's criticisms of transformational leadership. Berkivich found that the common criticisms among these authors were that (a) the foundational characteristic of transformational leadership's influence at work was unclear, (b) there was a paucity of empirical work that conclusively identified transformational leadership's impact on groups, teams, or organizations, (c) there was no clear distinction between the idealized influence and inspirational motivation constructs of transformational leadership. Rather, critics found that there was an overlap between these two constructs, and (d) the transformational leadership theory lacked sufficient identification of the impact of situational and contextual variables on leadership effectiveness.

Amidst critics' arguments against the transformational leadership concept, several studies support the use of transformational leadership in health care studies. Many studies link transformational leadership and business outcomes including those that motivate followers to increase productivity and achieve beyond expectations (Freeborough et al., 2015). Researchers who support this concept view transformational leaders as role models who exemplify moral discipline which results in positive ethical impact on organizations (Deinert, Homan, Boer, Voelpel & Gutermann, 2015; Freeborough et al., 2015). Moreover, supporters of transformational leadership contest that the practice of this construct results in positive outcomes such as commitment, satisfaction, direct

follower development, and indirect follower performance. Therefore, transformational leadership theory can be perceived as a change agent in the health care industry because of its focus on the morality and motivation of both leader and follower, its contribution to mental model convergence in teams, and its ability to motivate followers to place the concern and organizational goals above themselves (Vatankhah et al., 2017). Transformational leaders will need much more than the buy-in or support of its followers. Transformational leaders need to have effective controls in place to ensure compliance with the outlined goals and measure performance outcome of both individual and group effort alike.

The Impact of Internal Controls in Organizations

In the dynamic, complex, and ever-changing world of health care, the development and institution of internal controls is an integral part of an HMO's existence. An internal control system is an ongoing, comprehensive, and inclusive management process used to (a) monitor, verify, and validate the operational effectiveness and efficiency of an organization's management decisions; (b) ensure reliable financial reporting, and compliance with laws, regulations, and policies; (c) identify abnormalities, and adverse situations; and (d) identify, eliminate, mitigate, and manage risks (Mukhina, 2015). Internal control systems provide requisites for an organization's successful business development, improve quality of work, growth, sustainability, and competitive advantage (Mukhina, 2015). Aziz, Rahman, Alam, and Said (2015) recognized an internal control system as an important mechanism to safeguard an organization's overall objective and increase its stakeholder's value. Lopez-

Valeiras, Gomez-Conde, Lunkes (2018) perceived internal controls as strategies used to align employee behavior with organizational objectives.

Considering the high incidence of failures in governance, fraudulent activities, operational inefficiencies, corruption, and poor financial management in government-funded organizations, governments worldwide have enacted laws and regulations that force government-funded organizations to justify the sources and utilization of public resources, and improve the performance of their service delivery (Aziz et al., 2015). Health care organizations worldwide now operate in an increasingly complex, and highly regulated business environment, and internal control frameworks as foundational tools to conduct their operational activities (Aziz et al., 2015).

The enactment of the Health Insurance Portability and Accountability Act (HIPAA) and the PPACA are examples of the United States' federal regulatory controls that require HMOs to develop new internal controls to improve the operational efficiencies of the U.S. health care delivery system. These federal health care regulations mandate that health care organizations have a fiduciary duty to provide quality care for the people they service, efficiently manage health care funds, and comply with applicable rules, laws, regulations, and ethical codes that govern health care organizations (Pozgar, 2016). The complexity of these tasks cannot be taken lightly. HMOs are constantly challenged with changing their internal controls to meet federal, statutory, and contractual guidelines. In addition to addressing ongoing regulatory pressures face, HMOs must constantly make every effort to meet the contractual demands from multiple stakeholders, and maintain their competitive advantage amidst competition from existing

rivals/competitor HMOs and new entrants into the managed care industry (Chen et al., 2016). Meeting these regulatory requirements do not preclude HMOs from operating within the ethical confines of delivering quality health care services delivery to its recipients in a safe and equitable manner. Neither should it compromise the safety and security of the individual's physical being, medical records, personally identifiable information (PII), and protected health information (PHI).

Typically, the organization's leaders and higher management are responsible for the design, implementation, and maintenance of internal control systems. The Chief Executive Officer, however, has ownership of, and is ultimately responsible for the organization's internal control system, (Chen, Crossland & Luo, 2015). Ma'ayan and Carmeli (2016) argued that management's involvement in internal control and their support of ongoing monitoring of these processes improve ethicality, efficiency and effectiveness in organizations. The organization's management team determines the simplicity or complexity of an organization's internal control structure. As such, there is no empirical evidence that identifies any universal internal control structure for organizations to follow. An effective internal control system should include a control environment, control activities, monitoring and risk assessment tools, description of the subjects and objects of internal control, and information and communication (Mukhina, 2015).

A health care organization's leadership cannot effectuate internal control system without the participation and involvement of the organization's staff. Chughtai and Balanchet (2017) and Vatankhah et al. (2017) both considered the transformational

leadership paradigm as an ideal leadership style to effectuate change in organizations amidst the ever-evolving changes in internal controls because of the leadership theory's concentration of both leader and follower morality and motivation. Transformational leaders provide the mechanisms that influence followers to adopt the collective interest of the organization and buy into the tasks need to materialize organizational goals, federal and regulatory requirements, and contractual agreements (Sauoris, 2015). Transformational leaders also promote the concept of system thinking which encourage followers to perceive their individual contributions as integral parts of the organization's construct and its overall objectives.

Systems Thinking as an Internal Control Strategy

The concept of systems thinking originated in the 1960s. This paradigm posits that an organization is a system made up of intimately interconnected parts or units that must cohesively work together to sustain itself as a whole unit (Khan et al., 2018). Stalter et al. (2016) viewed systems thinking as a model that looked beyond the events to the patterns of behavior and the underlying systemic interrelationships which are responsible for these patterns and their associated events. Stalter et al. also embraced systems thinking as the understanding of open systems as complex adaptive systems that are constantly changing, resistant to change, counter-intuitive, nonlinear, and where the whole is greater than the sum of its parts. This allows leaders to simultaneously promote the needs of the entire organization, and the needs of its smaller units, that when connected make up the whole organization. Phillips, Stalter, Dolansky, and Lopez (2016) found that when using the systems thinking model, organizations develop systems and

processes that increased its ability to critically analyze, review, and evaluate existing procedures and activities, and report and recommend changes to management on various operations of the organization. The critical and analytical characteristics of systems thinking can positively impact an organization's internal control system, may provide real opportunities for improvement of current business practices, and mitigate risk exposure.

Roberts, Fisher, Trowbridge, and Bent, (2016) posited that by looking at the interconnectedness of individual roles to the organization, one can clearly recognize that the significance of the interactions between the organization's parts creates a whole that becomes greater than the sum of its parts, and drive innovation in health care delivery. When the systems thinking approach is used to address problem solving, rather than viewing or addressing the problem in isolation, the organization applies a comprehensive and integrative approach, and assesses the effects on the entire organization (Akl et al., 2017). This approach also presents an opportunity to develop more effective internal controls that satisfies a greater scope of the problem.

Grohs, Kirk, Soledad and Knight (2018) questioned the applicability of the systems thinking strategy when they challenged whether one's thinking could be measured. Grohs et al. stated that scientists have long debated the effectiveness or accuracy of measuring thinking which forms the basis of the systems thinking concept. They offered that for systems thinking strategy to remain authentic and relevant to today's world, approaches must be developed to measure performance of given tasks and to use those performance as a proxy for the construct. Phillips et al. (2016) did not share this view. Phillips et al's study to determine the relevance of systems thinking compared

the effects of its approach in nurse gradates of degree completion programs found that the critical components of system thinking helped nursing students and graduates to understand that its concept and associated responsibilities were still key to realizing sustainable outcomes, improvement in quality and safety in health care systems. It is imperative to note that while there are has been significant studies on application of the systems thinking approach, a dearth in this area of study still exists.

The impact of system thinking on health care industry. A health system consists of many integral components. Malik, Willis, Hamid, Ulikpan, and Hill (2014) identified service delivery, the workforce, information, medical products, vaccines and technologies, financing, and leadership and governance as the integral components of a health system. Malik et al. (2014) stated that although each component is independently critical for a health system's success, it does not operate in isolation. Rather, it must work together to achieve the overall objective of improved health outcome, access to care and organizational cost savings. The systems thinking model provides valuable frameworks to understand the complex and dynamic phenomena of health care (Roberts et al., 2016). Health care delivery systems previously operated as a cottage industry using a command and control strategy, with each unit independently focused only on its own performance (Lewis, Tierney, Colla, & Shortell, 2017). Information and communications technology contributed to the shift to the systems thinking model as it provided key tools and concepts for health care organizations to work together, which significantly improved quality of care, organizational cost performance, and the health system as a whole (Reid, Compton, Grossman, & Fanjiang, 2005). Transformative leaders in health care and other

industries, embrace the systems thinking model to link individual employee goals and responsibilities as intrinsic components of the overarching organizational goals and objectives (Roberts, et al., 2016). Although the shift to systems thinking did provide many benefits to the health care industry, embracing this approach does have its drawbacks. The systems thinking approach is a long-term strategy and may not necessary address short-term, immediate problems that health care organizations face. Additionally, the additional cost of implementing solutions across an organization had significant financial implications on the organization's bottom line.

The impact of systems thinking on HMOs. Regardless of its place in the health care industry, the executives of HMOs must recognize that in order to maintain a competitive advantage, HMOs must stay ahead of its competitors vying for its market share. To this end, many HMO leaders apply the systems thinking approach to their internal control processes to ensure that each departmental area is represented in team initiatives and strategic planning so that major decisions and effective business solutions are not made in isolation. The systems thinking model helps to uncover the real drivers for change and allows HMOs to synthesize its resources to develop value-based strategies and controls that deal with issues such as organizational efficiencies, innovation, disruptive technology, and market expansion as a whole (Chughtai & Balanchet, 2017). One such control is the development of a governance, risk management, and compliance (GRC) programs to help deal with and control inefficiencies and risks across the enterprise (Butler & Raiborn, 2015). The result is the development of value driven solutions and controls with innovative, changes to cost and capabilities (Wiltz, 2013).

Two questions that HMOs must ask when adopting the systems model are (a) how far ahead must health care organizations plan when using this model? and (b) upon what basis should this timeframe be measured? This is because one of the drawbacks that HMOs face using this model is determining how far ahead in the future the organization must plan. When prospectively planning, organizations must consider staffing needs, equipment needs, and space needs. How and when to invest in those resources pose a challenge to many HMOs (Wiltz, 2013). When the plans materialize into fruitful opportunities for the organization, there are rewards. Conversely, when things do not go as planned due to inaccurate forecasting, ineffective internal controls, or environmental changes, for example, the organization stands the risk of incurring significant losses. Many HMOs use a three-year strategic plan model.

Continuous Quality Improvement Strategy in the Health Care Industry

Organizational culture is a fundamental construct that affects many aspects of the organization's structure, its operational behavior, goals, objectives, and competitive advantage. In the medical delivery system, the key contributors and decision makers such as health care administrators, physicians, and governing boards have been fragmented and operated in silos. This dysfunctional organizational culture in health care delivery system did not reap positive results. High spending in health care and low quality of care were some of the effects that necessitated the need to reexamine this structure (Lewis et al., 2017). Recognizing the need to restructure the health care system a more effective and cost containing model, the PPACA introduced (and continues to introduce) a series

of initiatives to address this (PPACA, 2016). Continuous quality improvement (CQI) is one such initiative.

Boyle et al. (2014) described CQI as an evolutionary approach to quality improvement, employee empowerment, teamwork, and the identification and implementation of change. CQI focuses on systematic and continuous examination of organizations' work processes to examine the root cause of poor quality, recognizing and defining low performance, and utilizing fact-based management and scientific methodology to develop improvement strategies (Boyle et al., 2014). In this new model, interrelation, interdependence, and communication among the key contributors are critical in realizing positive outcomes.

Organization culture and the team approach to CQI. Organizational culture is critical to the interdependence of the stakeholders. Collective mindfulness is a component organizational culture that involves cooperation and involvement from everyone in the organization to identify failures in the organizational processes and devise ways to solve these failures (Chassin & Loeb, 2011). Collective mindfulness or the team approach to solving quality and other health-related problems is an important component of CQI in health care delivery (McFadden, Stock, & Gowen, 2015). McFadden et al. (2015) argued that a strong and positive organizational culture is a critical component of an effective CQI.

Benefits and drawbacks of CQI. There are benefits and drawbacks to using a team approach to CQI. In addition to collective mindfulness and the emergence of a safety culture (Chassin & Loeb, 2011), other benefits include improved leadership

commitment, improved communication, and robust process improvement (Nancarrow et al., 2013). According to Zismer (2011), loss of professional autonomy and control of productivity expectations, compensation rules, and expectations as some of the psychological drawbacks that physicians experience using the CQI model. Health care leaders feel threatened by this integrative model. With expanding physician leadership, health system leaders feel that their jobs are at stake by the possibility of physician takeover (Zismer, 2011).

Using CQI to build cross-cultural teams. Burns et al. (2012) presented a five-stage process for building cross-cultural teams. They are forming, storming, norming, performing, and adjourning. In the forming stage, members get to know each other and their purpose; the team members resolve conflicts in the storming stage, and become more cohesive in the norming stage (Burns et al., 2012). In this model, Tasks are defined during the performing stage, and they are completed during the adjourning stage (Burns et al., 2012). Although the development of an effective and cohesive team is one of the most critical functions in the CQI model, researchers identified both positive and negative implications of the impact of organizational culture on the CQI model. There is the need for further research to determine validity and causality between organizational culture and team approach to CQI (Boyle et al., 2014).

An Overview of Health Care Systems in Canada, the United Kingdom, and the United States

According to Maslow's theory of needs, health and safety is the second most important human need (Maslow, 1943). Countries all over the world recognize this need.

Based on each country's unique legal, ethical, economic, political, and cultural framework, its government develops security and health care systems to protect and serve its citizenry. The United States is no different in its attempts to develop the ideal health care delivery model. According to Jaworzynska (2016), the strength of a health care system can be determined on the structure of its primary care sector, which is the foundation of the system. Burns et al. (2012) added that an organization's design and its structure or system archetype represent the key tools needed to understand systems thinking that influence the behavior of the organization. Even the most basic health care organization exhibit a significant amount of detail and dynamic complexity.

The health care industry, driven by constantly changing regulatory guidelines, laws, and industry innovation, is overly complex to operate and manage. Like the United States, countries all over the world have developed health care systems for its citizenry based on their own unique legal, ethical, economic, and cultural framework. Countries such as the United States, Canada, and the United Kingdom have recognized the need for health care reform in the last decade; each country took a different approach to health care reform. Although no country can claim to possess the best model for health care delivery, how each is structured, managed, and administered uniquely sets one apart from the other and defines its overall outcome (Jaworzynska, 2016). This segment provides an overview of the Canadian, UK and U.S. health care delivery system and each country's recent attempt at health care reform.

Canada. Canada's health system and the country's commitment toward universal health coverage is considered one of the world's oldest and best health care delivery

systems (Clark & Horton, 2018; Evans, 2018). For decades, Canada's health care delivery model not only catered to its own internal healthcare needs, but it also made significant contributions to global humanitarian, migration, and medical crises (Clark & Horton, 2018). Canada leads its domestic health care delivery through its universal health care system and its global initiative through alliance building and collective action (Martin et al., 2018; Nixon et al., 2018).

Governed by the Canada Health Act (CHA) of 1984, Canada's internal health care delivery system is a complex system subdivided into ten provincial and three territorial, privately managed health care systems (Greenwood, de Leeuw, & Lindsay, 2018). Canada spends $4,602 per capita or 10.9% of GDP on health care costs (Mossialos, Wenzl, Osborn, & Anderson, 2015). Canada's health care model is a publicly funded, but privately managed model. The OECD reported that 70% of Canada's health care spending in 2012 was publicly funded (Mossialos et al., 2015). Canada's Medicare system provides free health care to its residents, including free point of service for medical necessary hospital and physician services (Marchildon, 2013). The primary goal of the CHA is to improve and maintain the health of Canadians (Sutcliffe, 2011). Canada's five-pillar health care model consisting of public administration, comprehensiveness, universality, portability, and accessibility was enacted through various arms of Canada health care system, namely Health Transfer, First Nations and Inuit Health Services, the Canadian Institutes for Health Research, and the Public Health Agency of Canada (Sutcliffe, 2011). These entities work together to provide federal

oversight of the program and track health outcomes. Physicians are key stakeholders in Canada's health care decision-making process.

The previous structure of Canada's health care model gave physicians clinical autonomy and control over the location and organization of their medical practices (Ambrose-Miller, & Ashcroft, 2016). This structure leveraged physicians at key positions when making health care decisions, wresting the power and influence from Canadian federal and provincial health care leaders. As a result, Canada's provinces and territories could not make any positive headways in changing its stagnated health care system and the country fell behind when compared to other countries' health care delivery systems in areas of health disparities, and access to care.

Recognizing the need to improve the access to and quality of care, and to reduce health care disparities, Canada set about to reform its declining health care system. In keeping with Canada's legacy of physician autonomy, Canada adopted an incremental reform strategy and implemented a voluntary approach for physician engagement. Because of Canada's governing structure, the objectives and goals of health care reform differ from provinces and territories. That said, there are fundamentally sound recurring themes amongst them that mirror the Institute of Medicine's six goals for improvement, which includes: safety, effectiveness, person centeredness, timeliness, and equity (Ambrose-Miller, & Ashcroft, 2016; Justice et al., 2016). Cost control is another central theme in Canada's health care reform (Farmanova et al., 2016). Beyond the implementation of basic safety provisions, the privately funded aspect of Canada's health system is left unregulated (Tuohy, 2012). When surveyed by the Commonwealth Fund

International (CFI), 42% of Canadians felt that the health care system worked well and needed only minor improvements, while 8% felt that the Canadian health system needed a complete overhaul (Mossialos et al., 2015).

United Kingdom. The UK health care delivery system, governed by the NHS and Social Care Act 2012 (World Health Organization, 2014) is a nationally tax funded, budget limited health care system with structures known as *quasi* markets provides access to care for all (Allen, 2013). Ranked 1st among the world's 11 most industrialized countries (Culzac, 2014), the UK spends $3,200 on health care per capita each year on its health care, amounting to 8.5% of its GDP, and provides government funded public health care system to its population (Jaworzynska, 2016). While health care coverage is free at the point of use to all ordinarily residents of the UK and nonresidents with a European health insurance card, non-European visitors or illegal immigrants are only eligible to treatment in an emergency department or for the treatment of certain infectious diseases (CFI, 2014). General practitioners provide primary care and act as gatekeepers for secondary care.

Prior to 2012, the UK health care delivery system fell under the guidance of the Health Act, the Parliament, the Secretary of State for Health, and the Department of Health. This group collaboratively had joint legal duty to promote comprehensive and free health care service to the ordinary citizenry of the United Kingdom (CFI, 2014). The NHS and Social Care Act 2012 currently governs administrative and budgetary oversight of the UK health care system with the primary goal of improving and maintaining the

health of its citizens which include access to care without discrimination and improving coordination and timeliness of services (CFI, 2014).

Poverty and low living standards were the UK's primary causes of poor health, life expectancy, and health inequalities in the UK. Agreeing that tackling the UK health inequalities was a matter of social justice, with real economic benefits and savings, stakeholders across the UK health spectrum assigned responsibility for delivering improvements to local authorities and Health and Well Being Boards (Royal College of Nursing, 2012). The NHS Outcomes Framework was designed to identify the gaps in the health care delivery system and to create strategies to address these issues.

Recognizing that the UK was losing its struggle with rising health care costs and a floundering economy, UK legislators passed the Health and Social Care Act 2012 (Donahue, 2014). According to Donahue (2014), this legislation presented the UK with a way to modernize the NHS and create avenues for innovation. Clinical Commissioning Groups (CCGs) run by general practitioners have now become responsible for arranging the care for the patients who live in their population. While the system will remain financed by taxpayers' dollars, the limit on hospital earnings have been uncapped (Donahue, 2014). Proponents of this reform saw this as an opportunity for health care providers to operate their practices like businesses, reign in wasteful spending, and increase the quality, and integration of care. Those opposed feared that the reform would fragment the system without having any significant impact on health care spending (Donahue, 2014). According to CFI, 63% of UK citizens felt that the health care system

worked well and needed only minor improvements, while 4% felt that the UK health system needed to be completely rebuilt (Mossialos et al., 2015).

United States. The PPACA governs the U.S. health care delivery system and the Department of Health and Human Services (HHS) is the principal agency that administers the program (PPACA, 2016). The United States spent $9,120 and $10,723 per capita on health care in 2013 and 2017 respectively, which represented 17.2% and 18% of the country's GDP (Cuckler et al., 2018). Unlike Canada and the UK, U.S. health care does not provide a single general public health care system as the primary source of health care for its the citizenry. Instead, the U.S. government developed a shared responsibility partnership model between the government, employers, and private individuals resulting in a patchwork of public and private insurance coverage (Mossialos et al., 2015). According to the U.S. Census Bureau (2014), 54% of Americans received employer-provided insurance, 34% received public program insurance, 11% acquired their own insurance, and 16% had no insurance. Medicaid, Medicare, and CHIP publicly funded health programs provide health care coverage to low income, seniors, and disabled individuals, including those with renal failure (Mossialos et al., 2015). Illegal immigrants are generally not allowed public health care except for emergency stabilization care (Mossialos, 2015).

Race, ethnicity, and socio-economic status are leading contributors to the wide disparity in the accessibility and quality of health care in the United States (Jha & Zaslavsky, 2014; Mossialos, 2015). To address some of the issues affecting its health care system, the U.S. government, in partnership with private insurance companies are

developing primary-care health programs focused programs improve patient treatment (Massialos, 2015). The creation of ACOs is another health care improvement initiative (Peterson, Gardner, & Muhlestein, 2014).

Though health care systems vary from country to country, even the most basic health care organization exhibits a significant amount of detail and complexity. Improving the quality of care, access to care, and cost containment are common goals for health care organizations in most industrialized countries. The following subsection provides a more in-depth review of the U.S. health care delivery system.

Key trends facing the U.S. health care system. The health care key trends facing the U.S. health care industry include the shifting needs of the health care population, the high cost of health care and its consumption of a large amount of federal and corporate expenditures (Obama, 2016). Demographics such as age, gender, economic and racial/ethnic composition of the U.S. population are major determinants of its future health care needs, and the World Population Review (2017) projected a steady population growth rate over the next four decades. The increasing cost of health care continues to pose a serious threat to the country's economic position and the health care industry. Data from the Census Bureau revealed that the U.S. population reached 326 million in 2017. Population growth is projected to continue steadily over the next four decades and will grow to 400 million in 2039 (World Population Review, 2017).

The average life expectancy of persons born in the United States in 2016 is 78 years. U.S. women have a higher life expectancy than men do. Women can expect to live for 81 years, while men can only expect to live for 76 years (World Population Review,

2017). The growing population of older adults with chronic health conditions requires more medical services than they did before and health disparities such as socioeconomic factors, such as economic status, racial and ethnic status, obesity, discrimination, and the regulatory climate of the health care system continue to challenge existing health care management organizations (Keehan et al., 2015).

The cost of health care continues to rise to exorbitant levels, posing a serious threat to the country's economic position and the health care industry. The U.S. government spent 17.2%, 17.7% and 18% of this country's GDP on health care spending in 2013, 2015, and 2017 respectively (Cuckler et al., 2018). In 2013, the U.S. government spent $2.8 trillion on health care and studies project that by 2026, 19.7% of the GDP will be attributed to health care (Cuckler et al, 2018). Obama (2016) recognized that this country could no longer sustain itself if it continued along the same path. Herland, Khoshgoftaar, and Bauder (2018*)* found an urgent need to contain the factors that significantly contributed to the rising cost of health care in the United States. These included, but were not limited to, ineffective health care management, fraud and abuse, medical errors, the provision of health care to uninsured or underinsured individuals, and the cost of research and development.

Working Toward a Solution: The New Health Care Model.

Pozgar (2016) stated that health care organizations have a fiduciary duty to provide quality care for the people they service, comply with applicable rules, laws, regulations, and ethical codes that govern them. This is a complex task, and as such, HMOs are constantly challenged with changing their internal controls to meet regulatory

and market demands from multiple stakeholders, while trying to maintain market share amidst competition from existing HMOs and new entrants into the managed care industry (Chen et al., 2016). As such, it is imperative to understand how these requirements affect how HMOs operate and how these changes influence the provision of health care services to patients.

Many researchers and pundits expressed negative views of the previous health system. Obama (2016) described the previous health system's mix of public and private coverage, oversaturation of private insurers, overspending, and failed health care policies as broken, and believed that it fell short of its true potential. D'Antonio (2016) felt that the previous U.S. health care insurance system was haphazard and fragmented. According to and De Vries, Bekkers, and Tummers (2015) and Goddard (2015), market imperfections and a culture that lacked organizational innovation plagued the U.S. health care delivery system.

Acting as gatekeepers, HMOs were prepaid health plans developed to reduce the cost of care, increase profits, and maintain quality of care for its members (Nunez, 2012). HMOs contracted directly with physicians, to eliminate unneeded facilities, and negotiated discounted prices with various providers to provide organized complete care (Nunez, 2012). Unfortunately, HMOs were unsuccessful at containing the costs of health care, which continued to rise at unsustainable rates.

When compared to 10 other high-income countries around the world, the U.S. health care costs are higher that almost every other nation, yet its health outcomes are worse than almost all others (Papanicolas, Woskie, & Jha, 2018). In 2016, the United

States spent 17.8% of its GDP $9,403 per capita on health care yet ranked lower that all other countries in health care efficiency (Papanicolas et al., 2018). A considerable sum of this money was spent on fraudulent health care activities, abuse or waste of health care services, and avoidable medical errors (Herland et al., 2018; Larkin, Swanson, Fuller, & Coetese, 2018). When compared to other health care systems around the world, the United States gained a system score of 66% (Edwards, Patterson, Vakili, & Scherger, 2012). The United States ranked 31st on life expectancy, 36th on infant mortality, 28th on healthy male life expectancy, and was the only industrialized nation that did not provide universal health insurance to its citizens (Edwards et al., 2012). In fact, according to Hamel, Blumenthal, and Collins (2014), 14.5% of the U.S. population were uninsured. A similar percentage represents the underinsured population who has some insurance, but not enough to cover their health care needs.

At the end of the 1980s, the U.S. health policy failed to produce an equitable, efficient health care delivery system. The quality of care declined and so did access to health care under the stewardship of HMOs. The Obama-led administration stepped in and demanded that HMOs must either immediately develop business solutions to improve operational efficiencies, reduce health care costs, and improve the quality of care for the American citizenry or face extinction (Obama, 2016; Schlesinger & Gray, 2016). The future of HMOs as we have come to know it is at risk.

An Overview of the Patient Protection and Affordable Care Act

Enacted in 2010 by the Obama-led administration, the PPACA is the most significant change to the U.S. health care system since Medicare and Medicaid (Obama,

2016). As government's approach to its looming health care crisis, the PPACA proposes a series of changes to the U.S. health care system over an eight-year period with a projected implementation completion date of 2018. These changes affected health insurers, Medicaid and Medicare programs, health insurance exchanges, employer wellness programs, health care fees and taxes, and health care management organizations (CMS, 2017).

The PPACA's triple aim is to (a) increase the availability of care and coverage, (b) improve the quality of care, and (c) reduce the health care costs overall. The PPACA fundamentally changed most aspects of health care, including health care insurance exchanges, Medicaid and Medicare programs, health insurers, employer wellness programs, health care fees and taxes, final delivery of care, and health care management organizations (CMS, 2017). The PPACA proposed a series of incremental changes over an eight-year period with an anticipated completion date of 2018. With the PPACA, President Obama promised to bend the cost curve for U.S. citizens so that people already insured would have affordable health insurance (Obama, 2016).

Some of the proposed benefits of the PPACA include increased age of child insurance eligibility, the elimination of the Medicare's donut hole by 2020, the elimination of denied insurance due to preexisting conditions (Blumenthal et al., 2015). The Obama administration allocated billions of tax dollars into the Medicare and Medicaid programs. While 32 million uninsured and underinsured Americans have benefited from the PPACA, over 9% of the U.S. population remain uninsured (Obama, 2016). While many individuals embrace the PPACA's wellness program and non-

discrimination of pre-existing conditions, they object to Obama's mandatory imposition of individual insurance or be faced with a tax or a penalty for noncompliance (Adashi, Clodfelter, & George, 2018). According to Blumenthal et al. (2015), one of the most controversial issues surrounding the PPACA is the individual mandate provision which requires all Americans to have health insurance or pay a penalty for noncompliance. Other drawbacks include the price of insurance will fluctuate based on earned income per household, limitation to the flexible spending accounts, and many seniors will lose Medicare Advantage plans (Briggs, Alderwick, & Fisher, 2018).

Prior to the PPACA's enactment, critics often blamed traditional HMOs for the poor state of the U.S. health care delivery system. The PPACA now recognizes ACOs as the system of choice to reconfigure the management of health care the U.S. health care (PPACA, 2016). This gives ACOs the welcomed opportunity to provide a new team-based management strategy, develop a competitive advantage, lead the HMO market, and ultimately replace other types of HMOs. Those traditional HMOs those who run the risk of being replaced reject the PPACA and refuse to take full responsibility for the currently health care situation (PPACA, 2016). Employers feel forced to provide insurance to its workforce or have fines imposed on them. From a political standpoint, the Democrats generally embraced the PPACA and the Republicans strongly opposed its viability and its constitutionality (Oberlander, 2018).

Accountable Care Organizations. The Obama-led administration assisted with the development and promotion of ACOs as the solution to existing HMOs (Gaffney & Waitzkin, 2016). With its proposed changes to the U.S. health care system, the

introduction of the ACA is redefining the management of health care. ACA's goal is to embark on a new delivery system that will cut health care spending, improve quality of care for health care recipients, and reduce the uninsured and underinsured health care population (PPACA, 2016; Pauly, 2018).

ACOs consists of groups of doctors, hospitals and other providers who partner to provide coordinated care for a defined patient population (Lanese, 2016; Schlesinger & Gray, 2016). This care coordination incorporates the fiscal management of the care with clinical accountability and transparency to CMS (Barnes, Unruh, Chukmaitov, & van Ginneken, 2014). There has been constant growth in the number of ACOs since its inception in 2010. Studies conducted by Alderwick, Shortell, Briggs, and Fisher (2018) and Kaufman, Spivack, and Steams (2017) revealed that there were over 900 ACOs serving over 32 million members. Oberlander (2018) and Schlesinger and Gray (2016) opined that the Obama-led administration's goal was to replace traditional HMOs with the new ACO health management model by 2020. The 2016 Trump-led U.S. administration continue with its ongoing attempt to repeal the PPACA and how this impacts the proposed ACO health management model is still uncertain (Oberlander, 2018).

The future state of U.S. health care. The entrance of ACOs in the health management industry poses a significant threat to other HMOs that preceded ACOs. With government's endorsement of the ACO as the health care delivery system of choice, HMOs stand to lose a significant portion, if not all its market share to ACOs (Gaffney & McCormick, 2017). If this is truly the government's plan, the success of the PPACA lies

squarely in the hands of ACOs (Barnes et al., 2014). While most observers generally accept that the U.S. health care delivery system leaves much to be desired, and intervention is immediately needed to mitigate its shortfalls (Gaffney & McCormick, 2017), the government's strategy to improve is not generally received in the same way. Not all researchers, scholars, and government officials share the view that a complete ACO takeover of health care management is the solution to the health care delivery problems that the United States currently faces. In their study, Frean, Gruber, and Sommers (2016) found that to date, the PPACA has not yet successfully fulfilled its mandate. They added that ACOs will not be able to manage the entire U.S. health care delivery system on its own. Rao and Hellander (2014) projected that if government eliminated traditional HMOs and left ACOs to manage the U.S. health care delivery system on its own, over 31 million Americans would be without insurance by 2023, and the demographic composition of uninsured would not change. Of those, uninsured, 4.3 million will be children and 1 million will be veterans (Rao & Hellander, 2014). Many critics propose an alternative solution.

An alternative solution. Frech, Whaley, Handel, Bowers, Simon, and Scheffler (2015) conducted a study to determine whether the ACO model better served the U.S. health care needs than existing HMOs. These researchers found that ACOs both had strengths and weaknesses. Depending on the health care population and the geographic area served, the ACO model was flawed and did not deliver its expected outcome. Their findings also suggested that when HMOs and ACOs are used together to manage care, health care expenditure is better contained than when one model is used on its own. The

researchers also found that the health outcomes of the population studied were better managed with this model.

An opportunity for HMOs to redefine their position as a viable MCO. Frech et al.'s (2015) findings presents a unique opportunity for HMOs to redefine itself and develop innovative internal control mechanisms to improve their processes by creating leaner, more efficient business practices that would reduce health care costs, and provide better quality health care to its members. This can be the opportunity that HMOs need to prove to the government and other stakeholders that they can still provide a viable alternative to ACOs in the areas where the ACO model has failed to deliver its expected outcome. With this strategy, HMOs can regain or maintain its competitive advantage in the health care management industry and ultimately, mitigate its own extinction.

The road ahead for HMOs will be challenging. HMOs must ensure that they implement controls designed to mitigate risks and provide processes that will confidently achieve operational effectiveness, efficiency, decisions making processes, reliable financial reporting, and compliance with laws, regulations, and policies. Even with the development of stellar internal controls and risk mitigation processes, the management of the human element can neither be ignored nor taken for granted. Regardless of the intent, human mistakes occur and can result in poor adherence to policies and procedures, failure to follow regulatory guidelines, medical errors, fraud and abuse, and other unnecessary health care spending (Dobrzykowski, McFadden, & Vonderembse, 2016).

Internal controls such as adherence to policies, procedures and regulatory guidelines can significantly decrease health care costs, improve the quality of care, and

save lives. Once developed, internal controls, are tested, implemented, and continually monitored for relevance and currency in meeting ongoing changing needs of this complex industry. Wall, Austin and Garros (2016) offered that effective internal controls in health care environments are strengthened through the provision of ethical education and resources to the workforce.

The politics of health care in the United States. Pauly (2018) and Osei-Owusu (2018) posited that the challenges faced by health care delivery systems were primarily centered around politics and governance. Based on the findings drawn from a study of attitudes toward health care health care reform in the United States, Shen and LaBouff (2016) observed that the ideological leaning of the governments in power affects the support for and content of health care reform initiatives. This supports Pauly's thinking. Doughty (2015) described U.S. health as neither healthy, nor caring. Doughty added that the U.S. health care reform was a politically idealized battlefield with democratic and republican states against each other and liberals against conservatives.

The first U.S. health care delivery model was established in 1915. According to Orentlitcher (2012), the U.S. Constitution and its statutory rights are fundamental to health care rights in the United States, but the rights granted by the political and judicial branches of the U.S. government were so incomplete and vulnerable that they were susceptible to erosion over time. Even after a century of the establishment of a national health care delivery system, three major issues: (a) health care reform; (b) the adverse effects of socialized medicine; and (c) the tension between individual liberty and

government aid still present challenges to the U.S. health care delivery model (Obama, 2016; Oberlander, 2018).

Berwick (2013) identified seven main contributors for the political paralysis in meaningful health care reform. He cited: (a) money in the status quo where the recipients of today's health care funds would want to receive smaller amounts in the future, (b) not enough time and effort spent sharing best practices across the country, (c) the silence of professionals and lobbyists, (d) the erosion of the public's trust in science, (e) the duality of the health-care industry's self-interest, (f) the ambivalence about the federalism of national health care reform, and (g) the nation's divided views about the provision of care to the poor.

A recent attempt at U.S. health care reform is the PPACA. This model draws from the failures of attempts made between 1987 and 2010 and is designed to move the country closer to the ideal that all persons, regardless of health status and income, should have access to health insurance (Obama, 2016). Although the PPACA positively impacted some aspects of the health care delivery system, U.S. health care reform is still a work in progress. Based on Doughty's (2015) observations, the PPACA will still not provide universal coverage for all Americans. By 2021, there will still be over 31 million Americans without health insurance (Orberlander, 2018)

The politics of the U.S. health care delivery system failed to provide a viable solution to the provision of accessible care at reduced costs to its citizenry. Health care reform should be depoliticized by the creation of a jointly established partnership among key stakeholders – governments, integrated systems, hospitals, physicians,

administrators, nurses, patients, family advocates – to reengineer health care delivery in the United States. As Berwick (2013) suggested in his study that a re-visitation of the core principles of the provision of health care for the patient by health care leaders and stakeholders is the urgently needed antidote for the political battlefield that health care reform has become.

Roles and responsibilities of health care leaders – the way forward. Health care management organizations must have the tenacity and the capability to react to the rapid and ever evolving change in the health care industry which can range from minor adjustment to radical transformation (Appelbaum et al., 2015). Successful and sustainable organizations require, among other things, well-honed leadership equipped with knowledge, competencies, and the necessary skills to influence staff and align them to the vision and direction of the organization (Miles & Scott, 2018). Health care leaders must have both direct and indirect impact on the organization's outcome. Appelbaum et al. (2015) described direct impact as the continuous shaping of the employees' attitude throughout the organizational change and indirect impact as the regulation of the antecedents and moderators of its predisposition to change.

Stakeholders in the health care organizations are usually the physicians, administrators, and the regulatory bodies that govern them. Sowers, Newman, and Langdon (2013) categorized the historical relationship between hospital leadership and physician medical staff as a unique, symbiotic interdependence. While both groups shared similar goals of increasing the quality of care using the most innovative techniques, and maximizing the professional autonomy of physicians, they operated in

silos and were governed by separate leadership bodies and aligned to different rules and guidelines (Burns et al., 2012; Sowers et al., 2013). Both groups' ignorance of the health care and operational inefficiencies, and the high cost incurred as a result of their lack of interrelatedness wreaked havoc on the surging and unsustainable cost of U.S. health care (Sowers et al., 2013) and the American GDP (PPACA, 2016). Like most institutions, health care organizations must recognize that they are made up of interconnected parts or units that must cohesively work together to sustain the whole entity (Lewis et al., 2017). Sowers et al. (2013) suggested that recognizing the important role that organizational knowledge has on motivating the culture of practice is an important building block for the leadership-physician alignment. Respect and recognition for each other's strengths and role in the health care continuum is also key. The benefits of this coalition include improved quality of care, cost containment and increased operational efficiency in health care organizations.

Although leadership ability is linked to subordinate performance, behaviors, and reactions, it is also associated to the leader's personality (Zacarro, Green, Dubrow & Kolze, 2017). As such, it is imperative that health care organizations have effective leaders on its workforce. That alone would not do in the organization's quest for effectiveness, efficacy, and cohesiveness. Leaders cannot work in silos. Rather they must develop a cohesive, integrated systematic model to address the organization's goals, objectives, vision, and its challenges in a holistic way. A health care organization is an organization generally governed by basic organizational administrative, operational, and legal functions, and while the leaders of health care organizations do not necessarily need

a clinical background, the leaders must have business, management, and leadership skills. That said, the best approach is to have a mix of the all stakeholders at the helm of health care organizations. So rather than each stakeholder viewing or addressing their problem(s) in isolation, health care organizations must apply a holistic approach in the management and leadership of the organization (Senge, Smith, Kruschwitz, Laur, & Schley, 2010). This approach allows health care organizations to synthesize its resources to develop value-based strategies that deal with organizational efficiencies, innovation, disruptive technology, and market expansion, which can result in value driven solutions with innovative, changes to cost and capabilities (Wiltz, 2013).

During my study of existing literature, I found that opportunities still exist for further research in some areas of health care management by HMOs. Opportunity exists for further research on what impact the reduction of health care's general and administrative (G&A) costs, fraud, waste, and abuse will have on HMOs in the wake of the Affordable Care Act, and whether HMOs can survive extinction. Since policies and procedures play a strategic role in an organization's culture and general framework, its development, and its operational and administrative processes, opportunity also exists for studies on the viability of HMOs' adoption of effective management of and adherence to policies and procedures as a strategy that would influence their ability to reduce health care costs, mitigate risk, increase profitability, sustainability, and maintain a competitive advantage in the face of ACOs' emergence as an alternative in the health management industry. Opportunity also exists for the exploration of the implications of HMO's satisfaction of legal and ethical requirements set forth by stakeholders such as federal and

statutory regulators and policy makers, contract owners, accreditation bodies, and patients. The objective of my study was to explore what internal control strategies HMO leaders in southeastern Pennsylvania used to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage.

Transition

Section 1 provided the foundation of the study. I established the background of the study with emphasis on the current cost of health care and its impact on the national GDP. HMOs' improper management of health care funds, the establishment of the PPACA, and government's introduction of ACOs to attain the PPACA's triple aim.

Section 2 discussed the project in detail. In this section, I described the purpose of the study, the research design, and methodological aspects that guided the study. I identified my role as the researcher and explained my rationale for selecting a qualitative single case study design. I also discussed how the study's participants were selected, the sampling method used, and the ethical considerations that I applied to the study. I also described the data collection, organization, and analysis techniques, themes, patterns, and concepts identified, and the data reliability and validity of the study. Section 3 presents a synthesis of the results of the study and discuss my findings. This section explains how the study's findings may contribute to organizational change in HMOs, management practices in health care, and offers recommendations for action, personal reflections, and opportunities for further study.

Section 2: The Project

This section contains a description of the project plan for this study. I present the purpose statement, discuss my role as the researcher, identify the participants of the study, and explain my rationale for my population sampling methodology. I also discuss the research method and design, ethical considerations, data collection, data techniques, data analysis techniques, reliability, and validity in this section. This section concludes with a transition and a summary.

Purpose Statement

The purpose of this qualitative, single site case study was to explore what internal control strategies HMO leaders used to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose health care they manage. Five directors representing different departments with varying number of years' service within a southeastern Pennsylvania HMO, and whose key roles included development, administration, and execution of the organization's goals and operational strategy participated in the study. Findings of this study may contribute to social change by presenting the participating organization or similar HMOs with an opportunity to reevaluate current operational processes and identify opportunities to improve organizational efficiencies that may reduce health care costs, and improve quality of care for the individuals whose healthcare they manage.

Role of the Researcher

A researcher's role in a qualitative study is explore, understand, and transpose their subjects' lived experiences into writing (Sanjari, Bahramnezhad, Fomani, Shoghi, &

Cheraghi, 2014). As the primary and only researcher in this case study, my role was to explore what internal controls strategies HMO leaders in southeastern Pennsylvania used to improve operational efficiencies, reduce health care costs, and improve quality of care for the patients whose care they manage. My role as the primary data collection instrument was to ensure the appropriate implementation of a data collection process, which included data collection, data coding, data interpretation, and documentation (Patton, 2015; Yin, 2017). My role as primary data collection instrument also included (a) validation of the quality and reliability of the data collected, (b) ensuring that the data collected aligned to the research question and the needs of the study, and (c) the mitigation of research bias throughout the data collection process (Yin, 2017).

I currently do not have any professional relationship with the study site organization or its leaders. I was previously employed with the study site, but my role was not on the level of director or above and did not meet the study criteria. I have access to the organization through some of my professional contacts. Although I am a healthcare professional and somewhat familiar with some aspects of HMOs, I have no first-hand knowledge of the strategic and/or organizational decision-making processes in this industry. Additionally, I had previously never conducted any research study related to my research topic.

In any study, researchers should be mindful of compromising the study's validity by infusing researcher subjectivity, and personal bias during the data collection, and or interpretation processes (Cypress, 2017; Fusch & Ness, 2015). Fosmire (2017) defined the Society of College, National and University Libraries' (SCNUL) seven pillars of

information literacy as critical components of bias mitigation. These pillars are identifying, defining the scope, planning, information gathering, evaluation, data management, and presentation (Boh Podgornik, Dolnicar, Sorgo & Bartol, 2016). I adopted these pillars in this study and vigorously followed them to mitigate any incidence of my own perspective during any phase of this study.

To further mitigate any researcher bias in my study, I developed a semistructured interview protocol (see Appendix) and followed a strict interview process when I conducted my interviews. I provided participants with consent forms prior to the interviews, which they completed, signed, and returned to me via email, regular mail, or in person prior to the commencement of the interview. Once I received the completed consent forms, I commenced each interview with an introduction, icebreaker questions, and a request for permission to record the interview session. Upon receipt of the participant's approval, the actual research interview questions began, and I recorded the session. I approached each interview objectively, limited my interjections, and only introduced probing questions to the participant when further clarification of a respondent's response was deemed necessary.

To ensure that the wealth of knowledge, insight, and perspective gained from the participants was truly their own, I neither offered personal opinions, nor interjected any personal bias during the interview. I ensured that both I and participants shared the mutual goal of gaining a better understanding of the organization's current position and defining its future as a leader in the HMO industry by identifying any existing gaps so that the leaders could use the information to develop processes for improvement to

maintain the organizations position in the market. My goal was to conduct each interview with minimum obstruction to the participant's day-to-day activities. I maintained professionalism in appearance and demeanor when interacting with the participants.

My adherence to the ethical standards of beneficence, autonomy, and justice outlined in *The Belmont Report* (National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, 1979) ensured that the study maintained respect for the participants, protected their privacy, and provided participants with informed consent. This also provided the assurance that I did not receive any personal benefit from this study.

Participants

Castillo-Montoya (2016) posited that when conducting scholarly research, the research question(s) must explicitly align with and express the research subject matter. Building on that tenet, the goal of the study should be the main factor influencing the technique used to choose the sample and the criteria on which this based. Therefore, one of my central foci was the selection of the study's participants. This study's population consisted of the employees at a southeastern Pennsylvania HMO, who, for at least 3 years, held positions of director or above within the organization. In the study, I reviewed the responses of a purposive selection of five executive leaders of functional departments whose responsibilities included making the operational decisions that aligned the organization's goals with its contractual, federal, and statutory regulations. The selected participants represented different departments within the organization and had a varying number of years' service at the organization.

The technique used for purposive, nonprobability sampling technique is often based on whether the sample is required to be illustrative, unusual, reveal key themes or useful in developing grounded theory (Yin, 2017). Purposefully selecting participants allows the researcher to gain understanding of the topic studied and receive responses from participants whose experiences align with the research questions (Patton, 2015; Yin, 2017). Robinson (2014) stated that theoretical and practical consideration must both be present when determining the sample size of a study. Therefore, based on the data collected and the type of study, the sample size, or number of participants may vary (Fusch & Ness, 2015; Saunders & Rohon, 2014). For a case study in homogeneous population, for example, Robinson stated that data saturation can be reached if data is collected from as little as one participant. In the case of a study with an ideographic aim, however, collecting data from between three and 16 participants will achieve data saturation.

Purposefully selecting participants who meet criteria strengthens the credibility and validity of a study (Marshall & Rossman, 2016). I selected five employees from different departments within the organization who had a varying number of years' service at the organization and played a critical role in the decisions that facilitated the organization's development. The research participants most suitable for this study had leadership responsibility for the oversight, development, administration, and execution of the organization's goals, operational strategies and policies and procedures within their departments. The size of this corpus ensured that the study met the generalizability, transparency, and data saturation criteria.

Saunders (2012) suggested the participants in a study ultimately depended on whether the researcher gained access to the participants, the amount of access granted by the leaders or gatekeepers of the research population, and the participants' willingness to consent to be involved. I followed the Walden University's Institutional Review Board (IRB) guidelines, sought permission from the organization's leadership to conduct the study, used the LinkedIn professional public media to collect a list of potential participants who met the research criteria. Patton (2015) and Yin (2017) both stated that gaining access to and establishing relationships with participants who meet the research criteria are critical components of a successful research study.

My initial steps in establishing relationships with the study's participants was via telephone, email, and in-person meetings. I extended invitations for them to volunteer for the study, purposively selected the participants, and provided the selected participants with an informed consent form. Participants were required to complete and return the signed consent form via email, regular mail or in person prior to the commencement of the interview. I used the opportunity during these interactions to briefly describe the study to the potential participants, outline the research criteria, and establish trust and collaboration with the participants.

I conducted face-to-face interviews with the participants to explore and understand (a) how these HMO leaders developed their internal controls to effect organizational change, health care cost reductions, and organizational sustainability, and (b) how their internal controls influenced risk mitigation and improved the quality of care for patients managed by HMOs. All participants received the same questions in the same

time allotted for each interview. To accommodate the participants, I conducted the interviews via inter-office meetings in the conference rooms at a location near the organization. I recorded and took copious, detailed notes of all the participants' responses to the questions and observed their body language. I advised the participants that their identities, and responses would be kept confidential in the doctoral study, and their identities would not be revealed in the doctoral study or when findings of the interviews were presented to the company.

Research Method and Design

A research method is the type of data collection, analysis and interpretation tools and techniques that a researcher may use to conduct a study (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2016). A research design consists of the plan and procedures for all aspects of a study (Sparkes, 2015). Succinctly stated, philosophical assumptions, strategies of inquiry, and specific methods form the basis of a research design or methodology (Levitt et al., 2016; Sparkes, 2015). This section provides an explanation for the research method and design used in this study, and the rationale for its selection over the other research designs and methods available.

Research Method

According to Groeneveld et al. (2015), qualitative and quantitative research methods are the two primary research designs used to study the social and the individual world. Both Sanchez-Hernandez (2018) and Molina-Azorin and Fetters (2018) advanced the mixed methods – an incorporation of both quantitative and qualitative methods – as the third type of research method. Quantitative research is a type of empirical research

that explains a social phenomenon or human problem by testing a theory or examining casual relationships of variables which are quantified and analyzed with statistics (Groeneveld et al., 2015). Qualitative research is an inductive, interpretative and naturalistic approach to the study of people, cases, phenomena, social situations, and processes in their natural settings in order to reveal the meanings that people attach to their experiences of the world (Yin, 2017). When considering how these research methods related to each other, Yin (2017) inferred that qualitative and quantitative research methods resided at both end of the research continuum. The mixed methods which represents a combination of the two methodologies, resides in the middle in the of the research continuum (Molina-Azorin et al., 2018; Sanchez-Hernandez, 2018).

The basis of my study which was understanding internal control strategies that HMO leaders used to increase operational effectiveness, lower health care cost, and improve the quality of care that their members receive, aligned with the advocacy and participatory worldview. Dorozenko, Roberts, and Bishop (2015) conducted a qualitative study to explore the social construction of intellectual disability from the perspective of staff who worked closely with people with intellectual disabilities. Keeffe and Andrews (2015) used the qualitative method to conduct a study to help researchers choose more responsive approaches to sharing understandings with adolescents. Like my own study, both studies were exploratory in nature and based on the advocacy and participatory worldview.

The advocacy and participatory worldview provide participants with an opportunity to voice their opinions, improve their awareness and make a difference

(Keeffe & Andrews, 2015). This worldview is generally aligned to the qualitative research methodology but allows for the use of the quantitative and mixed methods methodology as well (Keeffe & Andrews, 2015). While all three methodologies could be used, the quantitative and mixed methods methodologies were rejected since this study did not require the use of a hypothesis, objective questioning, quantification, or statistical analysis of variables. I chose the qualitative method because I wanted to explore management's perceptions of their internal controls and its impact on their organization using open-ended questions.

Research Design

Phenomenology, ethnography, and case study are the three most frequently used research designs for studies conducted in social, behavioral, and health sciences. These methods all attempt to understand a particular issue or phenomenon based on the perspectives of those who experience it (Yin, 2017). While these qualitive methods have similar data collection processes, there are distinct differences to note. An ethnography is a time-consuming research design that focuses on a group's culture (Yin, 2017). A phenomenological study focuses on the exploration of an understanding of the essence of experiences of participants to find the meaning for or characteristics of a phenomenon (Osborn & Smith, 2015; Patton, 2015). According to Yin (2017), a case study is a systematic, and comprehensive research method that addresses the logic of research design, data collection techniques and data analysis strategy. Costanzo and Di Domenico (2015) deduced that case study focuses on the in-depth exploration of one case or multiple cases and described its fundamental objective as a strategic revelatory tool used

to illuminate or expand conceptual perspectives. Costanzo and Domenico added that often, case studies addressed issues or phenomenon pertinent to the researcher's professional practice. Additionally, the case study method allows researchers to holistically explore issues within a real-life setting in an in-depth and exploratory manner on participants who suited the research criteria, and it also allows for the identification and analysis of themes and issues for similarities and differences among cases, and facilitates data collection from multiple sources (Yin, 2017).

I considered using the phenomenology as my study's research design for my study, but this design was not very practical, and did not support my needs the way that the case study method did so I opted instead for an exploratory, qualitative case study methodology. The case study design supported my study's attempt to explore how HMO leaders used internal control strategies to improve operational efficiencies, reduce health care costs, and improve quality of care for the patients under their management, and facilitated a systematic exploration and empirical understanding of the complex nature of the effectiveness of internal controls, or lack thereof, and presented the most complete and accurate portrayal of the issue under study. Using the case study methodology enabled my research to explore issues in-depth and in real-life settings, and used the case explored as the specific illustration (Johnson & Matthews, 2015; Keeffe & Andrews, 2015).

Population and Sampling

The collection of reliable, pertinent data in research is critical to the soundness or validity of the study's outcome (Fusch & Ness, 2015). Medeiros, Ladio, and Albuquerque

(2014) posited that in case studies, data collection contributes to improved understanding of the study's theoretical framework. Yin (2017) pointed out that because of the non-routinized method of data collection needed in case studies, continuous interaction between theoretical issues being studied and the data collected is critical. Resultantly, it is imperative that the participants selected to provide knowledge and information must be competent, reliable and can shed light to the issue being explored (Medeiros et al., 2014; Patton, 2015).

Defining the Population

The research population for this study were leaders at a southeastern Pennsylvania HMO with appropriate knowledge and expertise to provide appropriate information to address the study's objective of understanding what internal control strategies health care leaders used to improve operational efficiencies, reduce health care costs, and improve the quality of care for the individuals whose health care they manage. Each participant met the following criteria:

- Was at least 18 years or older;
- Held the position of director or above within the organization for at least three years;
- Had responsibility for making operational decisions that aligned with the organization's contractual, federal, and statutory regulatory requirements; and
- Had responsibility for the oversight and approval of the policy and procedures that guided the organization's operations.

There are six HMOs in the southeastern Pennsylvania region that dominate the market and based on my research of the companies' organizational leadership, at least four sites had at least 15 health care leaders who met the criteria for my study. I initially contacted two of these organizations requesting permission to conduct my study at their site, and one organization formally agreed to participate. I began contacting the prospective participants after I received approval to conduct the study from Walden University's IRB. I initially identified approximately 15 potential interviewees as my target population for this study, and for practical reasons, initially selected five participants for the study ensuring that each initial participant represented different departments within the organization. The number of participants I selected was large enough to capture a range of experiences but not too large to be repetitious.

I used the purposive sampling technique to select the research participants. This technique, also known as purposeful sampling is a nonrandom method used where participants must meet certain criteria for selection, and provides the researcher with some element of choice in participant selection (Elo et al., 2014; Gentles, Charles, Ploeg, & McKibbon, 2015; Palinkas et al., 2015). In research, purposive sampling can be applied to feasibility studies, sampling participants with specific knowledge or skill, comparisons of cultural practices, case studies and when the research population is too small for a random sampling (Palinkas et al., 2015). When properly used, purposive sampling can be as effective as random sampling methods and provide reliable and robust data (Gentles et al., 2015). Medeiros et al. (2014) cautioned that the application of purposive sampling or other intentional sampling techniques in single case studies

characteristically do not allow for generalization beyond the boundary of the case to the larger universe or population of like cases.

Of those potential interviewees in my study's population, I initially selected five participants for the study. Sonmez and Yildirim (2016) used a form of purposive sampling to maximize the variation of the participants selected for their study that identified difficulties newly graduated nurses from a Turkish University experienced within the first six months of employment. Bok et al. (2013) used a similar methodology to select their study participants in their study to understand how students sought feedback in a clinical workplace. I adopted a variation of Sonmez and Yildirim's participant selection to maximize the variety of experience and knowledge received from the participants of this study. I ensured that the five participants initially selected represented different departments within the organization and had a varying number of years' service at the organization.

Data saturation, the point where additional interviews provide no new information, enhances the validity of a study (Bentley, 2014; Fusch & Ness, 2015). Morse, Lowery, and Steury (2014) and Fusch and Ness (2015) argued that while the sample size of a qualitative case study may vary, there must be enough participants in a study to achieve data saturation. For practical purposes, I initially selected a subset of the available population for this study. This initial selection was large enough to capture a range of in-depth experiences that allowed for replication of the study, but not too large for the data to become repetitious. The size of the corpus also ensured that the study met the generalizability and transparency criteria (Morse et al., 2014; Yin, 2017). Other

participants were engaged because data saturation was not met with the initial participants interviewed.

I conducted face-to-face semistructured interviews with each participant in conference rooms at a facility near to the organization's compound. Strauss and Corbin (2015) recommended that researchers use multiple forms of communication as needed to reach the participants in advance of the study. Prior to the interviews, I contacted the participants via telephone, email, and in-person meetings, invited them to volunteer for the study, and provided each participant with an informed consent form.

During the interview, each participant received two main interview questions, each with four sub-questions to ensure that the interviewee explored the main questions. I allotted 45 minutes for each interview. During each interview, I recorded the participants' responses and observed their body language.

Ethical Research

Johnson (2014) and Schrenms (2014) advanced that the formalization of an ethical framework protected participants in a study. Bromley, Mikesell, Jones, and Khodyakov (2015) found that embodying ethical action, respecting participants, negotiating justice, and generalizing beneficence are four key principles researchers use to develop ethical frameworks for research studies. My study's framework included respect for autonomy, voluntariness, distribution of informed consents, and the development of adequate privacy, anonymity, and confidentiality controls, provided the research participants with some level of assurance that the data collected would not breach any accepted ethical practices and codes of conduct (Bromley et al., 2015). Yin

(2017) posited that following the guidelines of the researcher's IRB and obtaining its approval were the most imperative steps taken before conducting a case study.

Several measures were adopted prior to and throughout the study to ensure that my study was conducted in an ethical manner and that participants were adequately protected from ethical risks. I satisfied Walden University's prerequisite for researchers to explore the fundamentals of conducting ethical research by successfully completing the National Institute of Health's web-based training course on the protection of human subject during research, and gained approval to conduct this study from Walden University's IRB. The Walden University IRB approval number is 06-10-19-04908120.

I sought and received formal permission to conduct the study from an executive leader at the organization. Upon receipt of the IRB's approval, I informed the executive leader at the southeastern Pennsylvania HMO and began reaching out to prospective participants who met the criteria for participation in the study. Each participant received receive an invitation to participate in the study via email. This invitation included information outlining the objectives of the study, a participant consent form for review and electronic signature, and an explanation that their participation in the study was voluntary and that they had the opportunity to accept or reject participation at any time during the study without consequence or penalty including identification or memorialization of their contributions to the study.

Participants were also assured that their identities would be detached from specific survey responses via de-identification to provide privacy and protection from any retaliation, or compromise, based on their responses. Each participant's name was de-

identified, and a participant number was issued to each participant to protect their identity. Participants were not incentivized for participating in the study. All data collected is password protected and will be securely stored in locked folders in a computer hard drive and a file cabinet for 5 years and then destroyed.

Data Collection Instruments

In a qualitative study, the researcher is the primary data collection instrument (Odom, 2015). My role as a data collector was to design a data collection approach to record events and explore its meaning. The objective of my study was to explore what internal control strategies HMO leaders used to improve operational efficiencies, reduce health care costs, and improve quality of care for the patients whose care they manage. Monem (2015) recommended using multiple sources of evidence for data collection in case study research. I was not granted approval to review any of this organization's archival documents. Resultantly, I collected data from face-to-face, semistructured interviews and personal observations of five purposively selected participants.

Associates who held leadership positions of director or above for more than three years and had responsibility for direct oversight and approval for company policies and procedures were shortlisted and targeted for interview. By the nature of their leadership role, the ability to make strategic decisions for the operational processes in their area of responsibility, and length of time in the organization, this population presented the richest source of data for my study. During the face-to-face semistructured interviews, each participant was asked two main questions. Each question was followed by four sub-questions to help guide the conversation.

Castillo-Montoya (2016) and Martin, Galentino, and Townsend (2014) used interview protocols to guide the data collection process for their studies. I developed a semistructured interview protocol (see Appendix) to ensure consistency at each interview, to document key contributions made by the interviewee, to document my observations during the interviews, and to document any additional questions that I asked to gather further information from the participants.

Gleaning from the strategies adopted by Andrasik, Chandler, Powell, Humes, and Wakefield (2014), I obtained expert review of my interview questionnaire from my doctoral research chair and a methodologist. I also utilized member checking, transcript review, and explicit descriptions to achieve validity and reliability for this study. After each interview, the data was transcribed and summarized to ensure identification and memorialization of the key points of the interview. I invited the participants to check the interpretation of the interview and edit as necessary to ensure that the interpretation reflected what was conveyed during the interview.

Data Collection Technique

Data collection, a series of activities aimed at gathering and measuring suitable information to answer an emerging research question, is a critical component of a research or study (Elo et al., 2014; Yin, 2017). The accuracy and credibility in the data collection phase of a study is essential to maintaining the integrity and trustworthiness of the research (Elo et al., 2014). The primary activities in the data collection process for a qualitative study include, but are not limited to, identifying the site(s) and or individual(s) to conduct the interview, gaining access or making rapport with the subjects, purposefully

sampling, collecting the data, recording the information collected, resolving field issues, and storing data (Khan, 2014). Khan (2014) demonstrated the effectiveness of these activities in his literature review paper on the qualitative research methods.

My exploratory case study attempted to gain an understanding of the internal control strategies HMO leaders in southeastern Pennsylvania used to improve operational efficiencies, reduce health care costs, and improve quality of care for the patients whose care they manage. I applied face-to-face, semistructured interviews, and personal observations as my data collection methods for the purpose of this study. Yin (2017) held the view that these methods were commonly used in qualitative studies and assisted the researcher in achieving triangulation. In both of their studies, Costanzo and Di Domenico (2015) and Fusch and Ness (2015) posited that triangulation provided the opportunity to demonstrate variation in the information collected, delivered a means of cross-checking the information's consistency, and mitigated researcher bias.

Some researchers consider telephone interviews and Skype interviews viable alternatives to face-to-face interviews. Although Skype or telephone interviews may offer both researcher and participants savings in time and travel costs, and provides greater anonymity around sensitive topics, researchers often lose physical rapport and interaction, and the ability to observe the participants' body language achieved with face-to-face interviews (Lieffers, Haresign, Mehling, Arocha, & Hanning, 2018). Recorded, semistructured face-to-face interviews was my primary data collection source.

I started each interview with an introduction and icebreaker questions, before delving into the actual research interview questions. I asked the participants two main,

open-ended research questions: (a) what can HMOs do to develop or enhance its internal controls to satisfy the guidelines set forth by the PPACA and other state and or federal guidelines? and (b) how does this organization address accountability for the distribution, acknowledgement, and adherence to internal control measures by its workforce? Each main question was followed-up with four sub-questions to gather the pertinent information needed for this study. I also used probing questions for further clarification of a respondent's response when I deemed it necessary.

I used a semistructured face-to-face interview protocol (see Appendix) to guarantee consistency during interviews, to document the interviewees' key contributions and my observations, and to document any additional questions asked. To enhance the credibility of this study, I transcribed the recording of each interview, summarized the key points, and invited participants to ensure that my interpretation of the interview accurately reflected their responses.

Data Organization Technique

Data collected in a qualitative case study include electronic evidentiary information, such as narrative information, hard copy documents and other material collected from the field, and the researcher's report (Yin, 2017). Orderly compilation, member checking, and organization of data collected in a study preserves the credibility, and integrity of data, and makes the data accessible, reportable, and retrievable in the current and future studies (Chen & Zhang, 2014; Patton, 2015). Administering proper data organization techniques to the study's data also increases the reliability of the case study (Chen & Zhang, 2014; Elo et al., 2014; Patton, 2015).

I organized my research data to achieve the following six objectives: (a) consistency in modes of collection; (b) keeping track of data collected; (c) ease of access to the data collected; (d) proper data storage; (e) data privacy and protection; and (f) data termination or destruction. I recorded each participant interview using a portable micro tape-recorder and copious notes and tagged each tape according and notes taken to the participant's code name. Any interview notes and observations taken during the interview were appropriately documented in the space provided on the interview protocol (see Appendix) that I created.

I catalogued all data collected using an alpha-numeric filing system and developed a master log to list all the data I collected. Each item or document was tagged according to the document file name, date collected, data type, participant identification number, and file location in this database. There was also a column on the log where I logged any additional notes and or comments.

All electronic data created or collected are stored securely on my password protected computer which serves as my primary copy of my material. I created a back-up folder to store copies of the material on my home network. I used a triple security authentication method to ensure security and privacy of the electronic documents. All document and files are password-protected in password protected folders on my password protected computer systems. The passwords are different for each level of protection.

All other tangible documents such as paper documents and tape recordings are safely stored in a securely locked file cabinet. The research data is always accessible to

me as only I know the passwords for the electronic files and possess the keys to the filing cabinet. I withheld the name of the organization (study site) further protected the privacy of my research participants by de-identification. Each participant was coded with a participant number. My data analysis refers to participants by their code names only. All data collected will be destroyed after five years.

Data Analysis

I developed an interview protocol consisting of two main questions and eight sub-questions (see Appendix) to guide my research in this explorative case study. The data I collected from face-to-face semistructured interviews with 5 purposively selected participants and my personal observations during the interviews aligned with the conceptual framework for this study, (Elo et al., 2014), and formed the basis for my data analysis and interpretation. Coding was the primary data analysis technique I used for this study. Coding, the process of organizing material collected in qualitative studies into concepts and themes, brings meaning to the information collected in a qualitative study and facilitates data interpretation and analysis (Levitt et al., 2016; Yin, 2017).

I chose NVivo 12, a qualitative data analysis software to analyze my research data. When compared to the Atlas.ti software, NVivo 12 seemed more commonly used with interview data, was better able to analyze multiple types of data (Woods, Paulus, Atkins, & Macklin, 2015) and create hierarchical visualizations. My coding process included interview transcription, document reviews, assignment of codes, assignment of nodes (data categories), development of themes, and investigation of potential relationships between concepts and or participant characteristics (Woods et al., 2015).

I developed a framework which formed the basis and guidelines for my qualitative data analysis. I prepared my data for analysis by transcribing the interviews, typing up field notes, and arranging the data types based on the information source. I read and reread the data collected multiple times to gather a full understanding of the general sense of the information collected. I used the NVivo 12 tool to develop a coding schema to summarize the topics, concepts, and patterns, and created nodes to identify the data themes and major findings of the study.

I adopted a strategy of constantly comparing newly coded material to previously coded material to determine consistency in emerging themes and concepts, and then I correlated the key themes with current studies and the study's conceptual framework. (Borrego, Forestor & Froyd, 2014; Elo et al., 2014) posited that themes, concepts, or units of analysis must be large enough to be considered whole, but small enough to provide relevant meaning during the analysis process. Bearing this in mind, I narrowed the study to four key themes, namely (a) appropriate resources, (b) communication, (c) continuous audit and assessment, and (d) holistic approach to patient care.

After coding the data, and completing the analysis of the study, I developed a narrative paragraph to describe my themes and substantiate my findings. This included frequency of nodes, themes, and terminology, and the relationship between codes. This also expounded on how the themes correlated to the study's conceptual framework and to new literature since writing the proposal.

Reliability and Validity

When properly demonstrated in a qualitative study, reliability and validity portray accuracy and repeatability, mitigate variability of interpretation, and limit the time used to convince stakeholders of the study's quality (Cypress, 2014; Grossoehme, 2014). A study's findings achieve validity and reliability when the researcher can (a) demonstrate reliability and validity of the data collected, (b) exhibit trustworthiness or goodness of the data collection tools, and (c) show consistency in the analytical process of the study (Nelson, 2016). In a qualitative study, a defined set of methodological strategies or quality assessment tools must be created and logically followed to achieve reliability and validity (Elo et al., 2014; Yin, 2017). Rice, Kloda, Shrier and Thombs (2016) found that the researchers in their study developed a 16-item checklist as a quality assessment tools (QATSDD) to determine their study's validity and reliability. Rice et al. (2018) suggested that researchers should develop or customize a QATSDD tool to increase credibility in other qualitative and or quantitative studies. Nelson (2016) suggested that researchers should develop mechanisms to demonstrate credibility, transferability, dependability, confirmability, and intra-coder reliability to establish a study's validity and reliability. The reliability and validity of my study was established utilizing the 12 strategies I developed to demonstrate the study's dependability, credibility, transferability, and confirmability.

Reliability

The collection of reliable, pertinent data in research is critical to the soundness or dependability of the study's outcome. Saunders and Rohon (2014) described reliability in

qualitative research as the degree to which a study's data collection technique, if repeated, can generate the same research findings. Simply stated, reliability or dependability is based on a study's neutrality, and its ability to generate consistent results or outcome if the same study is replicated at a later date (De Massis & Kotlar, 2014; Nelson, 2016). The main areas that impact a study's reliability is the study's repeatability and replication of its findings, accuracy of the study, and the mitigation of error and bias (Anney, 2014; De Massis et al., 2014; Turgut, 2014). Following De Massis's (2014) recommendation, I developed a case study protocol that clearly outlined the data preparation techniques I adhered to.

Aycock, Clark, Thomas-Seaton, Lee, and Moloney (2016) and De Massis et al. (2014) strongly suggested the use of a database to organize data collected in research. I created a study database and organized my research data using this database. My objectives were to achieve (a) consistency in modes of collection, (b) a tracking log of data collected, (c) ease of access to the data collected, (d) proper data storage, (e) data privacy and protection, and (f) appropriate data termination or destruction.

I also created an interview protocol (see Appendix) that I consistently followed during each interview. My interview protocol outlined the main objective of the study, identified the interviewee criteria, the two main research questions and their sub-questions. I included blank space on each interview protocol to take notes from the interview, to document other topics of follow-up questions, and to list any documents received from the interviewee.

My doctoral research chair and a methodologist provided me with a review of my interview questions. I conducted and recorded my semistructured face-to-face interviews with all participants, consistently utilizing the space provided on the interview protocol (see Appendix) to record key notes and observations gathered from each interview. My data collection was not limited to the recorded participant interviews. I also documented any observations I observed during the interview. Collecting data from multiple data sources for my study, allowed me to gather contextual information that the recorded interview alone did not provide (Fusch & Ness, 2015; Yin, 2017). These steps assisted with mitigating any researcher bias in my study.

I reviewed the recording of each interview several times before transcribing and summarizing the interview to ensure that the key points were accurately noted, identified, and documented. I achieved member checking by inviting participants to verify and validate that my interpretation of the highlights of the interview truly reflects what they conveyed during the interviews. To further mitigate researcher bias, I reviewed each participant's interview response and my recorded observations independently of each other during the data analysis phase of the study. The codes and themes for each interview and observations were also reviewed separately before I compared the data sets to each other to develop emerging themes and similarities. Interviewing at least five participants further enhanced the reliability of my study because it ensured that I met data saturation.

Validity

Saunders and Rohon (2014) described validity as the extent to which a research instrument or method accurately measures the theoretical entity that it was designed to measure, the analysis is appropriate for the data collected and the findings truly reports the outcome of the study. Establishing a study's credibility, transferability, and confirmability demonstrates the validity of the research conducted (Anney, 2014; Teusner, 2015). Additionally, to establish validity, Yin (2017) recommended that researchers should maintain a chain of evidence and investigate and test rival explanations.

Credibility describes that the accurate, or truthful portrayal of the data collected from participant interviews and other data collection methods (Anney, 2014). Credibility occurs when the data collected from the participants' responses address the focal point of the study and readers can relate to the experiences portrayed (Chen & Zhang, 2014; Patton, 2015). Member checking is one of the strategies used to ensure that the data collected is accurate and credible. Confirmability is attained when the researcher can demonstrate that the data collected is the actual interpretation of the participants' views without any researcher bias (Anney, 2014; Teusner, 2015). Anney (2014) defined transferability as the neutrality, consistency, or replicability of the findings. Simply stated, transferability relates to the applicability of the study's finding to other setting or groups (Elo et al., 2014).

I achieved validity in my study by addressing the elements that Anney (2014) and Teusner (2015) used in their studies. I collected data from recorded, semistructured, face-

to-face interviews, and recording key notes and observations I noticed during the interviews. Resultantly, this enabled me to gather contextual information that the voice recorded interviews alone did not provide thereby achieving triangulation and improving the quality of the study.

I consistently utilized and followed my interview protocol (see Appendix) during each interview and allowed the interviewees to provide their responses without interruption. My study initially consisted of interviews from five participants. I ensured that I interviewed as many participants as I needed until I achieved data saturation.

I reviewed each interview transcript for accuracy, used thick descriptive detail in my interpretation of the participants' interview responses, and summarized each interview to ensure that I identified and documented the key points. In order to achieve member checking, I invited each participant to verify and validate that my interpretation of the highlights of the interview truly reflected what was conveyed during the interview. I established neutrality of the study and bias mitigation by independently reviewing each participant's interview response and my documented personal observations independently of each other during my data analysis phase of the study. The NVivo 12 software program assisted me in the identification of the codes and themes for each interview and other data set separately before I compared the data sets to each other for emerging themes and similarities.

Transition and Summary

The exploration of what internal control strategies health care leaders at a southeastern Pennsylvania HMO use to improve operational efficiencies, reduce health

care costs, and improve the quality of care for the patients they manage forms the basis of this study. In this section, I described the study in detail. My role as role as the researcher ensured that the implementation of a data collection process, validation of the quality and reliability of the data collected, and the mitigation of research bias throughout the data collection process appropriately met the ethical standards as set forth by Walden University's IRB. Using the purposive sampling technique, five associates who held leadership positions of director or above were selected to participate in this qualitative case study. I followed the IPA's guidelines to conduct my analysis of the data collected. To maintain the study participants' privacy and protect them against ethical risks, I sought and received approval from Walden University's IRB and applied the ethical standards set forth by this institution.

The following section of this study, Section 3, describes the study's applicability to professional practice and its implication for social change. In this section, I present the results and the findings of the study based on my analysis of the data collected. My data analysis and interpretation include the themes, patterns and concepts identified in the study. I describe how HMO leaders may apply the study's findings to improve their organization's internal controls and how this change may improve the quality of health care that the American citizenry receives and reduce health care costs in the United States. Finally, I offer recommendations for action and further study for consideration.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative, single site case study was to explore what internal control strategies HMO leaders used to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose health care they managed. I conducted semistructured interviews with five organization leaders at an HMO in southeastern Pennsylvania whose roles included development, administration, and execution of the organization's goals and operational strategy. I collected data using transcribed participant interviews and field notes from the interviews with the data collection protocol approved by the Walden University IRB (06-10-19-04908120).

The interviews were recorded with a digital recorder and/or documented using copious notes taken during the interviews. I transcribed the interviews, conducted member checking, manually coded the data, and then imported the data into NVivo12 software for thematic coding. Four essential themes emerged from the analysis. Participants emphasized the significance of (a) having appropriate human and technical resources, (b) maintaining effective and ongoing communication, (c) conducting ongoing assessments of organizational processes as key internal control strategies, and (d) adopting a holistic approach to the treatment and management of patient care.

Presentation of the Findings

The overarching research question was as follows: What internal control strategies must HMO leaders develop to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage?

I conducted semistructured interviews with five healthcare leaders from an HMO in Southeastern Pennsylvania whom I selected using purposive sampling. All participants in the study held organizational leadership positions and met the criteria for participating in the study. Each participant provided comprehensive responses to the interview questions. The interviews were conducted at an offsite location near the facility. I used NVivo 12 to assist in coding, identifying themes, and analyzing the transcribed interviews. The participants are labeled as Participant 1 through Participant 5. I asked each participant 10 questions during the semistructured interviews. The average interview time was approximately 45 minutes. In addition to the interviews conducted, I recorded key notes and participant observation as data collection methods for my study. Yin (2017) held the view that these methods were commonly used in qualitative studies and assisted the researcher in achieving triangulation. Triangulation provided the opportunity to demonstrate variation in the information I collected, delivered a means of cross-checking the information's consistency, and mitigated researcher bias in my study (Costanzo & Di Domenico, 2015; Fusch & Ness, 2015).

Upon completion of interviews with participants, I transcribed the recordings of interviews and the copious notes I took. I provided the narrative of the scripts to all participants for member checking and review. The participants provided feedback on the narratives to ensure that the narratives correctly represented their responses and had no errors. After member checking and comprehensive review, I imported the data into NVivo 12 to evaluate the relationship within the data and developed common themes from the output of the software. The deductive content analysis for this study included

exploring strategies by demonstrating connectivity to the conceptual framework and literature reviews.

The conceptual framework for the study was transformational leadership. Burns (1978) developed the transformational leadership conceptual framework with the premise that transformational leaders promoted pro-organizational employee behavior by inspiring and motivating positive change in their followers' attitude and expectation toward common goals. All aspects of operational efficiency maximation, healthcare cost reduction, and patient care management involve organization alignment and execution of internal controls strategies. The participants' responses supported the transformational leadership framework that leaders served as role models for their workforce, positively influenced workforce participation, and encouraged employee alignment in their administration and execution of internal controls strategies to maximize the organization's objectives and overall performance outcome (Freeborough & Patterson, 2015).

I used the relationship between the literature review, study findings, transformational leadership framework and the systems thinking model to develop an understanding of what internal control strategies HMO leaders must develop to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage. I reached data saturation when no new information emerged from the interviews, key notes, and participation observation. Four major themes emerged from the data analysis and coding process: (a) appropriate

resources, (b) continuous audit and assessment, (c) communication, and (d) holistic approach to patient care (see Table 1).

Table 1

Summary of Major Themes

Theme	Description	% Frequency
Theme 1	Appropriate Resources	32.03
Theme 2	Continuous Audit and Assessment	30.88
Theme 3	Communication	15.21
Theme 4	Holistic Approach to Patient Care	21.89

Theme 1: Appropriate Resources

Having appropriate resources was the first theme I identified in this study. Our health care delivery system continues to evolve with increasing complexity and is becoming more expensive to manage. Elrod and Fortenberry (2017) stated that health care organizations must proficiently design optimal pathways, operational efficiencies, service delivery, and the best care possible to their patients. Poorly managed HMOs are blamed for the unsustainable health care costs, low quality of health care, and diminishing access to healthcare dilemmas that the U.S. health care delivery system currently face.

HMO leaders need to develop strategies to navigate through the complex U.S. health care delivery system and allay these concerns. HMOs must find ways to rebrand and redefine themselves, such as developing innovative internal control mechanisms and

improve their processes by creating leaner, more efficient business practices that satisfy patient care needs and foster resource conservation, return on investment, service excellence, and enhanced market coverage (Elrod & Fortenberry, 2017; Frech et al., 2015).

The complexity of a health care delivery system relies heavily on human and technical resources to operate (Rosenberg & Ferlie, 2016). Marsilio et al. (2017) conceptualized the health care organization as a work system in which people performed multiple tasks using various tools and technologies in a physical environment. Marsilio et al. added that under specific organizational conditions, those work system interactions impacted care processes and patient outcomes. All five participants mentioned that having appropriate resources was a strategy that an HMO could use to enhance its internal controls strategy. Participants 1, 2, and 5 provided detailed examples of how their organization utilized their resources to maximize productivity and efficiency. Participant 1 stated,

> We have organizational charts and these organizational charts are designed and developed based on what the business needs and what the contractual needs are for our organization. Once we put the organizational structure in place to support the infrastructure of the business needs then we take a look at our budget for sustainability, then we look at cross-functionality, and we look at them from embryo to end in these different impacts that we may realize against this budget. We build our teams internally based on the requirements that we have.

Participant 3 felt that HMOs needed the right personnel to develop and maintain the organization's internal controls. Participant 3 added that leaders must be prepared to invest in the correct systems or technologies and train the workers so that the workers have the skillset they need to perform their functions. Participant 2 stated,

> You cannot just keep hiring people at a job because there is just not enough money to keep throwing at employees. And so, the staff and the departments and the organization needs to look at how they are working and the systems that we are using [to create] the most efficient system.

Participant 2 recognized that striking the correct balance between its human/social resources and technological resources, and engaging these two resources is one strategy that HMOs can use to maximize positive outcomes.

All participants indicated that their organization used teams and groups to perform cross-functional activities across the enterprise, and that the use of interdepartmental teams helps organizations improve business decisions, operational strategies, and overall performance. Marsilio et al. (2017) posited that multidisciplinary teams are undoubtedly a key factor in the design and delivery of health care delivery processes. Health care organizations benefit when critical departments and units are represented in team initiatives and strategic planning. This strategy maximizes value-based strategic planning and ensures that major decisions and effective business solutions are not made in isolation (Chughtai & Balanchet, 2017). Participant 4 stated that HMOs should develop teams, create policies and procedures, use technical learning systems, and other guidance as internal control strategies. Participant 5 added that the teams should

constantly use electronic systems to monitor what was going on in the industry whilst paying attention to adherence to their contractual obligations.

When health care leaders synthesize their human and technical resources and utilize interdepartmental teams and technical resources to create corporate governance modules, they lay the foundation for the development of innovative strategies and internal controls (Chughtai & Balanchet, 2017). Malik et al. (2014) opined that having an interdepartmental team approach will allow HMO leaders to work together to achieve their overall objective of improved health outcome, access to care and organizational cost savings. Participants 1, 2, 4, and 5 identified the audit, risk, compliance, and quality teams. Participant 1 said that these teams worked closely with businesses owners to assess their areas' performance for compliance with federal guidelines, internal guidelines, and financial reporting requirements. Participants 1-4 identified care management teams. Participant 4 said that when gaps in operational process or enhancement opportunities were identified, designated care management teams would develop process improvement plans to simultaneously drive the organization's practices to meet performance outcomes, whilst adhering to state and federally stipulated guidelines for the quality of care they must provide their members. HMO leaders may apply the findings of this study regarding staffing and technology retention to readily position themselves to improve organizational sustainability, profitability, and optimize patient outcomes. Finding the right balance between having the right team with the right skillset and investing in the correct systems or technologies is an important contributor to an HMO's success.

Theme 2: Continuous Audit and Assessment

HMOs were originally designed to effectively manage health care funds and provide quality care for the individuals whose health care they manage (Pozgar, 2016). However, as healthcare costs continue to rise without the returns of improved health care outcomes, HMO leaders must examine current organizational practices to understand its operational shortfalls to remain relevant in managed care. All participants articulated that their existence in the managed care depended on observance and compliance with federal, and statutory guidelines and meeting contractual obligations.

HMO leaders must find ways to implement improved internal control processes that will confidently achieve operational efficiency, cost effectiveness, and improve decisions making processes without compromising their fiduciary duty to provide quality care for the people they service, and maintaining compliance with applicable laws, regulations, and policies (Egener et al., 2017; Lewis et al., 2017). Every participant recognized the role auditing and monitoring contributed to organizational governance, compliance, financial performance, and performance improvement strategy. All participants also articulated that audits, assessments, and governance were part of their leadership functions. Participant 4 stressed, “the healthcare climate is constantly changing, especially when there are changes in government and we must keep on top of those changes”, and Participant 3 found that this approach also impacted the organization’s ability to provide optimum care to patients. Participant 5 said that this strategy allowed organizations to, “look at their present state, and compare it with the organization’s goals and with industry benchmarks.” Participants 1, 3, and 5 indicated

that assessments were implemented to monitor and mitigate financial risks and productivity. Participant 5 explained, “When you compare compliance with controls against the company’s productivity and profit-making ability, this can be a gauge to see whether the company is meeting financial expectations and functionality at a profit or at a loss.”

According to Mukhina (2015), effective internal control systems should contain monitoring and risk assessment tools that continually audit and assess the health care organization’s performance and goal achievements. Organizational audits and assessment are improvement-driven components of the corporate governance structure (Mariani & Tieghi, 2018; Mihret & Grant, 2017). Pierre et al. (2018) found that recent auditing and assessment practices assist with policy change and administrative reform. Participant 1 said the team would develop production, and auditing reports in place to, “assess where we are and what mechanisms we have in place to meet requirements.”

When properly used, continuous auditing and assessment allow health care organizations to (a) identify root causes of operational inefficiency, and poor-quality service, (b) recognize and define low performance, (d) identify impending risks, and (e) utilize fact-based management and scientific methodology to develop quality improvement strategies (Boyle et al., 2014; Pierre et al., 2018). Additionally, continual auditing and monitoring will improve HMO leaders’ ability to develop systems and processes that critically analyze, review, and evaluate existing procedures and activities, monitor compliance with contractual obligations/federal guidelines, and report any

recommend changes to management on various operational components of their organizations (Phillips et al., 2016).

Participants 1, 3, and 5 shared the view that the organization's risk adjustment teams would design and develop internal controls, policies, and process improvement plans if it identified gaps in processes that had negative effects on productivity or patient care. Participant 5 added that constant and ongoing review of organizational practices was necessary, "because sometimes people write down the controls, but somewhere along the line, they forget them and no longer follow their own guidance." Participant 4 stated,

> This is just a constant revolving door of changes that take place that we need as an organization to accommodate and fit ourselves into compliance. Doing these things would have a positive effect on organizational change. I mean that the organization eventually has to change because it can't remain static with the changes that take place for members. For the regulatory bodies that govern us they're constantly changing and so we've got to change to accommodate that and all these internal controls and internal processes and policies have to be updated on a consistent basis and the outcomes for the organization will be more efficiency, and the outcomes for the members will be more positive.

An HMO's assessment and governance program cannot be limited to monitoring and improving their systems and processes. Even with the development of stellar internal controls and risk mitigation processes, the management of the human element can neither be ignored nor taken for granted. HMO leaders, human resource staff, and the

organizational culture must be continually monitored, assessed, and held accountable for performance outcomes. Chughtai and Balanchet (2017) and Vatankhah et al. (2017) supported this position. These authors held the view that a health care organization's leadership cannot effectuate internal control system without the participation and involvement of the organization's staff. This strategy aligns with the transformational leaders' approach to quality improvement, employee empowerment, teamwork, and presents opportunities for the identification and implementation of positive change (Bakalikwira et al., 2017; Boyle et al., 2014; Sauoris, 2015). According to Participant 5, employee accountability, "is something we take very seriously here. Every associate [employee] is accountable for making sure they are aware of our workflows and that they follow them." Participant 1 said,

> Staff must acknowledge that they receive the policies, AP goals or whatever controls we have in place. They must also acknowledge/sign that they agree to comply with the internal control measures and guidelines that they have to follow to perform their functions.

Participant 4 noted,

> The organization's QA, auditing, and compliance teams constantly collaborated with their business leads to ensure that all staffed sign off on their responsibilities so that they will be held accountable for any shortfall. The auditing teams also audit and test processes for shortfalls. Any shortfalls we identify, the team will develop processes to improve them and work with the staff involved.

Participant 3 indicated stated that process checklists and workflows were available in simple, straight-forward, documented instructions that allowed staff to do exactly what was required for each step. Participant 2 indicated that these documents were available to staff at all times. Participant 2 was responsible for assessing staff performance against predesignated thresholds and reporting the results to management and the board.

Mihret and Grant (2017) described the auditing function as an internal control system that can be used to increase productivity and maximize returns. Auditing and monitoring of patient experience and health outcome cannot be ignored in an effective governance program because HMOs use patient outcomes as a productivity measure. All participants mentioned programs used to audit and assess patient outcome. Participant 1, 2, 4, and 5 mentioned STARS by name. STARS is an auditing tool that measures clinical outcomes. Participants 1, 2, 3, and 4 mentioned HEDIS measures as another tool used to measure clinical outcomes and compliance with federal statutory guidelines. Participant 2 said that their auditing and assessment teams monitor numerous measures impacting the patients. These measures include network adequacy, patient access to care, barriers to care, high volume care, dollar claims values, ER visits, hospital stays, and readmissions. Variables such as medical history, chronic diseases, living conditions, housing, and social determinants of health are also used to assess a patient's current general disposition and health care needs.

HMO leaders can leverage the findings of their audit and assessment to deliver performance feedback, strategize improvements in their organizational processes, implement risk mitigation controls, and deliver innovative strategies to achieve

operational effectiveness, efficiency, decisions making processes, reliable financial reporting, and compliance with laws, regulations and policies. HMOs may also significantly reduce health care costs for both patients and U.S. health care spending, and possible allow for reallocation of unspent health care funds to other government-funded programs, such as housing and education, to better serve the U.S. population, thus providing an improvement in the quality of life for a greater number of the American citizenry.

Theme 3: Communication

The health care management industry is highly charged with complexities, exposed to major risks, and constantly under pressure to change health care delivery to address cost effectiveness, organizational efficiency, and optimized patient outcomes (Etges, 2019; Kroning & Annunziato, 2020; Meyer, 2017). Effective communication is an important component in navigating through these complexities and effectuating positive results. Amudha et al. (2016) posited that communication and teamwork were the cornerstones in health care and all patient care decisions depended on effective communication among healthcare providers. All participants mentioned communication and collaboration in their responses.

Foronda et al. (2016) evidenced a direct correlation between miscommunication and poor outcomes, such as delayed treatment, misdiagnosis, medication errors, patient injury, or death. Hassan (2018) shared Faronda's viewpoints but offered effective communication as the solution to reverse these negative outcomes. Participants 1, 2, 3, and 5 said that staff communicated with providers in their network to discuss patient

needs. Participant 2 mentioned that care managers would sometimes communicate with patient and healthcare providers simultaneously via conference calls to discuss patient needs, while Participant 5 indicated that staff sometimes encouraged patients to communicate with their providers. All participants mentioned communicating with the patients as a means of improving their health outcomes. All participants indicated that they reached out to patient via telephone calls; however, Participants 1 and 3 added that patient care connectors also conducted in-home visits to communicate with patients about their care.

Kroning and Annunziato, (2020) defined collaborative communication as a strategy that utilized knowledge and information among partnerships and groups to promote situational awareness in healthcare, and to improve health outcomes. Communication is a strategy that transformational leaders in health care and other industries use to engage members of their teams, influence team behavior, and link individual employee goals and responsibilities as intrinsic components of the overarching organizational goals and objectives (Kramer et al., 2019; Roberts et al., 2016). Kroning and Annunziato (2020) added that communication in high-intensity environments required understanding of the context of the situation, and accurate information which allowed stakeholders to think creatively, understand the desired outcomes, devise solutions, disagree without arguing, and reduce conflicts. That said, health care communication can neither be limited what to D'Agostino et al. (2017) described as communication centered on the providers' side of the clinical encounter, nor can it be simply extended to the provider and patient relationship. Rather, communication in health

care must be collaborative, multifaceted, and multidirectional along the entire managed care continuum which also included the HMO leaders, teams, administrative staff, clinical staff, patients, caregivers, physicians, and other health care providers.

All participants in the study indicated that ongoing communication was a critical part of the organization's workflow and was present throughout every level of the organization. All participants also indicated that information is constantly communicated to staff via various means including, but not limited to staff meetings, email, intranet, general communication via marketing, and education and training modules. Participant 2 stated

> Well in my department, we use a lot of emails, but I personally also have a weekly mandatory one-hour "lunch and learn for all of my staff. In that meeting, we review policies, process changes, any new information, staffing changes and all sorts of information. We sometimes have folks from other departments come in and speak to the team. So that is how my folks get notified of these things.

Participant 3 and 5 noted that the company's management put steps in place to ensure that associates are timely notified of any significant change in policies or organization workflows. Participant 4 said,

> Communicating to our staff plays a critical role in making sure that everyone is accountable for their part in making our organization run smoothly and adhere to our guiding principles. Staff are constantly informed and educated about their roles and how it fits into meeting our organizational goals. They have to

acknowledge that they are aware of their roles and responsibilities. Staff must document their acknowledgments and we track and log them.

Mukina (2015) offered communication as a must-have element of any effective internal control system. My findings supported this position. Information sharing and multifaceted and multidirectional communication among stakeholders can contribute to an improved health care delivery model that promotes greater collaboration among stakeholders, and may significantly improve quality of patients outcome, organizational cost performance, and the health system as a whole (Kroning & Annunziato, 2020; Reid et al., 2005). As Kroning and Annunziato (2020) suggested, HMO leaders may find that promoting effective and collaborative communication throughout the health care team, as well as with patients and families, may also create opportunities for authentic relationships, and foster and a culture of learning across the health care continuum.

Theme 4: Holistic Approach to Patient Care

The United States spent $9,120 and $10,723 per capita on health care in 2013 and 2017 respectively, which represented 17.2% and 18% of the country's GDP (Cuckler et al., 2018). When compared to the 10 other highest-income countries around the world, the United States spends the most on health care, yet its health outcomes are worse than all the others (Papanicolas et al., 2018). HMOs were created to assist with the management of the U.S. health care delivery. HMOs' primary roles as prepaid health plans were to act as gatekeepers for the disbursement of quality health care for patients, reduce health care costs, and increase profits (Nunez, 2012). HMOs generally failed to live up to these expectations and have been blamed for, among other things, the

unsustainable health care costs, low quality of health care, and diminishing access to U.S. healthcare delivery.

All participants mentioned the organization's structure, financial responsibility, and its fiduciary duty to satisfy the patient needs. Participant 1 stated that after implementing the organizational structure and budget in place, the organization develops cost containment initiatives, makes improvements in quality initiatives to facilitate health care delivery and access programs. Participants 2 and 3 both expressed that the organization must be efficiently managed so that their patients receive consist care and access to care. Participant 5 added, "When you compare compliance with controls against the company's productivity and profit-making ability, this can be a gauge to see whether the company is meeting financial expectations and functionality at a profit or at a loss. Participant 4 said

> Our internal controls make sure that we keep up with the goals and guidelines we set as an organization, and also what is set by law. It also makes sure that we keep up with our competitors in the industry. Of course, we cannot forget our responsibility for providing our patient with excellent care. I believe that the controls we have around patient care delivery also keeps us in business and is what makes us leaders in our industry.

Now with the emergence of ACOs as an alternative to HMOs, the market share of HMOs in the health management industry is at risk. Participants 3 and 5 expressed concerns about financial sustainability amidst the introduction of ACOs into the market. Participant 3 indicated that the organization had to stay vigilant and abreast with industry

trends to remain competitive and viable. Participants 1, 4, and 5 did not believe that ACOs posed a threat to their organization's market share. Participant 4 offered that the organization's current processes contributed to their existing placement at leaders in the industry.

HMOs must find ways to reform, reimagine, and reposition themselves as viable stewards of the U.S. health care delivery system. Berwick (2013) and Kuziemsky (2018) suggested that a re-visitation of the core principles of the provision of health care for the patient by health care leaders and stakeholders is the urgently needed antidote for health care reform. Bui et al. (2017) considered understanding the factors that impacted health care spending as an essential first step in addressing this dilemma. Dieleman et al. (2017) identified population growth, population aging, disease prevalence or incidence, service utilization, and service price and intensity were the five primary factors associated with health care spending increases in the United States. Waste as a result of unnecessary and unfounded care was also a contributor to health care spending (van Leeraum, 2019). Cutler et al.'s study in 2019 supported van Leeraum's finding when their study showed that unnecessary treatment and testing ordered by over 60% of both physician and patient participants in their study resulted in waste due to unnecessary and unproven care. van Leeraum believed that culture and relationship change was urgently needed to bring quality care and costs in harmony, thereby improving service delivery.

A major challenge HMOs face is to demonstrate their ability to improve patient access to care and increase health outcomes, whilst reducing the overall cost of care. This is no easy task. van Leeraum (2019) considered health care cost containment as a major

challenge for health care organizations and found that many healthcare organizations usually viewed health care cost and quality care as tradeoffs, and often substituted one for the other. Collectively, all study participants inferred that their organization took a holistic approach to patient care management. Participants 1, and 5 described this as the organization's "embryo to end" approach to health care management which consists of the HMO's leader and staff's collaboration, physicians, other service providers, and patients to develop care designs that enhance patient and customer experience while reducing healthcare costs. Delancey (2018) termed this care model as a patient centered care (PCC). Participant 1 said that an interdisciplinary team worked with providers, pharmacists, and other care providers to obtain a comprehensive view of the patient needs and together this group find ways develop treatment plans to deliver the appropriate level of care to the patient.

Participant 2 added that care team members would contact the patients and work with them to develop the care plan so that the patient, "is involved with determining what their own health care goals may be." All participants highlighted the organization's patient education and outreach programs as part of this holistic patient care strategy. Participant 5 said that these programs empowered the patients with knowledge about their conditions, explored barriers that hampered access to care, provided the patients with the ability to make informed decisions about their health care such as when to call their primary care physician versus when to go to the emergency room. Participants 2, 3, and 4 also described having relationships with physicians, pharmacists, and other care providers

to discuss patients' needs and to coordinate delivery of medically necessary procedures, prescriptions, and medical equipment.

The holistic, patient centered care approach to care management aligns with the transformative leadership style and the systems thinking methodology. Adopting a holistic, patient centered approach can provide HMOs with opportunities to reduce the cost of patient care management, and improve patient health outcomes (Delancey, 2018). HMO leaders may adopt this approach to better understand the comprehensive needs of each patient, and develop customized care plans, and treatment plans to deliver the appropriate level of care that each patient needs. This strategy will also provide patient education, encourage patient partnership, and increase patient participation in managing their own health care needs.

Applications to Professional Practice

HMOs are labelled as key contributors to some of the dilemmas that the U.S. health care delivery system currently face, namely the unsustainable health care cost, diminishing quality of and access to healthcare. It is therefore imperative for HMO leaders to develop strategies to navigate through the complexity of the health care delivery system, and positively mitigate, if not alleviate these concerns. HMOs must find ways to redefine themselves by developing innovative internal control mechanisms, and improve their processes by creating leaner, more efficient business practices (Elrod & Fortenberry, 2017; Frech et al., 2015).

This research is applicable to the sustainability of HMOs because the objective of this study was to explore strategies HMO leaders use to improve operational efficiencies,

reduce health care costs, and improve quality of care for the individuals they manage. A synthesis of the study HMO's operational practices that I gathered from data analysis of the interview transcripts, copious notes taken during the interviews, my review of professional literature, and the transformational leadership conceptual framework formed the basis of this study's findings. The alignment of the body of knowledge I gathered provided information needed to address my research question. All participants in this study emphasized the criticality for HMOs to find ways to redefine themselves and their processes amidst the current health care climate. The findings of this study supported the position that effective management, distribution, and adherence to internal controls in health care management organizations were attainable, and once achieved, could significantly reduce health care costs for both patients and U.S. health care spending and improve the quality of care that patients receive.

The findings of this study may prove helpful to HMO leaders who have been unsuccessful in effectively managing their business operations and or fail to provide optimal patient care management. The findings of this study may also encourage HMO leaders to modify their current operational practices, and HMO leaders may implement the recommendations from this study to improve operational efficiencies, reduce health care costs, and improve patient health outcomes.

HMO leaders may apply the findings of this regarding staffing and technology retention. It is impossible for any organization to successfully operate a business model without appropriate human and technical resources. The U.S. health care industry is no different. The complexity of a health care delivery system relies heavily on human and

technical resources to operate (Rosenberg & Ferlie, 2016). HMOs must be willing invest in the resources necessary to readily position themselves to improve organizational sustainability and profitability, and optimize patient outcomes. Based on my findings within this study, finding the right balance between having right team with the right skillset, and investing in the correct systems or technologies was a critical factor to an HMO's success.

HMO leaders may apply the use of interdepartmental teams to improve business decisions, operational strategies, and overall performance. HMO leaders should not make leadership decisions in silos. Rather, HMO leaders should encourage collaboration among departments and units when making critical business decisions. This approach maximizes value-based strategic planning and minimizes the potential for major decisions to be made in isolation (Chughtai & Balanchet, 2017). This allows HMO leaders to work together to achieve the overall objective of improved health outcome, access to care, and organizational cost savings (Malik et al., 2014). Based on my findings within the study, HMO leaders' adoption of a multidisciplined approach to decision-making allows is critical factor to the HMOs' success as this approach serves to holistically promote the needs of the entire organization, and the needs of its smaller units at the same time.

HMO leaders may apply the development of an overarching governance program to improve business decisions and operational strategies. Ongoing governance and examination of an HMOs' work processes can identify root causes of operational inefficiency and poor-quality service, recognize, and define low performance, identify

impending risks, and utilize fact-based management and scientific methodology to develop improvement strategies (Boyle et al., 2014). This allows HMO leaders to develop systems and processes that increase their ability to critically analyze, review, and evaluate existing procedures and activities, and report and recommend changes to management on various operations of their organizations (Phillips et al., 2016). HMOs, including their leaders and staff must be continually monitored, assessed, and held accountable for performance outcomes. HMO leaders can leverage their findings to deliver performance feedback and strategize changes in their organizational processes.

HMO leaders may apply holistic approach to patient care management to reduce the cost of patient care management and improve patient health outcomes. HMO leaders can adopt this holistic, embryo-to-end approach to patient care to understand the comprehensive needs of each patient, and develop customized care and treatment plans to deliver the level of care that the patients need. This strategy also requires patient education, patient partnership, and patient participation in managing their own health care needs. HMO leaders' adoption of this managed care strategy can streamline patients' needs and minimize unnecessary spending for items and procedures that are medically unnecessary. This approach had favorable implications on patients' health care outcomes and overall wellbeing (Bataldan et al., 2016).

All participants stated that having appropriate human and technical resources, collaborating with interdepartmental teams in strategic decision making processes, conducting ongoing assessments/governance of organizational processes, and adopting a holistic approach to the treatment and management of patient care as key internal control

strategies for their organization's success in improving operational efficiencies, reducing health care costs, and improving the quality of care for the individuals whose health care they managed. HMO leaders who learn to effectively implement these internal controls strategies could achieve business success.

Implications for Social Change

The modern-day health care delivery system is ever-evolving, complex, and becoming more expensive to manage. Knowledge gained from this study could help health care leaders to find ways to better manage their HMOs (Emami & Doolen, 2015). Health care organizations benefit when critical departments and units are represented in team initiatives and strategic planning. This ensures that major decisions and effective business solutions are not made in isolation. When health care leaders synthesize their resources and utilize interdepartmental teams and technical resources to create corporate governance modules, they lay the foundation for the development of innovative strategies and internal controls that can address issues such as organizational efficiencies, disruptive technology, patient outcome satisfaction, and market expansion (Chughtai & Balanchet, 2017).

Knowledge gained from this study can also positively impact patient health care outcomes. The paradigm shift from the concept of addressing a patient's problem to one that promotes patient education, patient partnership, and patient participation in managing their own health care needs can have positive implications on the patient's health care outcomes and overall wellbeing (Batalden et al., 2016). The effective management, distribution, and adherence to internal controls in health care organizations can also

significantly impact the reduction of health care costs for patients, and overall health care spending in the U.S. The possibility exists for the reallocation of unspent government funds to other government-funded programs, such as housing and education, to better serve the U.S. population, thus providing an improvement in the quality of life for a greater number of the American citizenry.

Recommendations for Action

It is no secret that the cost of the U.S. health care continues to rise and burden the U.S. economy. Researchers, Gruber (2017) and Herland et al. (2018) attributed HMOs' ineffective management of the government's health care funds as a key contributor to this rising cost. The HMO as a managed care option is now at risk, and HMO leaders face the challenge of navigating through the complexity of the health care delivery system and the cost of managing it to find ways to implement processes that will confidently achieve operational efficiency, cost effectiveness, and improve their decisions making processes. HMOs must achieve this without compromising their fiduciary duty to provide quality care for the people they service and maintaining compliance with applicable laws, regulations, and policies. As such, it was imperative to understand how these requirements affected how HMOs operate and how their strategies influenced the provision of health care services to patients.

The focus of this study was exploring internal control strategies to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals in HMO organizations. All participants at the study's subject HMO supported the position that effective management, distribution, and adherence to internal controls in

health care organizations were attainable, and once achieved, could significantly improve patient health outcomes, and reduce cost for patient care and U.S. health care spending overall. The strategies that worked best for leaders at the subject HMO included having appropriate human and technical resources, conducting ongoing assessments of organizational processes, maintaining effective and ongoing communication with key stakeholders, and adopting a holistic approach to the treatment and management of patient care as key internal control strategies. These strategies strongly aligned with the knowledge gathered from the review of professional literature, and with generally accepted business practices.

My first recommendation is for HMO leaders to acquire appropriate human and technological resources in relation to the simplicity or complexity of their organization's business model and operational goals. Health care organizations rely heavily on human and technical resources to operate, thus having the right combination of appropriately skilled workforce and technical resources is key for HMOs. Participant 3 stated that having the right team with the right skillset and investing in the correct systems or technologies was a critical to the organization's success. HMOs must be willing to invest in the recruitment of a skilled workforce and providing these employees with the tools needed to optimally perform their functions. When HMOs attain the right balance between staffing and technology, HMOs can more readily position themselves to improve organizational sustainability, profitability, and patient outcomes (Rosenberg and Ferlie. 2016).

My second recommendation is for HMO leaders to adopt the systems thinking methodology as an operational strategy because health care organizations benefit when critical departments and units are represented in team initiatives and strategic planning. All the participants at the study HMO mentioned the utilization of interdepartmental teams to create corporate governance modules. This strategy synthesizes its resources to develop value-based strategies and minimizes the potential for major decisions and effective business solutions to be made in isolation (Chughtai & Balanchet, 2017). Through regular discussions, and ongoing meetings, these teams can combine their skillsets and experiences to lay the foundation for the development of innovative strategies and internal controls that can address issues such as organizational efficiencies, disruptive technology, patient outcome satisfaction, and market expansion (Chughtai & Balanchet, 2017).

My third recommendation is for HMOs to establish an overarching governance program that requires a continuous quality improvement, and accountability for its stakeholders as an internal control strategy. An effective internal control system should include a control environment, control activities, monitoring and risk assessment tools, risk mitigation, descriptions of the subjects and objects of internal control, information and communication (Mukhina, 2015). Continuous examination of HMOs' work processes can be used to examine the root cause of poor quality, recognize and define low performance, identify impending risks, and utilize fact-based management and scientific methodology to develop improvement strategies (Boyle et al., 2014). As role models, health care leaders can leverage the transformational leadership framework to examine

their organization's internal and external environment, strategize the organization's strategic and task objectives, and deliver performance feedback and encouragement to their followers (Freeborough & Patterson; 2015). HMOs, including their leaders and staff must be continually monitored, assessed, and held accountable for performance outcomes.

The cost of health care delivery in the United States is greater than in any other country in the world, yet its health outcomes are worse than almost all other developed countries, and ranked lower than these countries in health care efficiency (Dieleman et al., 2016; Papanicolas et al., 2018). Gruber (2017) and Herland et al. (2018) found that ineffective organizational controls was a key contributor to HMOs' inefficient management of health care funds and poor delivery in quality of patient care management. My fourth and final recommendation is for HMO leaders to adopt a holistic approach to healthcare management that involves encouraging patient inclusion in their own health care needs. Participants 1 and 5 described the subject HMO's approach for patient care management strategy as an "embryo to end" strategy. HMO leaders can create interdisciplinary teams of medical directors, case managers and care coordinators who will develop rapport and collaborate with the patients, their primary care providers, pharmacies, durable medical equipment providers, etc. to get a comprehensive view of what the patients' needs are and develop customized care plans and treatment plans to deliver the level of care that the patients need.

HMO leaders should also consider creating an environment that promotes patient education, patient partnership, and patient participation in managing their own health care

needs. This approach can have positive implications on patients' health care outcomes and overall wellbeing (Batalden et al., 2016). My recommendations for action emanated from the subject HMO's best practices, the study's conceptual framework and research support. HMO leaders could leverage their strategies with the findings and recommendations of this study to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals they manage.

Recommendations for Further Research

The purpose of this qualitative, single site case study was to explore what internal control strategies HMO leaders used to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose health care they managed. Shapiro and Naughton (2015) defined limitations of a research study as factors that established the study's focus, scope and its external boundaries. This study was limited to the views of organizational leaders at an HMO organization in Southeastern Pennsylvania. Although the results of this doctoral study may apply to other similar HMO organizations, and may be transferrable to other settings, I identified three opportunities for further studies.

My first recommendation for further research is to replicate the study as a multiple case study to other geographic locations in the tri-state area of Pennsylvania, New Jersey and New York because patient population, and regulatory or statutory guidelines that influence internal controls may differ from state to state. My second recommendation for further research is to broaden the scope of the study to include employees with nonmanagerial roles. Adding the perspectives and experiences of the

organization's nonmanagement workforce are who are directly impacted by these internal control strategies would help the researcher to determine whether similarities exist between the organization's leaders' perspective and those of the nonmanagement workforce. This study concentrated on feedback from an HMO responsible for the management of patient healthcare which is one type of service provided on the healthcare continuum. My third recommendation for further research is to expand the research to healthcare providers, such as hospitals or urgent care centers who are responsible for patients' healthcare needs. This would provide the approach from another aspect of the healthcare continuum.

Reflections

Completion of my doctoral studies was a personal goal for as long as I can remember. I wanted to become an academic leader with the business acumen that would make a difference in how the world looked at the management and delivery of healthcare. This degree has afforded me with just that. The knowledge that I acquired as a Walden University doctoral student/graduate impacted my academic, professional, and personal development. I could not have done this without the training and guidance from my lecturers who taught me the fundamentals of doctoral studies in healthcare management and my doctoral study committee members and academic advisor who guided me through completion of my research study.

I am a better person today because of the rigors of this program and the high standard that my Walden professors expected of me. My ability to utilize qualitative and quantitative research methodologies to conduct research and present evidence based

scholarly recommendations have increased my confidence as a professional. I am now aptly poised to make positive contributions to the business and healthcare industries, and impact social change.

Though each academic accomplishment I attained drew me closer to the reality of attaining my DBA, my journey was not an easy one. There were many adversities and challenges along this journey. As a result of my with hard work, perseverance and lots of sacrifice, I overcame these obstacles in ways I would never have imagined were possible. This doctoral degree bears the testimony I found the resilience and resolve to persevere and push through.

I am humbled and honored to add this degree to my family's academic accomplishments and bear testimony to my family, friends, and colleagues that with hard work, perseverance, and lots of sacrifice, nothing is impossible. I will never take lightly this honor that has been bestowed on me.

Conclusion

Dieleman et al. (2016) stated that the cost of health care delivery in the United States is greater than in any other country in the world, and its continued rising costs pose serious threats to the country's economic position and its health care industry. Researchers project that by 2025, over $2.7 trillion, or 47% of the U.S. national health costs will be managed by HMOs (Hartman et al., 2015; Keehan et al., 2016). Notwithstanding the large sums of money allocated to this industry annually, health care delivery has been inefficiently managed, which has led to a disjointed health care system, poor care coordination, and deficient patient treatment and engagement (Shen & Norris,

2016). A study of this nature is critical for managing healthcare delivery in managed care organizations. The findings of this study indicated that HMO leaders could successfully use internal control strategies to improve operational efficiencies, reduce health care costs, and improve quality of care for the individuals whose healthcare they manage. The four themes that emerged in the findings of this study were (a) appropriate resources, (b) continuous audit and assessment, (c) communication, and (d) holistic approach to patient care.

Based on the findings, HMO leaders should ensure that they have appropriate human and technical resources to efficiently and effectively perform functions to maximize performance outcomes and cost savings. I recommend that HMO leaders foster a collaborative relationship among leaders, department managers, and employees so that the organization can take a holistic view of their operations and encourage employee buy in. The findings of this study also support that the needs and circumstances of the patients cannot be ignored. I recommend that HMO leaders consider the overall needs of patients when planning for patient care. A patient's understanding and involvement in the care plan and his/her ability access the care needed will result in a more informed patient and may have positive effects on overall health outcomes.

The four themes identified aligned with the transformational leadership conceptual framework as they positively influenced workforce participation and supported employee alignment in their administration and execution of internal controls strategies to maximize the organization's objectives and overall performance outcome. The four themes were also consistent with the literature review. The HMO leaders

developed these internal control strategies not only from a cost saving perspective, but also because they improved operational efficiencies and improved the quality of care that patients received. The experiences the participants shared in this study were consistent with professional healthcare practices and provided a better insight to the organization's practices. The development of innovative strategies and organizational best practices that effectively operationalized this HMO's business management processes demonstrated implications for positive social change and can be incorporated into other HMOs' internal control strategies.

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Appendix: Interview Protocol

Interview Protocol for Doctor of Business Administration Dissertation Study Walden University School of Business and Technology	
Project Name:	**Can Effective Internal Controls Secure HMOs Survival in the U.S. Managed Care Industry**?
Institution:	**Walden University School of Business and Technology**
Interviewer:	**Elizabeth David, DBA Doctoral Candidate**

Study Overview

This study seeks to explore how leaders in Health Maintenance Organizations'(HMOs) adoption of effective internal controls such as the management and distribution of policies, procedures, adherence to contractual guidelines, and the implementation of organizational goals can influence health care management organizations' (HMOs') ability to reduce health care costs, mitigate risk, increase profitability, sustainability, and maintain a competitive advantage in the health care industry. This study will be submitted and published as partial fulfillment of the requirement for the Degree of Doctor of Business Administration at Walden University.

Introductory Protocol

You have been selected to participate in this study because you have been identified a leader in your organization who has the knowledge and expertise to provide appropriate information to address the study's objective, and meet the following criteria:

- You are 18 years or older;
- You hold the position of Director or above and have responsibility for making operational decisions that aligned with the organization's contractual, federal, and statutory regulatory requirements;
- Your responsibility includes oversight an approval of the policies and procedures that guide the organization's operations; and
- You have worked with the organization for at least three years.

This 45-minute interview will be audio-recorded. Prior to participating in this study, you will be required to complete a Consent Form. The Consent Form is designed to inform you of your rights based on Walden University's IRB guidelines. This includes an explanation on how (a) only the researcher will have access to the taped recordings which will be destroyed after transcription (b) your information will remain confidential, (c) your participation is voluntary, and (d) you may withdraw at any time and for any reason without penalty. By signing the Consent Form, you attest that you have read, understood, and acknowledged receipt of the Consent form.

Interview Questions

1.	**What can HMOs do to develop or enhance its internal controls and to satisfy to the guidelines set for by the PPACA and other state and/or federal guidelines?**
1.1	**How can internal controls affect organizational change and improve sustainability in the changing climate of health care management?**
1.2	**How does your internal controls strategies mitigate patient risk, and influence the quality of care that patients you manage receive?**

1.3	**What strategies have you implemented to improve patients' access to care?**
1.4	**How has the introduction of accountable care organizations impacted your organization's competitive advantage in the HMO industry, and what measures, if any, have your organization implemented to address this?**

2. How does this organization address accountability for the distribution, acknowledgement, and adherence to internal control measures by its workforce?	
2.1	**How is the internal workforce initially made aware of changes to and/or the creation of internal controls such as policies, procedures, and other guidelines?**
2.2	**How does the organization qualitatively and/or quantitatively monitor and measure adherence to internal controls?**

2.3	**What mechanisms (internal or external) are used to manage the organization's internal controls and organizational guidelines?**
2.4	**What are the ethical and or legal implications, if any, of non-adherence to organizational internal control measures?**

Other Topics Discussed (If any):

Documents Obtained from Interviewee:

Post Interview Comments or Leads:

Member Checking: