2020

Leadership Strategies to Maintain Hospital Business Office Productivity During a Merger

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This is to certify that the doctoral study by

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Walden University
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Abstract

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by

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MBA, Beulah Heights University, 2013

BA, Kentucky State University, 1996

Doctoral Study Submitted in Partial Fulfillment

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Abstract

In 2017, healthcare system mergers in the United States set a record with 115 deals made and 11 involved sellers with net revenue of at least $1 billion; however, it is common for hospital business office productivity to suffer during a merger. Grounded in the theory of business process re-engineering, the purpose of this qualitative single case study was to explore strategies hospital leaders in the southeastern United States used to maintain business office productivity as they completed a merger. A review of documentation from archival records supplemented in-depth interviews with 7 purposively selected hospital leaders. Yin's 5-step analysis guided the coding process of participants' responses, and member checking was used to validate the transcribed data. The major themes of the study revealed that strategies for hospital leadership maintaining business office productivity require (a) presenting unified and consistent messaging, (b) openly sharing outsourcing advantages, (c) making a concerted effort to alleviate the fear of the unknown, and (d) proactively addressing potential challenges. A recommendation for hospital leaders is to preemptively confront the potential obstacles and elucidate opportunities presented by the merger. The implications for positive social change include the potential for hospital leadership to increase productivity, enhance patient quality of care, and improve surrounding communities' economic stability.

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Dedication

I dedicate this study to my Lord and Savior, Jesus Christ, who allows me to do all things. I also dedicate this study to my family. I want to thank my mom Kathleen, who is the ultimate encourager and has always affirmed and inspired me. I want to thank my sister Patricia, who has been my provider, defender, confidant, and cover for my entire life. I want to thank my brother Rick, who is the most fearless, smartest, "*awesome-est-est*" brother any man can ask for. My aunt Nita and Uncle Lenny for opening my eyes to so many possibilities in this world. I love you all beyond measure. My completion of this doctoral degree is a milestone that I hope will make each of you proud and demonstrate just how valuable I esteem education. I am grateful for your unending support and prayers. Mostly, I want to thank my wife Tammy especially, who is the ultimate encourager, confidant, and inspiration toward me achieving my doctoral degree. You are quite literally my heart, and I will always love you and no other. Life with you has proven to hold endless possibilities. Finally, I dedicate this dissertation to my son Austin, who I pray will see completion of this journey as an inspiration that you have what it takes to do anything you put your mind to. It's in your DNA.

Acknowledgments

I want to thank Dr. Marilyn Simon, my dissertation chair and mentor for your coaching, good nature, endless patience, and generous support. I am honored to have you as a mentor and friend. Dr. Marilyn Simon your support has been awesome right from the beginning of this journey and beyond. I appreciate your encouragement, assistance, support, and motivation. In addition, I would like to acknowledge Dr. Jamie Patterson for your initial encouragement for this journey. I would like to acknowledge my second committee member, Dr. David L. Moody for your wise counsel and guidance. I would like to acknowledge Dr. Jim F. Savard for your keen eye and beneficial advice during the Utilization Review. I would like to acknowledge Christina Hummel, Anne Fears, and Dr. Shanika Bentley for your unwavering support throughout this process. I am not sure you realize just how vital you were to this process. I am grateful for the continued support of my family, friends, and colleagues, who provided words of encouragement along the way.

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Section 1: Foundation of the Study

In 2017, healthcare system mergers in the United States set a record with 115 deals made and 11 involved sellers with net revenue of at least $1 billion (Garmon, 2017). Leaders combine hospitals as a strategy for sustainability in consolidated markets (Zall, 2016). There was a need to investigate hospital strategies for maintaining business office productivity during a merger. The purpose of this qualitative single case study was to explore strategies hospital leaders in the southeastern United States market used to maintain business office productivity as they completed a merger process. I used the tenets of Business Process Re-engineering (BPR) as a conceptual framework in analyzing leadership strategies for maintaining hospital business office productivity during a merger (see Hammer, 1990).

Background of the Problem

As healthcare systems become more competitive, healthcare providers have consolidated through mergers and acquisitions (Zall, 2016). Healthcare systems are acquiring physicians' practices, insurers are acquiring entire healthcare systems, and hospitals are merging for competitive advantages and survivability for economic health, market share, and specialization offerings (Postma & Roos, 2016). The merging of two hospital systems involves the integrating of many different moving parts in a way that maintains the prescribed objectives of the combined entity (Garmon, 2017).

Hospitals are complex entities even during stable periods. The potential chaos of unclear processes that can result from merging two hospitals can decreased business office productivity (Cascardo, 2018). There is some anticipated disruption in business

office productivity as two business offices combine. The state of business office productivity is dependent on the flow of timely and accurate information (Mindel & Mathiassen, 2015), the clash of cultures (Gordon, 2015), and the presence of uncertainty.

Decreased business office productivity can destabilize the finances of both the target and acquiring hospital, threatening the success of the merger and even the existence of the hospitals (Dobrzykowski, McFadden, & Vonderembse, 2016). The business office facilitates reimbursement for hospital services (Healthcare Financial Management Association, 2017). Components of the business office like coding, billing, follow up, and appeals are crucial when gauging business office productivity (Mindel & Mathiassen, 2015). A significant decline in crucial business office components directly affects the hospital's financial wellbeing. As a result, hospital leaders should consider strategies to maintain business office productivity during a hospital merger (Jonasson, Kjeldsen, & Ovesen, 2018).

Problem Statement

Although approximately 83% of all mergers fail (Hirsch, 2015), the number of mergers continues to increase. Both the acquired business and acquiring business' total productivity generally decreases during the merger process while productivity does not significantly recover to the premerger level until several years after a merger (Sapkota, Ivanov, Bachman, Vermillion, & Goyal, 2019). The general business problem is the decline of business office productivity during a merger. The specific business problem is that some hospital leaders lack strategies to maintain hospital business office productivity during a merger.

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies hospital leaders in a southeastern U.S. market used to maintain business office productivity during a merger. The target population was hospital leaders in two midsized hospitals in a southeastern U.S. metropolitan area who were able to maintain business office productivity during a merger. The implications for positive social change include the potential for hospital leaders to maintain business office productivity during a merger, to continue to have a positive economic effect on their communities, and to maintain service quality to patients.

Nature of the Study

The three types of research methods are qualitative, quantitative, and mixed methods (Lewis, 2015; McCusker & Gunaydin, 2015). I used the qualitative research method for this study. The qualitative research method is a type of social science research in which researchers collect and work with nonnumeric data in the form of verbal communication, documents, observations, or images (Wilson, Onwuegbuzie, & Manning, 2016). Using the qualitative method could aid with exploring the efficacy of abstract constructs within strategies regarding business office productivity during a merger process. A quantitative method was not appropriate for this study because quantitative researchers seek to examine relationships among variables using numerical data to generalize from a sample (see McCusker & Gunaydin, 2015), which was not the intent in this study. Mixed methods researchers collect, analyze, and use both quantitative and

qualitative data (Venkatesh, Brown, & Sullivan, 2016), therefore, since only qualitative data was obtained, a mixed methods approach was also not appropriate for this study.

The design for this study was a single case study. In a case study design, the focus is on a general situation in a real-life setting (Yin, 2018). Researchers use case studies to acquire data subject to interpretation in the creation of new knowledge (Yin, 2017). A single case study design allows researchers to explore real-life, bounded systems through the collection of detailed data from multiple sources and identify specific themes or patterns to enable understanding of a phenomenon (Yin, 2018).

I considered ethnography, which is a design that involves studying people in their cultural context and the ways that culture influences their behavior as individuals or as a group (see Draper, 2015). The focus of this research was not on the people but on the strategies used to maintain business office productivity during a merger process making ethnography not appropriate. In addition, I contemplated a phenomenological approach. Using a phenomenological design can aid in the study of conscious experiences (Spaulding, 2015). As the focus of this study was not on the personal meanings of the individuals experiencing a phenomenon, the phenomenological design was not suitable. A qualitative single case study was appropriate for exploring the strategies used by hospital leaders to maintain business office productivity during a merger to understand the relationship between the strategies applied and the resulting impact.

Research Question

What strategies do hospital leaders use to maintain hospital business office productivity during a hospital merger?

Interview Questions

1. What was the primary expected benefit of the merger within the business office?
2. How did you safeguard against overestimating the expected benefit of streamlining redundant processes that result from combining two business offices?
3. What strategies did you implement to maintain business office productivity during the merger at the operating unit for which you are responsible?
4. Please explain any restructuring of organizational processes to improve service, speed, accuracy, and/or cost performance.
5. What types of measurement was used to understand the existing practices prior to the merger?
6. How would you describe the personnel interaction or cooperation between the two merging entities during the merger process?
7. What strategies did the organization for which you are/were responsible address the top three challenges to maintaining business office productivity during the merger?
8. How did you measure business office productivity success at the completion of the merger?
9. What else would you like to add that we have not yet discussed regarding the strategies used to maintain business office productivity during a merger?

Conceptual Framework

The conceptual framework for this single case study was the business process reengineering (BPR) model. I conducted an in-depth exploration to identify strategies used by hospital leadership to reorganize the administrative procedures of two hospitals to streamline the hospitals into one consolidated procedure. In 1990, Hammer (1990) established the BPR model to explain how the leadership of large complex organizations faced challenges eliminating redundant effort. Using BPR can aid in identifying and tracking challenges in mergers and acquisitions to evaluate leaders' strategies to maintain business office productivity during a hospital merger (Brennan, Sampson, & Deverill, 2005). BPR entails thoroughly restructuring organizational processes to improve service, speed, accuracy, and cost performance (Hammer, 1990). The conceptual framework provides a potential context from which to understand the strategies under study during the process of combining two business offices.

Hammer (1990) developed BPR to explain the strategies for maintaining an adequate level of an organization's productivity. With this conceptual framework, I explored strategies used to reconfigure the business model during the merger process. Key factors that affect business office productivity include setting standards, corresponding accountability, and using resources (human and material; Brown, 2019). The BPR model was applicable to this study because the model creates value in the healthcare field. BPR encompasses (a) the development of method intentions and business concepts, which is comprised of specific business objectives such as improvement in the quality of output, time-savings, cost reduction, measurement, and

understanding of existing practices; (b) identification of business practices for reorganization; and (c) the construction and designing of the model of the new process (Hammer1990). I used the BPR model to analyze the contributing components of the revenue cycle during a merger and explore how variations in the contributing components during the transition might affect business office productivity.

Definition of Terms

Some of the terms in this study have interchangeable meanings. Some of the terms are unique to the revenue cycle of a hospital business office where leaders measure business office productivity components. The subsequent terms for the purposes of this study are as follows:

Back-end (of the Revenue Cycle) - All administrative procedures essential to correct reimbursement for services. Reimbursement is the method of compensation, typically by a third-party payer (i.e., insurance companies) for medical treatment rendered to patient or ancillary hospital costs. The back end of the revenue cycle includes coding of the medical record and billing, denials management, customer service, and all bill collection activities to include follow up and cash application (Britt, Adams, & Snow, 2015)

Front-end (of the Revenue Cycle) - All administrative processes essential to patient throughput, including, scheduling of patients for services, patient registration, insurance documentation and verification, and coding of the medical record (LaPointe, 2017).

Revenue Cycle - All business processes involved in moving a patient through the hospital and ensuring payment to the hospital (LaPointe, 2017).

Assumptions, Limitations, and Delimitations

To expose the components that could constrain the research, I have listed perceived deficiencies that could impact the access to resources or hamper the line of reasoning that exist in any human inadequacies. In this section are the assumptions, limitations, and delimitations necessary to further explore the phenomena to be studied. The subsequent subsections include an explanation of the assumptions, limitations, and delimitations that may impact this study.

Assumptions

Assumptions are facts considered to be true, but which cannot be verified by the researcher (Anderson, 2017). All operations considered for this study were assumed indicative of actions executed with the goal of maintaining productivity during the merger process. The first assumption was all organizational leadership was acting in the fiduciary interests of the organization for which they are authorized to make policy decisions. Furthermore, the second assumption was each leader possessed functional knowledge and the applicable skillset to critically expound on the processes and considerations of strategies for maintaining business office productivity during a merger. The third assumption was that respondents answered honestly, having given appropriate thought to the subject-matter.

The fourth assumption was that existing processes analyzed available in written/manual form by operational authorities and department heads are an accurate

depiction of the recorded content. The participants did ethically provide all documentation considered for informational purposes as a secondary source of confirmation and validity through access to document archives maintained by the organization. Regulation constraints made access to some segments of documentation unavailable due to the presence of Protected Health Information (PHI) as well as the time involved in mining large quantities of documentation for each episode.

Limitations

Limitations emphasize the threats to validity both internally and externally that are out of the researcher's control (Wölfer et al., 2017). The multiple complexities of the hospital business office prevent the possibility of evaluating the many nuances and variables that may contribute to increases in business office productivity (Zall, 2016). The intent of this study was to investigate the strategies related to maintaining productivity during a merger. While assuming outliers and anomalies, the narrow scope of this study focused primarily on the measurable components that contribute to business office productivity of merging midsized urban hospital systems in the south eastern United States. An example of things beyond the scope of study might include anomalies such as inclement weather or power outages, which would prevent the otherwise normal workflow of business due to a fluctuation in the complement of human resources, or the ability to operate the necessary resources. Participants may feel uncomfortable or anxious during their interview or exhibit bias in their responses to interview questions (Bourne & Robson, 2015). Existing internal auditing procedures used during the normal course of business ensured the data are reliable.

Delimitations

Delimitations are the borders established by the researcher that could introduce ethical considerations and curtail the scope of the study (Batongbacal, 2015; Rodner, 2015). Location can also be a determinant of the scope of the study (Qiu & Gullett, 2017). The scope of this study was limited to the production key indicator based on claims billed, followed up, cash posted, appeals executed leading to denials being overturned, and not clinically specific productivity or a measure of any medical service. This limit stems from the measurable benchmarks that are engaged to evaluate hospital revenue cycle as defined by Zall (2016). A midsized urban hospital was the basis for this analysis of productivity of a hospital business office. The hospital leaders use standardized productivity practices that are like other midsized, urban healthcare system hospitals in the southeastern United States.

Significance of the Study

Healthcare leaders going through a merger may be able to use the findings of this study to maintain business office productivity during the merger. Reviewing the study findings could assist hospital leaders in establishing a set of protocols for maintaining business office productivity during a merger. A decrease in business office productivity during a merger could result in the failure of the merger. If hospital leaders can use the findings in this study to maintain business office productivity levels, they could avert a potential merger failure.

Implications for Social Change

The implications for positive social change include effective strategies for successful mergers that could help maintain business office productivity in hospitals. Maintaining the business office productivity can lower the risk of hospital closures or decreased service quality that typically result from failed mergers. Diminishing business office productivity will cause a decline in the overall financial health of a hospital (Cascardo, 2018).If business office leaders in hospitals apply effective strategies to maintain business office productivity during a merger, there was a higher likelihood that the communities affected by the merger can retain proximate access to quality health care ("Dartmouth Atlas Data", 2019).

A Review of the Professional and Academic Literature

The purpose of the literature review was to investigate hospital considerations for maintaining business office productivity during a merger. The purpose of the study was to explore the strategies of hospital leaders who have maintained business office productivity during the merger of two hospital systems. The existing literature on this subject was insufficient and researchers have yet to produce a governing theory using writings on the topic.

The literature review includes the analysis of peer-reviewed articles, dissertations, and books on mergers and acquisitions (M&As), and revenue cycle management. The literature review also includes looking at past studies to reveal the substance of the phenomenon. I searched Walden University’s online resources such as SAGE journals, EBSCO, and ProQuest. Internet queries also involved Google and Google Scholar online

libraries. The primary electronic database used for the literature review was the EBSCOhost Discovery Service at Walden University.

Additional relevant sources for the literature review were selected journals and the ProQuest Dissertations and Theses database, and pertinent books. Ward-Smith (2016) asserted that a researcher should review the literature to identify best practices and to regulate how other authors explored the main topics being studied to embrace evidence-based practices in health care. Neill (2017) posited that a systematic approach to a literature review begins with using keywords related to a researcher's topic or research question.

Literature Review Strategy

The literature review strategy included a search of related studies and searched terms that included *mergers and acquisitions, health care system, revenue cycle, revenue integrity, patient financial services, financial management, integrated healthcare organization, billing, coding, follow up, cash application, meaningful use, synergy management, accounts receivable, reimbursement, productivity,* and *qualitative case study research methods and techniques.* The review of literature segment includes literature from seminal books pertinent to the research question: What strategies do hospital leaders use to maintain hospital business office productivity during a merger?

I have structured the literature review to include five main parts. The objective in part one, was to gain a holistic understanding of M&A (particularly those relating to hospitals), including the triggers, strategies, types, and hindrances. In part two, there is an in-depth analysis of Hammer's (1990) BPR model. Part three includes a brief background

into various causalities of merger failures. Part four contains an analysis of contributions to the business office revenue cycle (specifically the Patient Financial Services) that provided a basis of assessment for maintaining productivity. The final section is a review of literature pertinent change management.

Context of the Study

The goal of this study was to reveal strategies hospital leaders use to maintain hospital business office productivity during a merger. As part of medical industry reforms, healthcare organizations are increasingly employing a self-renewal merger process, commonly used by organizations around the world to deal with technological changes, increases in competition, and government regulation (DeHaas et al., 2017). Every hospital merger is unique with respect to key factors such as business processes, culture, size, location, and resources (Angwin & Meadows, 2015). When hospitals merge, there is an integration process of combining the key factors of the acquirer and the acquired into a single entity, which normally engages both people and processes (DeHaas et al., 2017). The focus of this study was on strategies used to maintain hospital business office productivity during a hospital merger, primarily involving the revenue cycle. Representatives of the Healthcare Financial Management Association (HFMA) defined revenue cycle as all the administrative, as well as clinical operations that contribute to the capture, management, and collection of patient services revenue (Mindel & Mathiassen, 2015). The continuously evolving revenue cycle landscape necessitates an increasing need for more thorough preauthorization and precertification, the ability to respond to underpayments or variances, and the ability to absorb more frequent delays in payment

(Rauscher & Wheeler, 2008). The inability to maintain these areas during a merger could result in merger failure.

Mergers often fail because organizations struggle to execute the merger effectively (Friedman, Carmeli, Tishler, & Shimizu, 2016). Lack of support for any causality to a merger failure is partly due to the considerable number of variables involved (Angwin, 2012). Hospital leaders require strategies to address those expected variables.

Causalities contributing to hindrances to hospital mergers include but are not limited to the failure of leaders to establish an environment that aids in the transfer of knowledge and capabilities between entities (Gunkel, Rossteutscher, Schlaegel, & Wolff, 2014; Zhang et al., 2015). Hospital merger failures carry extraordinary risk for vendors, employees, shareholders, business partners, and ancillary community collaborators (Eaton & Kilby, 2015; Osarenkhoe & Hyder, 2015). Garzella and Fiorentino (2014) asserted that there is a risk of diminished value that threatens the expected value creation that was the basis for the merger. The profitability of a hospital can impact the success or failure of a merger. Maintaining hospital business office productivity or revenue cycle productivity as the term is also understood, and therefore, hospital profitability requires the optimal execution of all contributing components of the revenue cycle, including the scheduling of the patient through to reimbursement of the final invoice for the medical service (Anderson, 1988; Krantz, 2006; Ladewig & Hecht 1993). Successful hospital revenue cycle management processes have increased in significance in the current hospital business office environment due to changing billing obligations and stricter

guidelines; particularly the management of accounts receivables and patient revenues (Petaschnick, 2018).

Revenue cycle productivity affects all hospital operations and consequently the achievement of hospital goals (Petaschnick, 2018). Some challenges in managing the revenue cycle optimally in an era of reform include (a) compliance reforms, (b) payment reform, (c) reduced payment, (d) expansion of insurance coverage, and (e) quality improvement (Boyd, 2017). The management of the revenue cycle also influences other facets of the hospital, such as the systems, structures, and culture among employees (Petaschnick, 2018). Hospital leaders are the architects of organizational processes and structures (LaPointe, 2016). Hospital leaders consider a myriad of factors in facilitating the process of an organization.

Hospital leaders constantly modify and restructure processes that contribute to the overall operation of the revenue cycle process to maintain or improve revenue cycle productivity as desired (Naus, Faint, & Dwyer, 2018). Inconsistencies exist across hospital systems regarding the details of the revenue cycle process and measurements (Stockamp, 2003). Some hospital leaders still rely on manual processes to complete revenue cycle tasks while others have enhanced their capabilities with the adoption of current technologies; each with varying degrees of success (LaPointe, 2017). Hospitals leaders have competent revenue cycle management if the accounts receivable average days are in the 50s, 60s, and even 70s (Beaulieu-volk, 2015). However, leaders cannot assess overall hospital performance based solely on achieving similar accounts receivable (AR) days (Stockamp, 2003). Barriers to consistency in assessing revenue cycle

performance exist throughout the cycle (Saharia, 2016). Successful restructuring of business office processes requires constant modification.

BPR

To meet the objectives of this study, I identified and characterized the interrelated components of the hospital's revenue cycle and understand the relationships between those contributors in the application of BPR theory. The BPR model stems from the principles of redesigning existing business practices, resulting in dramatic improvements in productivity (Hammer, 1990). Published academic research concerning BPR has been limited since the mid-1990s. The research that does exist includes BPR cost-benefit analysis (Richard & Agwor, 2015), BPR success factors (Guimaraes & Paranjape, 2013), and the implementation of BPR (Ram, Wu, & Tagg, 2014). Dewi, Anindito, and Suryadi (2015) studied how BPR could positively affect customer service within an organization. Chen, Yang, and Tai (2016) explored how BPR impacted of the construction industry. There was also research conducted about how a hospital used BPR to redesign the patent system (Kuan-Yu & Chunmin, 2013). Hammer and Stanton (1995) demonstrated the early applications of the BPR model.

Using the BPR model, I assessed hospital leadership's ability to start from the foundation and rethink revenue cycle processes in a way that improves and maintains productivity as well as delivering value to the patients during the transition of the merger process. Focusing on the context of hospital mergers, I used business process reengineering theory to understand the interrelation between the contributing components of a hospital's revenue cycle in the considerations of hospital leadership in charge of

managing the combination (Gunkel et al., 2014; Zhang et al., 2015). Understanding the threats to maintaining adequate productivity within the components of the revenue cycle and the causality of those threats can enable hospital leadership to respond appropriately (Vasilaki, Tarba, Ahammad, & Glaister, 2016; Zhang et al., 2015). Exploring the considerations of leadership in the successful strategies employed to maintain hospital business office productivity during a merger was the topic and BPR theory served as the framework.

I used BPR theory as a framework to analyze leadership strategies for maintaining hospital business office productivity in all phases of a merger. The principles of BPR emphasize the ability to map the processes of a particular organization and assigned measurable units to the steps in those processes, monitor those units, diagnose issues and challenges within those processes, suggest improvements, and continuously monitor performance based on those processes (Hammer, 1990). BPR is a guide for systemic approaches to understanding the methods of manipulating business office productivity (Caffrey, Wolfe, & McKevitt, 2016). BPR theory allows researchers to understand the optimal level of productivity for each component of a complex system such as a hospital's revenue cycle with the implication that hospital leaders may be able to target, strategize, and manipulate productivity in each area of the revenue cycle (Caffrey et al., 2016). Hammer (1990) used BPR theory as a framework for understanding and radically redesigning the processes in organizations to improve specific services, speed and accuracy, and cost reduction.

Brainard and Hunter (2016) observed that the hospital's revenue cycle is complex and contains many variables. Hospital leadership should be able to understand the complexities involved in the revenue cycle and establish some predictabilities for influential variables (Cutler, Wilker, & Basch, 2012). Having a better understanding of the strategies that successfully manipulate the revenue cycle's components can help hospital leadership develop and implement processes necessary for the maintenance or improvement of business office productivity (Cutler et al., 2012). Effective methods for hospital leadership to collaborate between two merging hospitals and establish processes that meet regulatory guidelines, ensure accuracy, decrease waste, and reduce cost during the transition time of the hospital merger is beneficial (Cutler et al., 2012).

Hospital leadership amid a merger should endeavor to effectively combine both the revenue cycle processes with a model that promotes efficiency and cost-effectiveness in a hospital (Tucker, 2013). The first principle in BPR is to be clear about the objective (Cleven, Winter, Wortmann, & Mettler, 2014). Hospital leadership should define and clearly establish the objective of combining two different processes to create a singular process to the end that goals for time, quality and accuracy, and cost are met (Brueller, Carmeli, & Drori, 2014; Jo, Park, & Kang, 2016). BPR may provide a framework to assess decision making amongst hospital leaders as well as whether strengthened productivity due to the redesigning the functionality of the organization into cross functional teams was the outcome. Using the BPR model developed by Hammer (1990) as a guide to conceptualize radical change, I can gauge whether the implementation encourages hospital leadership to improve revenue cycle business processes for both the

acquirer and the acquired, rethink the challenges of the people and the organization, and reorganize business office departments responsible for specific contributions into cross functional teams that are responsible for the entire process, end to end. To this end, the second principle of BPR necessitates that I gauge the organizational commitment from all participants responsible for enacting the change (see Cleven, et al., 2014). According to the BPR, a successful implementation for reengineering the revenue cycle mechanism of two converging hospitals would require commitment from top management at both entities (Al-Ali, Singh, Al-Nahyan, & Sohal, 2017). Mature organizational cultures with set ideals and beliefs can threaten the commitment to a radical change in processes (Cleven et al., 2014).

The third principle of BPR can aid in evaluating how hospitals leadership determines the scope of reengineering (Cleven et al., 2014). Using the BPR model as applied to assessing the merging of two hospital business offices, I focused on eight key components of the hospital's revenue cycle to include (a) scheduling and preregistration, (b) point of service registration counseling/collections, (c) utilization review and case management, (d) charge capture encoding, (e) claim submission, (f) third-party follow-up, (g) remittance processing and rejections/denials, (h) payment posting/cash application, appeals, and collections. Since it is unrealistic to change the processes in a complex organization all at once, usually a subset of prioritized processes are targeted for development to meet a chosen goal (Al-Ali et al., 2017). To understand the scope, the hospital leadership should assess the current practices and identify any critical hindrances that require immediate attention (Mohapatra & Choudhury, 2016).

The eight key components were the focus of the study to explore the considerations of leadership strategies, the challenges to those strategies, the adaptability of workers to embrace the change in conjunction with the implementation of the strategies, and the strategies impact on the process productivity. Hospital leaders can reduce the organizational layers that result from having duplication in revenue cycle processes as the two entities merge (Hammer, 1990).The fourth principle of the BPR model shifted the focus to whether hospital leaders assign process owners to be in charge of each initiative (Cleven, et al., 2014). Ideally, these process owners would possess the authority and influence to push through changes in the process (Cleven et al., 2014).

Hospital leaders serve competing interests such as the need to reduce cost, increase customer responsiveness, and increase service quality for patients, while at the same time maintaining productivity through a merger (Caffrey et al., 2016). The fifth principle of BPR can be used to determine how hospital leadership identifies and develops process improvement initiatives (Cleven et al., 2014). BPR best practice is for leadership to redesign each selected component of the process targeted for modification (Hammer, 1990). The changes could be system or procedural changes (De Waal, Maritz, Scheepers, McLoughlin, & Hempel, 2014).

The BPR model can gauge the successful integration of processes, systems, people, technology, and environments (Mirzoev & Kane, 2017). Technology and networking infrastructure, including communications and networks would have to be flexible to adapt to any radical change (De Waal et al., 2014). BPR requires the

consideration of major infrastructure projects regarding any merger productivity endeavors (Mohapatra & Choudhury, 2016).

Finally, the sixth principle for BPR focuses on the processes that hospital leaders establish to monitor the new processes implemented (Cleven et al., 2014). Because complex organizations are continuously evolving, the need to monitor the processes is continuous. BPR is about changing an organization to adapt to and reflect new business realities (Hammer, 1990).

Healthcare Business Considerations

While for-profit hospitals can easily be considered as companies, nonprofit hospitals also run as companies (Boyd et al., 2017). The bottom line for hospital system mergers is hospitals must guarantee that activities can be sustained (Angwin & Meadows, 2015). Flexibility and adaptation to changing conditions ensure success for merging hospital systems (White & Wu, 2014).

How to mitigate the effect of lost income is the task for hospital administrators. Administrators must consider modifications in a manner that does not negatively influence the quality of care received by patients (Boyd, 2017). Payment systems for hospitals affect how hospitals function (Cleverley, 1990). The efficiency of hospitals correlates with enhanced value (Cleven et al., 2014). When hospital finances are managed well, patients receive better care (Dobrzykowski et al., 2016).

The factors for maintaining productivity during a merger are (a) clarification of the particular issues to be solved by the Health Information Technology, (b) consensus-building among stakeholders, (c) consideration of different alternatives, (d) consideration

of costs versus advantages, (e) adequate planning, (f) infrastructure development, (g) adequate personnel training, (h) ongoing progress assessment, (i) system maintenance, and (j) long-term maintenance of the undertaking (Yen et al., 2017). Considering Yen's et al. (2017) 10 points, administrators can help with HIT interventions planning and execution. Clarifying the issues that technology can fix is critical to effective intervention (Richard & Agwor, 2015).

Yen et al. (2017) posited the harmful effect on successful processes that an assumption of advantages can have. It is essential to indicate objectives because it improves the probability of sharing the same objectives with all those engaged in the shift. Indicating objectives also decreases waste (citation). Sometimes it may seem like HIT is the best way to fix an issue. Using specific issue analysis aids with introducing other methods of fixing an issue (Edmunds et al., 2016). In addition to clarifying issues, consensus building, is crucial (Lefroy & Yardley, 2015). Issue analysis procedures are often complicated and having consensus among all parties can depend on effective execution.

Yen et al. (2017) determined that whatever the scale of the project, leaders should reach an agreement. Successful consensus building occurs by creating a strategizing team. The team should represent all those affected by the change and consider all elements during planning (Yen et al., 2017). Additionally, the other stages include considering different alternatives and considering expenses versus advantages as critical to planning the scope of the intervention (Yen et al., 2017). Leaders need time to consider alternatives and efficiency depends on applying adequate techniques (Yen et al., 2017).

Increased care helps to avoid unnecessary technological modifications due to the complexity that often accompanies HIT execution (Yen et al., 2017). Consideration of expenses versus advantages aids with preserving effectiveness. The choice that yields optimal advantage is the most inexpensive way to satisfy the requirements of the organization (Yen et al., 2017). Yen et al. (2017) emphasized that other stages included the significance of adequate planning and growth of infrastructure. Careful consideration may guarantee that projects, during execution, do not deviate too far from the initial scope (Larson, 2015). Proper planning should be flexible, but the issues and needs of the organization considered.

Proper development of infrastructure improves the probability of proper functioning of the technology (Yen et al., 2017). Improper operation may result in lower organizational effectiveness (Koppel, 2016). Yen et al. (2017) determined that inadequate preparation of employees reduces employee satisfaction. Employee dissatisfaction may result in decreased effectiveness and clinical outcomes for patients. Training managers must consider the budgeting operations of individual positions as a priority because training accounts for a large portion of the budget (Holten & Brenner, 2015).

It is important to improve profitability and healthcare systems in the areas of services provided, served populations, payer mix, staffing, and financial indicators (Dunn et al., 2018). Performance criteria will be included with important products from other sources and the profitability enhancement model. Other performance enhancement models include plan-do-study-act (PDSA), lean ideas, and Six Sigma (LSS; He & Goh, 2015). Rosemann and Brocke (2015) discovered that organizations could obtain market

share and apply understanding and data using Excel and ongoing process improvements. Process enhancement teams apply LSS instruments and ideas to important procedures in organizations to enhance economic efficiency (He & Goh, 2015).

Mergers and Acquisitions

In this subsection, I will elaborate on M&As and their qualities. The term *mergers and acquisitions* refer to the act of combining two organizations into one organization (Jewoo & Tianshu, 2014). Vazirani (2015) added to the definition by saying that a merger is a situation where a business, including all assets, liabilities, and individual personnel merges with another business. A frequent occurrence in the marketplace is the formation of new organizations formed through mergers.

Cording, Harrison, Hoskisson, and Johnson (2014) addressed M&As along with stakeholder theory and worker satisfaction. What influences one stakeholder will affect other stakeholders within the stakeholder theory. Over and under-promising patients or staff during the M&A will have adverse effects (Dewi, Anindito, & Suryadi, 2015). Over and under-promising patients manifests in lower productivity (Cording, Harrison, Hoskisson, & Johnson, 2014). The reduced productivity will continue to impact stakeholders. To study the effects of a hospital merger on revenue cycle productivity, there have been many theoretical choices. I found BPR was the best fit, since BPR considers all system involved in an M&A so that the new entity can be faster, more efficient, and run smoother. Employees are experiencing several modifications within a M&A. How these changes are brought to their attention and perceived to be conducted during this moment is a close fit for BPR.

Merger History

In the global economy, mergers are a prevalent occurrence. The waves of merger activity began at the end of the 19th century (Gaughan, 2010; Varizani, 2015). This wave of mergers occurred during the post-depression financial development (Vazirani, 2015). However, Vazirani (2015) and Lipton (2006) discovered the first merger wave between 1893 and 1904. The largest recorded mergers on a global scale were reported in 2015 (Thomson Reuters, 2015). With this short history of mergers, in the rest of this section, I reviewed why mergers occur, the success rate of mergers, and the impacts of mergers on organizations and personnel. There are three types of mergers:

1) Horizontal Merger: A type of merger between two organizations in the same industry. The primary aim of horizontal mergers is to increase revenue by offering an added range of products to an organization's existing customers (Oberg, 2008). Horizontal mergers aid organizations by reducing the threat of competition in the marketplace. For example, Coca-Cola and Pepsi beverage division would be a fitting example of a horizontal merger.
2) Vertical Merger: Differs from a horizontal merger in that a vertical merger signifies the merging of two different organizations that produce different goods and services resulting in a specific finished product. Improving efficiency or reducing cost is the main goal of this type of merger (Oberg, 2008). An example would be Nike merging with a leather supplier to reduce costs.

3) Conglomerate Merger: Conglomerate mergers happen when the merging organizations are participating in completely unrelated industries. There are two types of conglomerate mergers: mixed and pure. A mixed conglomerate merger occurs when organizations are pursuing only market or product extensions (Oberg, 2008). A pure conglomerate merger happens when the two companies have nothing in common. An example would be if a soft drink company merges with a leading athletic-footwear company.

The Merger Process

Complex issues often occur during a M&A (Brueller et al., 2014). Often organization leaders are not adequately prepared to handle the integration of cultures and procedures (Rogan & Sorenson, 2014). Organizational structure mixes individuals, procedures, and all business apps and procedures (Alaranta & Mathiassen, 2014). Successful mergers can have a beneficial impact. Mergers can have a beneficial impact on participants (Kandzija, Filipovic, & Kandzija, 2014). Hyder and Osarenkhoe (2015) stated rising employment rates and job prospects for the population surrounding the merged entity could be included as a beneficial impact.

Reasons for Mergers

Corporate groups have been merging for centuries, but there may be reasons for each corporation to address the changes that need to be resolved during the merger phase. Rodrigues (2014) discovered a multitude of reasons mergers could occur, for example, the importance of markets, technology, or market size decline. Mergers and acquisitions are one way for organizations to gain market share, boost efficiency, and remain ahead of

contenders (Brueller et al., 2014; Buiter & Harris, 2013; Rogan & Sorenson, 2014). There are times that mergers and acquisitions help to decrease the number of rivals (Rogan & Sorenson, 2014). During the merger and acquisition, organizational leaders can pursue internal or external development while the two entities are combining (Tijani-Eniola, 2016). Internal development takes longer than external development, as leaders use resources during the effort (Tijani-Eniola, 2016). M&As are one type of internal development (Tijani-Eniola, 2016).

Why Mergers Fail

Francis, Hasan, Sun, and Waisman (2014) observed that lack of communication, broken alliances, and absence of data as the major causes of failed mergers. Van Dyke (2015) spoke about the need for a governing body to be responsible for all economic problems during a merger and have someone lead the other components of the newly merged entity in order for the merger to be a success. May and Noether (2014) determined that the composition of the market has a significant effect on whether the merging companies will increase market share, price and production. Mergers, however, can have both beneficial and negative effects on businesses. Employees must alter and adapt to the newly created joint venture (Al-Ali, Singh, Al-Nahyan, & Sohal, 2017).

Merger Effects on Personnel

Organizations lose an average of one-quarter of the leadership in the first postmerger year and 60% in the five postmerger years (Krug, Wright, & Kroll, 2014). Postmerger there is also increased manager turnover (Krug et al., 2014). A few reasons for this turnover are to minimize resistance, reduce communication issues, and reduce

uncertainty while creating control (Krug et al. 2014). When someone in organizational leadership considers the M&A to be detrimental to his career or lower his work status, the likelihood of leaving the organization rises (Krug et al., 2014). During a M&A, leaders tend to worry about termination, loss of status, and capacity to make decisions as well as loss of independence (Krug et al., 2014). Higher postmerger management turnover has an adverse impact on the postmerger productivity and overall performance (Krug et al., 2014). Cho, Lee, and Kim (2014) clarified that retaining management and employees with greater tenure is useful in order to improve the performance during the merger.

Higher turnover during a merger will also consume a significant amount of time and resources (Krug et al., 2014). The chaos of mergers can cause employees on the staff level to experience a feeling of loss and neglect (Rogan & Sorenson, 2014). They may get psychologically distressed, leading to inefficiency in carrying out their tasks as well as higher staff turnover (Rogan & Sorenson, 2014). The relative deprivation results in lower organizational engagement and lower worker productivity (Cho et al., 2014). Lower organizational engagement and lower worker productivity is less likely if employees identify with the merged organization in terms of culture (Cho et al., 2014).

During a M&A, employees have an increased feeling of vulnerability (Diab, Safan, & Bakeer, 2018). Workers pay extra attention to the provided indications. Face-to-face communication is the most reliable way to communicate about an upcoming merger as communicators listen to verbal queues, while also seeing visual indications (Galpin & Whittington, 2010; Mishra, Boynton, & Mishra, 2014). The responses to these indications may reduce not only employees' own satisfaction but may also reduce the treatment

quality and productivity with clients and other stakeholders (Cording et al., 2014). Employees need ample guidance from leaders in moments of transition and seek advice from management during the process (Nadim, 2015).

Ethical leadership is essential to gain employee trust and maintain engagement and confidence in the process (Sharif & Scandura, 2014). Another aspect of employee engagement is the level of commitment and motivation staff member have toward their work (Bakker, 2014). When staff members feel their job has significance, they demonstrate vigor and enthusiastically want to be at work (Bakker, 2014). Engaged workers will focus on commitments and possess a general good attitude toward fellow employees (Bakker, 2014). There will be less resistance to change with the M&A when there is a healthy cultural fit post-merger (Bauer & Matzler, 2014). Zuckerman and Golden (2015) discovered that their greater productivity occurs within organizations when leaders concentrate on merging not just the organization but merging the organizational cultures. Changes in corporate culture, which generally happen on the acquired entity's side, are most probable to happen during a merger (Sapkota et al., 2019).

Engaged staff members are more likely to stay faithful, talk about the organization in a favorable way, and be high performers (Mishra et al. 2014). Front-line managers have a significant impact on the commitment of employees during a merger. During a merger, staff is more involved when front-line managers provide a high level of assistance (Mishra et al., 2014). Management's open, coherent communication generates a greater level of staff commitment (Mishra et al., 2014). Internal communication

improves productivity and employee positivity (Korzynski, 2015). Internal communication also generates confidence in the merger process and increases commitment among managers and employees (Mishra et al., 2014). Moreover, internal communication offers the right data for staff to conduct and fulfill their job responsibilities (Mishra et al., 2014). Internal communication is a crucial component of establishing relationships between management and employees, especially in a turbulent or changing work landscape (Karanges et al., 2014).

Sharing information and radical transparency between management and subordinates gives the employee a sense of belonging and confidence in the process (Mishra et al., 2014). Centralization, decentralization, chain of control, chain of command, and specializations are fields where the focus should be on creating a more committed workforce in the merger process (Nieberding, 2014). For post-merger inclusion, organizational authenticity is useful (Cording et al., 2014). Leadership during a M&A should not over or under promise anything as promises only reduce organizational authenticity (Cording et al., 2014). During the vulnerable process of the merger, the confidence of staff members can become impaired. Furthermore, mistrust results in lower productivity, lower job satisfaction, and higher turnover rates (Cording et al., 2014).

Healthcare Mergers

The dramatic increase in M&As for the healthcare industry began around the time of the implementation of the Affordable Care Act (Lineen, 2014; McCue, Thompson, & Tae Hyun, 2015). Some of the rise in M&As in healthcare is due to greater norms of reimbursement and the need for increased productivity (McCue et al., 2015). Tijani-

Eniola (2016) posited that healthcare M&As in the United States are in the front of the field. Leaders of healthcare mergers and acquisitions coordinate care, assume danger, and implement best practices (Tijani-Eniola, 2016).

According to Korbi (2015), the healthcare institution's environmental situation is the first component deemed to guarantee advantage. This component represents a wide array of factors of internal processes that may force the healthcare organization to alter and these variables are beyond the healthcare organization's control (Korbi, 2015). These variables include technological development that is possibly outdated compared to present healthcare technology (Korbi, 2015). Another variable is competition that may relate to healthcare systems losing, competitive advantage, legal and regulatory factors that may require a healthcare organization to have additional legal and regulatory demands (Korbi, 2015). There are numerous other social and economic factors (Korbi, 2015).

Ganta and Manukonda (2017) indicated that another key aspect is organizational harmony. Organization harmony means that procedures, individuals, and different units within the organization should work together in harmony to achieve the organization's goals and objectives (Ganta & Manukonda, 2017). People should have clear knowledge of the mission and vision of the hospital. The hospital system must also shape the different procedures and plans implemented to achieve set goals and objectives of the organization (Klar, 2018). The other aspect of change management to consider is the energy dynamics or power forces at work that are implementing the change within the

organization. O'Connor and Jackson (2017) argued that energy dynamics relates to an organization's flow of authority and hierarchy.

Leaders responsible for change need to consider which units' personnel within the hospital should focus on as a means of impacting the hospitals choices and outcomes Arabiat, & Shin, 2015). By determining the hospital's biggest influencers, it is easier for leaders to determine the personnel and departments that need change (Ganta & Manukonda, 2017). Leaders must also consider the hospitals' capabilities and resources when implementing change (Klar, 2018).

As the hospital leadership implements new processes, the hospital's leadership needs to guarantee that it has the economic, human, and other resources necessary to execute the change process effectively (Heckmann, Steger, & Dowling, 2016). Hospital leaders to make sure that the staff involved in the modified process have the required abilities and expertise to bring about the change (Heckmann et al., 2016). Leaders must also make sure that the hospital has the funds necessary to execute the process of change (Cameron et al., 2016). Carnall (2018) indicated that the actual method is to implement the change process with all resources considered.

Effective execution of the change process is a short process when all stakeholders within the hospital align with the plan for change prior to execution (Klar, 2018). Paying attention to resource details may ensure that the new processes will be successful. The nature of implementing a change in a hospital's process requires the leadership to consider the rationale or motivation behind the change (Diab, Safan, & Baker, 2018). After considering economic and human resources, funding, rationale, and motivation,

healthcare organizations effectively and efficiently implement the change process (Klar, 2018). A successful implementation will lead to an improvement in the quality outcomes of services provided to patients and the patient's level of care (Manca, 2015).

Revenue Cycle

The healthcare industry is undergoing extreme changes in which reimbursements are continuously declining (Yaduvanshi & Sharma, 2017). Management policies for operations need to guide healthcare professionals to address economic survival issues (Krzakiewicz & Cyfert, 2017). Earnings management within a healthcare organization includes cost reduction and increased cash flow (Dong, 2016). Receivable management accounts should incorporate strategic processes to collect payments for patients and insurance payers and prevent cost reductions or inadequate care.

Representatives of the Healthcare Financial Management Association (HFMA) defined revenue cycle as the managerial and medical tasks that aid with the collection, guidance, and involvement of the funds received from patient assistance (Rauscher, S., & Wheeler, J. (2012). Furthermore, the term includes the entire life of a patient account from creation to payment. The revenue cycle process starts when a patient schedules an initial appointment and concludes when all claims and payments resulting from the appointment and subsequent settlement of services (Cascardo, 2018). The most important components of the hospital revenue cycle are front-end core responsibilities that occur during patient contact and back-end responsibilities that occur after the patient is discharged (LaPointe, 2016). Organization leadership attempting to merge the business processes of two different organizations must develop and implement policies and

processes with appropriate performance measures intended to standardize and optimize the collective processes (Angwin & Meadows, 2015).

Although generally focused on medical billing and revenue collection, hospital leaders have concentrated consideration on the front end of the revenue cycle (LaPointe, 2016). Beginning with scheduling an appointment, and the pursuant registration, revenue cycle staff registers the patient and gathers demographic, insurance, and clinical information (Cleverley & Cameron, 2007). The revenue cycle staff also confirms the eligibility of the patient for the specific services to be provided, which often requires obtaining a specialist' referral, precertification, or preauthorization of services (Cleverley & Cameron, 2007). Staff computes the expected out of pocket expense for the patient in terms of copayments and deductibles (LaPointe, 2016). Staff will counsel patients on the financial considerations of their visit and identify patients who have no or inadequate health insurance coverage (Cascardo, 2018). Staff is then able to assist those patients meeting eligibility requirements for public health insurance programs, such as Medicaid, Medicare, or state sponsored children's health programs (Hempstead, Sung, Gray, & Richardson, 2015).

Throughout the value stream of a patient visit, providing healthcare services to patients is the primary business of a hospital and the phase of the hospital revenue cycle during the generation of revenue (Cascardo, 2018). Once a patient receives services, it is important to collect all charges for these services and record the information in the documentation system of the hospital to prevent diminished reimbursement because a patient receives a service not entered (Cascardo, 2018). In addition, the length of time

from point of service to charge entry is a critical factor in the efficacy of hospital revenue cycle management as delays in charge entry lead to delays in billing, cash collection, and a reduction in revenue collection speed (May, 2004). As a final step, the case receives a diagnosis and a code for the procedure before a preparing a bill (Cleverley & Cameron, 2007). Accurate and comprehensive clinical data provide the opportunity for medical coders to qualify to receive the optimum level of reimbursement and thus increase patient revenue (Berger, 2008).

Back-end functions, such as billing and collections are the areas where revenue cycle management is readily identified (Goldstein, 2015). Up-to-date, well-functioning billing practices help prepare prompt and accurate bills (Hackbarth & Gamble, 2017). A crucial task in the billing system is the editing of claims, which helps to find possible errors in claims before sending to payers, thus ensuring that the hospital minimizes rework while collecting the correct fee for services provided and shorten the amount of time from filing claims for actual payment (Cleverley & Cameron, 2007).

If there is a delay in bill payment, follow-ups and denials management can help the business office increase the amount of patient reimbursement through the claim recovery process, which involves correcting and resubmitting previously rejected claims (Eldenburg, Schafer, & Zulauf, 2004). Furthermore, effective management of denials may help to reduce the remaining time of receivable accounts. The revenue process of the hospital ends with the collection and posting of the collected monies. Upon collecting and recording the fee, the patient’s balance will be reconciled by accepting (additional) benefits, charity care, and bad debt (Cascardo, 2018).

Successful hospital revenue cycle management processes have increased in significance due to changing billing obligations and stricter guidelines, particularly the management of accounts receivables and patient revenues (Beaulieu-volk, 2015). The revenue cycle process requires a more thorough preauthorization and precertification, the ability to respond to underpayments or variances, and the ability to absorb more frequent delays in payment (Rauscher & Wheeler, 2008). Customarily, the hospital revenue cycle management has concentrated on the reduction of average accounts receivable collection days (Yin, 2017).

Things that must happen in an efficiently functioning hospital business office

American methods of health information management are outdated (Kiel et al., 2016). The use of paper and the capacity to access data across platforms devalues the clinical documentation (Meyers, 2016). Doctors have difficulty offering high-quality care without a central patient data bank (Kiel et al., 2016). Furthermore, the absence of access to and sharing of data leads to increased healthcare expenses (Saarnio, Suhonen, & Isola, 2016; Skochelak, et al., 2016). The following data need to be accessible in order to guarantee adequate patient care: a) clinical, b) financial, c) regulatory, d) demographic (linked to quality and security), e) government health, and f) epidemiological (Meyers, 2016). Sharing this data with all stakeholders will enhance patient results (Kelsey, Karen, & Hude, 2017). While considering protecting patients, unless changed, certain regulations will continue to hurt patients. Sharing data on health enhances the quality of care (Meyers, 2016). It is necessary to consider core elements when implementing change (Gurganious, 2016). Of the various systems created to handle change in the healthcare

industry, there are multiple factors that can guarantee a hospital optimizes the multiple advantages of each model (Holten & Brenner, 2015). Optimizing the multiple advantages of each change model helps facilitate the application of change management.

Productivity

Productivity is a measure of the efficiency of a person, machine, process, or system, in converting inputs into useful outputs (Ku, Frogner, Steinmetz, & Pittman, 2015). Leaders determine productivity by dividing average output per period by the total costs incurred or resources (capital, energy, material, personnel) consumed in that productivity period (Business Dictionary, 2019).

Accounts Receivables

Accounts receivable (AR) are amounts owed by customers for goods and services purchased on credit (Aghaei-Hashjin et al., 2014). Instead of immediate payment, customers might have, for example, a 30 or 60-day period to pay the invoice for those goods or service (Aghaei-Hashjin et al., 2014). Aghaei-Hashjin et al. (2014) posited that strategic planning for collecting the outstanding debt is the responsibility of the management team with account knowledge and those within the financial department who consult on payment collection (Lai & Gelb, 2015). Health care organizations manage accounts receivables through income cycles governing insurance companies, billing processes, and reimbursement protocols (Frandsen, Powell, & Rebitzer, 2015). The need to manage the income cycles emphasizes the significance of receivable management accounts, which is essential to organizational economic well-being.

The receivable element of any healthcare organisation is essential to profitability

(Shorr, 2015). Talonpoika, Kärri, Pirttilä, & Monto (2016) assert that operational working capital is critical to profitability. Before payment, health facilities supply services, and the supplier depends on the patient for payment (Shorr, 2015). The business model for the reimbursement of services supplied by healthcare organizations is the intention of paying for the service (Gurganious, 2016).

Receivable management accounts apply policies to guarantee effective and efficient payment from patients and insurance payers for services rendered (Foerster et al., 2017). For sustainability and financial independence, the capacity of hospital system leaders to obtain compensation from patients and insurance payers is crucial (Shorr, 2015). The collection method enlisted by healthcare organizations seeks to maximize the medical facility's income cycle management (Shorr, 2015).

It is not a direct process to collect payment for medical services rendered, but it is for the practice to flourish (Weinstock, 2015). Collection process barriers include bank billing errors, unpaid insurance payers, or failure to obtain or misinformation from the correct patient (Shi, Zurada, Guan, & Goyal, 2015). Consequently, poorly incorporated strategic planning during the implementation process to avoid patient and insurance nonpayment becomes a problem during the bill collection process (Shi, Zurada, Guan, & Goyal, 2015).

Monitoring AR guarantees that payment is timely, and the organization's outstanding revenues owed decline over time (Beaulieu-volk, 2015). The traditional type of compensation is the fee-for-service (FSS) model, as insurance companies pay for each patient service (Mabotuwana, Hall, Thomas, & Wald, 2017), and collecting payment on

time is a sustainable strategy. Furthermore, collecting payments that affects the hospitals financial future knowledge of where income comes from and service-related costs are essential elements the financial manager strategic planning (Sheet, 2017). Healthcare systems recombination of insurance and payment techniques obtain patients and insurance payers (Loy et al., 2016).

Ultimately, the organizations economic stability policies and financial management employees incorporate plans to maximize earnings (Dong, 2015). The analysis of receivable accounts revolves around the amount of days it takes for payers to obtain reimbursement, which includes patients, insurance payers, and public institutions (Dong, 2015). The receivable cycle of accounts breaks down by days, weeks, or months into time increases; and improvement in the management of receivable accounts will boost effectiveness and revenues (Foerster et al., 2017). In addition, receivable management policies within operations management will enhance patient and insurance payment consistency (Shi, Zurada, Guan, & Goyal, 2015). Financial executives analyze the patient mix and insurer coverages (Johnson & Garvin, 2017). By selecting patients and kinds of insurance coverages, manager accounts strategize with activities to identify methods to enhance profitability and sustainability. The economic and operational advantage of receivable management reports is to narrow the margin between profitability and the healthcare entity's costs (Shi et al., 2015).

Since the early 2000s the healthcare industry has been undergoing extreme changes resulting in reimbursements for services continuously declining (Yaduvanshi & Sharma, 2017). Management policies for operations need to guide healthcare

professionals to address economic survival issues (Krzakiewicz & Cyfert, 2017). Earnings management within a healthcare organization includes cost reduction and increased cash flow (Dong, 2016). Receivable management accounts must incorporate strategic processes to collect payments for patients and insurance payers to prevent cost reductions or inadequate care.

Change Management

Changing a scheme implies that a fresh more appealing state of being has evolved (Walton, 2016). As a means of creating a complex system model strategy in the public health sector, an employee requires the ability to adopt a wide strategy for designing, implementing, and evaluating measures needed to alter a system to accomplish improvements (Rutter et al., 2017). Therrien, Normandin, and Denis (2017) further assumed that in the hospital environment, healthcare is complex, but it can change with the implementation of the theory of complexity.

Workers can merge the distinct stakeholder levels in a healthcare system with crisis preparedness and leadership when the theory of complexity is implemented (Therrien et al. 2017). Although at the organizational level change can occur, it can also occur at the individual level. Interventions in the healthcare sector can affect employees with regulations in job environment requirements and using resources to change performance enhancement (Gordon et al., 2018). Individual changes are synonymous with individual interventions in this example. Han and McKelvey (2016) proposed that complexity theory is one framework for changing organization’s capacity to network, gain accountability, trust, legitimacy, and governance to attain economic well-being.

Roberts et al. (2016) claimed that complexity theory poses as an intervention when applied to health care education and learners may discover new methods. Other forms of learning can occur with role playing in the healthcare sector. Dunn and Riley-Doucet (2017) assumed healthcare leaders used complexity theory as a lens to examine clinical educators to create a simulation of role playing to improve the training of care for terminally ill patients.

Cruz et al. (2017) proposed that a framework of complexity theory applied to education might contribute to the learning explanation as well as social transformation change. Changing within a scheme involves moving from a familiar process to an unfamiliar process. In the hospital industry, to generate a chance for improvement, the billing manager can adjust from a familiar method to an unfamiliar method (Shoaib & Kohli, 2017). Change, however, will occur through conversion, which requires individual education. Complexity theory tenets portend that feedback loops from all stakeholders constantly change systems from (Kohli, 2017).

Response to a healthcare system shift needs to generate continuous improvements in a healthcare facility (Jaworzynska, 2017). Larson (2015) posited that a good reaction to healthcare change projects requires numerous attempts and relies on a complete system be effective. Lefroy and Yardley (2015) proposed that the use of the concept of complexity could enhance the reaction to change by raising the result value. However, the reaction to change suggested by Nasario de Sousa Filipe Duarte (2016) relies on the perceived situation of feedback and the workplace. The enhanced value can come from self-criticizing all changes and understanding the social aspect of company assessment

(Lefroy & Yardley, 2015). Ma, Peng, and Sun (2014) argued that the theory of complexity has a way to quantify how complex a biological system is and the ability to adapt and operate in an environment that is constantly changing.

There are similarities that need to be compatible with the capacity to alter the workplace to include inner and external difficulties relative to the healthcare industry. Organizations can generate inner complexities such as company growth or new procedures to react to external complexities to guarantee ongoing adaptability (Schneider, Wickert, & Marti, 2017). Change adaptability is the capacity to constantly scan the environment for process improvement possibilities. The capacity to adapt involves the past and present changes reviewed and adjusted, while considering the complexities of the company and people's social component. In the end, the reaction to change includes the billing manager's capacity to not only adapt to change within but also to adapt to the evolving Medicare laws that constantly fluctuate the health care climate (Zhang et al., 2015).

Willingness to Change

Kirrane, Lennon, O'Connor, and Fu (2017) asserted that organizational changes are affected by the willingness of individuals to accept or reject the changes proposed. Kirrane et al. (2017) examined the literature and uncovered how willingness only improves when normative reductive change approaches are in effect and the perception of the staff is more learning oriented. The readiness to accept change can also function as a facilitator or an obstacle to the process of change (Allen, 2016). The willingness to accept change assists staff in achieving change and project goals (Holten & Brenner, 2015).

Employee readiness demonstrates the cognitive and emotional inclination toward the change plan versus the status quo (Holten & Brenner, 2015). According to Holten and Brenner, there are four major variables that influence staff willingness to accept changes: (a) the process engaged in the operation, (b) the context of a worker, (c) the content of the change, and (d) the character of the individual implementing the change. Hornstein (2015) established that changes are related to communications, the level of engagement of staff to the change, and the possibilities to engage in the change, are beneficial measures for worker willingness regarding their attitudes of resistance.

The connection between willingness and attitudes of resistance require further inquiry (Bell, 2015). Using information collected from survey answers of 102 staff level employees engaged in the change process in New Zealand and Australia, Hornstein (2015), established a connection between the willingness variables such as empowerment to engage, change-related communications, and employee engagement. Hornstein also highlighted the effectiveness of participative, employee-centered implementation of change initiatives in service industries.

Resistance to Change

Resistance to change is a major obstacle to the change process. Furthermore, resistance to change can stem from the appearance of a neglected opportunity of leaders to demonstrate appreciation for something in the organization (Cameron et al., 2016). Cameron et al. (2016) asserted that resistance to change becomes an issue when not directly addressed and resolved. Cameron et al. (2016) asserted that resistance to change

includes the natural human inclination as a sort of defense mechanism and argue that resistance should not become a barrier to the change.

Cameron et al. (2016) posited hospital staff often fear the unknown and therefore resist the change. This is a natural human response to any type of change (Cameron et al., 2016). Burnes (2015) asserted that opposition is something strategically resolved. Accepting the resistance to change is a necessary stage in preparing to tackle new ideas. The acceptance allows hospital leaders to adequately prepare staff and motivate workers to accept the change (Allen, 2016).

Trust

The amount of confidence that employees have in any organization's leadership as well as their executives has a serious impact on the implementation of change in the execution of the processes (Diab, Safan, & Bakeer, 2018). Hornstein (2015) stressed the role confidence plays in an organization by studying the connection between interpersonal and organizational variables that influence the interactions between leadership and staff. The dynamic impacts the efficiency of an initiative for change. Using both qualitative and quantitative research, Hornstein established that the application of change policies could shape high rates of engagement to change in a favorable way. According to Hornstein (2015), the outcome of a prominent level of dyadic confidence is the actual desire to change. Leadership displays of confidence play a substantial role in the successful execution of change processes (Diab et al., 2018).

Implementing Healthcare Change

While hospitals are always under considerable pressure to improve the quality of services provided, multiple challenges affect the process (Allen, 2016). The challenges include a shortage of personnel and a shortage of required financial resources to guarantee a higher quality of services provided (Allen, 2016). There are usually distinct circumstances that require the implementation of changes in hospitals to align the availability of resources and to satisfy distinct stakeholder expectations (Bengat, Odenyo, & Rotich, 2015).

Hospital leadership experience multiple challenges and increased pressure attempting to improve quality while facing multiple issues, such as personnel shortages and absence of funds (Agyeman-Duah, Theurer, Munthali, Alide, & Neuhann, 2014). Factors that may influence changes in healthcare are like those that hinder changes in other industries (Allen, 2016). For example, Williams, Perillo, and Brown (2015) highlighted the situation of nursing instructors toward evidence-based practices could function as a barrier to successful change projects, such as adopting recent information technology. Williams et al. (2015) asserted that had there been a favorable attitude regarding the change among the nursing instructors, there would have been a greater willingness to use such methods. Negative perceptions of the impacts of IT, however, could influence nurse instructors causing issues based on their concerns about using new systems (Pineau Stam et al., 2015). In addition, Bengat et al. (2015) examined the connection between change-related communication, exchanges between executives and supporters, and the impact of such expectations on change results.

Bengat et al. (2015) conducted structural equation modeling on 395 randomly selected nurses using a theoretical model based on a predictive and nonexperimental design and found that a positive expectation could substantially affect commitment to change. Bengat et al. (2015) further stated that the chance of exchange and communication between administrators shapes the choices of nurses to adapt to change or shape the expectations about possible change. Bengat et al. (2015) found that when considering the commitment to change, the expectations of nurses about changes are important.

Larson (2015) claimed that when implementing organizational change, change management in the healthcare industry faces the same difficulties as other industries. There are many changes in the healthcare industry in the present setting, both from an operational point of perspective to a level of government strategy (Edmunds et al., 2016; Houngbo et al., 2017). Implementation of the Affordable Care Act has changed the healthcare delivery system in the United States in terms of the organization, finances, and clinical aspects of medical practice (Birk, 2016). Other government regulations have moved healthcare from a majority fee-for-service based delivery to a value-based purchasing model (Cassatly & Cassatly, 2015). Another significant modification in the U.S. healthcare system was the recent upgrade of diagnosis coding from ICD9 to ICD10 in 2015 (Hellman, Lim, Leung, Blount, & You, 2018). Therefore, change is prevalent in healthcare organizations and stakeholders need to adapt accordingly so that the method of change management can be efficient and effective (Al-Ali, Singh, Al-Nahyan, & Sohal, 2017).

Successful application of change management includes taking measures to overcome difficulties as a means of obtaining the required state (Lewin, 1947). Although hospital leaders have experienced important pressure to enhance the quality of their facilities, multiple difficulties impacted the activities (Larson, 2015). These difficulties include a shortage of nurses and the absence of funds needed to guarantee high-quality service. There are different circumstances that require hospital adjustments to align the accessible resources with stakeholder expectations (Bengat et al., 2015).

According to Kogan, Conforti, Yamazaki, Iobst, and Holmboe (2017), the change management process in the healthcare industry guarantees that different stakeholders in the sector embrace new methods of changing the organizational culture and recognize multiple advantages, ensuring sustainability. Several healthcare organizations need to address the greatest challenge in implementing change management, which is the confusion that individuals feel during moments of change (Cameron et al., 2016).

The presence of uncertainty enables many people to not respond to change because of a lack of understanding of the change (Kogan, Conforti, Yamazaki, Iobts, & Holmboe, 2017). One of the methods that healthcare organizations can use to guarantee effective change is by applying the 4Rs, reason, result, route, and role (Diab et al., 2018). The first R is the reason the organization is making the shift to staff by the executive.

According to Kirrane, Lennon, O'Connor, and Fu (2017), understanding the reason for the shift enables staff to gather responses to the issue of why the change is essential for the organization, while the staff and other stakeholders support ensuring the change process. By knowing the reason the change is taking place, the staff and other

stakeholders who may influence the change process can tolerate the multiple changes in the organization's processes and changing culture (Kirrane et al., 2017). According to Diab et al. (2018), the focus is on the outcomes on hospital management to achieve a successful change process.

Results are what the healthcare institutions' activities and procedures will look like after the change process (Allen, 2016). Management needs to clarify the new processes produced as a result of the change process, clarify the new technologies adopted as a result of the change process, and clarify all stakeholders' future expectations as a result of the change process (Allen, 2016). The results also include an explanation of the anticipated benefits of implementing the modifications.

Some of the expectations of applying the change process, according to Saarnio et al. (2016), include saving expenses, saving time to serve patients, enhancing the quality of services provided to patients, and enhancing the effectiveness of all hospital procedures. These expected advantages require an appropriate explanation for all stakeholders that may affect the process of change. Diab et al. (2018) argued that the route to change is the method or route followed during the change.

The path indicates how to carry out the change process and how the healthcare system will shift from the present manner of operations to the required manner of operating in the future when a healthcare organization implements change. The following steps involve definition along with an explanation of the actions and the duties performed at each point of the process of change execution. Timelines aid with completing the activities to determine and discuss with the stakeholders the general timetable of

implementation of the entire change process (Bengat, Odenyo, & Rotich, 2015). Other implications need defining for the tasks, including the cost of implementing the change process (Yen et al., 2017).

The function of the change process is the last thing to establish for stakeholders. The function comprises of what the change process will mean for staff in terms of their expectations, advantages, or shortcomings after implementation (Yen et al., 2017). The function delineates fresh laws and circumstances in which staff are required to work due to the change process being implemented (Yen et al., 2017).

In the event that the change process involves changing employee roles and responsibilities, the executive must ensure that there is clear communication about the new roles with employees so that they can understand the expectation during the change process (Seamons & Canary, 2017). In the event it is clear what the new role of the different staff and other stakeholders will be after the modification process, executives must prepare workers to be flexible and positive while supporting the change process (Diab et al., 2018).

Change Management Models in the Healthcare Industry

Using Lewin's (1947) change theory and Kanter's (2008) empowerment theory can guide organizations with implementing multiple organizational modifications to enhance the quality of care. The development of the organizational model for transformation in healthcare systems was designed to assist healthcare organizations with enforcing change at all stages of activities to provide a safer and greater quality atmosphere and patient care level (Kogan et al., 2017). Kogan et al. (2017) determined

the model directed at ensuring that healthcare organizations can ensure an enhanced patient care environment by redefining the main elements of the activities. Some of the main parts implemented are the organization's mission, the vision, and the policies.

The mission, the vision, and the policies are helpful with assisting healthcare organizations with providing the organization's direction and priorities. Another main section of the organizational model for change in transformation is the organizational culture, which describes the values held by the health institution and the behavioral standards of the staff and other stakeholders (Cameron et al., 2016). The procedures and operational tasks performed within the healthcare organization are further appropriate elements of the organizational model for change in transformation (Cameron et al., 2016). These procedures and features assist with identifying how caregivers do the job in healthcare facilities to provide patients with the required services.

To promote patient activities and service delivery, healthcare organizations need different types of infrastructure in place to act as the basis for the different activities taking place. These foundations include IT systems that support multiple institutional company activities, human resources allocated to different duties to ensure patient service delivery, financial services, and facilities management that ensure patient care services are delivered efficiently to patients (Naus, Faint, & Dwyer, 2018).

Four elements identify the main activities of healthcare institutions, a) supporting procedures, b) instructions, and c) resources (Thompson, 2017). Successful healthcare process changes require aspects of transformational change (Thompson, 2017). The main activities include the incentive to transform, which implies an internal pressure exerted

that forces the healthcare organization to undergo changes to identified parts needed to enhance service delivery (Thompson, 2017).

While the organization's impetus for transformation relates to external pressure for change, different inner variables may also force change (Fokkema, 2016). Forces such as the flow of authority or the hierarchy of the organization can impact change (O'Connor & Jackson, 2017). Change managers can consider which people, and which units within the organization have the power and influence to lead a change process (Hwang, Al-Arabiat, & Shin, 2015). The other vital component for organizational change in healthcare is the quality commitment of leadership (Fokkema, 2016). Healthcare institution managers should acknowledge that the level of quality is below par and therefore aid with the change process to enhance the quality of services (Carnall, 2018). This shift in change includes identifying the required level of quality that the healthcare organization should attain (Fokkema, 2016).

Fokkema (2016) stated that staff should be engaged in numerous enhancement projects directed at improving activities within the organization. The execution of multiple development projects and employee participation aids with guaranteeing a significant improvement in the organization's general performance and effectiveness (Stevens et al., 2017). The primary benefit of involving staff in implementing projects is employee insight can be helpful in ensuring an effective change process (Carnall, 2018).

Another vital aspect for changing execution in healthcare organizations is the alignment directed at attaining organizational objectives by allocating resources and implementing multiple activities at all stages of the activities (Kuipers et al., 2014).

Fokkema (2016) indicated that this allocation alignment happens by involving staff and other important stakeholders in implementing the multiple change measures aimed at improving activities.

Finally, organizational leaders should guarantee separate limits within the organization between different individual parts considered in order to improve the quality of service (Naus et al., 2018).

Factors Affecting Merger Changes

Various factors impact the execution of the change initiative and changing variables could function as change facilitators and provide favorable support to the initiative (Lewis, Passmore, & Cantore, 2016). Some of the primary variables include work style, communication styles, cultural environment, personnel resistant to change, personnel willingness and flexibility towards change, and personnel's confidence in the hospital's leadership (By, Armenakis & Burnes, 2015; Seamons & Canary, 2017).

One of the primary factors affecting the execution of changes in processes in any organization, whether medical or otherwise, is effective communication between leadership and staff and the organization's culture (Cameron et al., 2016). It is primarily the personnel that have to change during the change process, not the hospital (Cameron et al., 2016). The shift in personnel thinking must be effective to achieve the initial benchmarks that hospital leaders desire (Cameron et al., 2016). Seamons and Canary (2017) highlighted the critical success factors that are responsible for effective change management. These factors include ideas of consciousness, desire, understanding, capacity, and strength.

Seamons and Canary (2017) conducted a literature review and a pilot study to develop a survey to investigate the efficacy of organizational change with specific communication factors. Seamons and Canary surveyed the personnel and divided them into categories that included personnel who ever experienced change, personnel who have completed a change process, and personnel who have yet to experience a change process.

Kuster et al. (2015) found that forces such as frequent interaction with staff, the centralized leadership structure, employee data accessibility, and the character of the administrator influenced the communication variables and therefore affect the achievement of the change process initiative. Employee awareness is a tool for initiating a change in an organization's processes. The more employees had a clear understanding of all implications and requirements of the planned process changes, the easier the change is for leadership to implement (Kuster et al., 2015).

The main objective of the hospital's leadership is to allow the recognition of employees for their contributions and to create favorable attitudes toward the change initiative (Georgalis, Samaratunge, Kimberley, & Lu, 2015). It is significant to have mutual comprehension between leadership and frontline staff. In addition, leaders have to delve deeply into all issues of concern for the hospital by ensuring that both the hospital as well as the staff do not have unmet requirements (Georgalis et al., 2015). Effective hospital leaders recognize not only the importance of mutual comprehension, but the leaders also discern findings that diagnose the change scenarios before executing any change process (Kogan, Conforti, Yamazaki, Lobst, & Holmboe, 2017).

Hospital leadership should provide employee recognition during change by educating the personnel of the advantages and benefits of the proposed change and thereby gain acceptance (Cameron et al., 2016; Shin & Konrad, 2017). Achieving the level of acceptance by the personnel is a vital step toward the successful implementation of all organizational process changes (Hwang, Al-Arabiat, & Shin, 2015). The business office of the acquired hospital should institute changes to processes to align the business office processes of the acquiring hospital (Klar, 2018). In such an undertaking, it is not enough to have an understanding that a change is coming; staff need to be aware of using a methodology to effect the change (Van den Heuvel et al., 2013).

Van den Heuvel et al. (2013) observed that when organization personnel receive data about a change, they immediately begin to adapt because they can actively participate in the change and establish links of significance to their own lives. According to Hornstein (2015), it is obvious that changing the business process results in a structural change. Hospital changes and innovations require modifications at all levels of the hospital, including personnel, the organization's culture, the organization structure, strategy, performance management, actual procedures, and the technology used, all of which must be communicated properly (Cameron et al., 2016). Whenever change takes place that is incompatible with personnel's learning styles, confusion, and stress can lead to a decrease in the productivity of the worker or department (Smollan, 2015).

Confusion and stress among employees undermine the ability of an organization to execute new technology or procedural change in a timely or efficient manner (Smollan, 2015). Considering the strategy of how best to lead staff through change is crucial to

achievement. By et al. (2015) asserted that it is essential that leaders consider cultural preferences and differences when shaping a significant portion of the businesses culture, processes, and interactions. Cultural preferences and differences are essential to change management strategies (By et al., 2015).

The governing structure of the hospital guides leadership, communication, and business office practices. Other aspects include policies and procedures that determine organizational goals, planning, task, and direction (By et al., 2015). Since the primary goal of hospital leadership is to improve general efficiency, leadership should consider these critical factors (By et al., 2015). As Hornstein (2015) asserted, the pitfalls of opposition to the change from employees who are reluctant to accept change decreases when considering the important elements during the process.

Smollan (2015) proposed that if there were a fragile connection between the actual change process and the significant dimension, it would lead to adverse conditions and stress of the personnel. Smollan (2015) described the stage of conceptualizing, which helps employees to connect requirements and expectations with the dimensions of the change in order to remove any barriers or obstacles to the change. The change management strategy must include all the required resources and well-established, communicated goals in this stage. During a crucial change process, Smollan (2015) pointed out several organizational stress indicators that were present. Those stress indicators include increased absenteeism, turnover, and poorer productivity (Fugate, Kinicki, & Scheck, 2002).

When making comprehensive changes such as announcing a new task, when restructuring takes place, the introduction of new authorities, or if there are any changes in familiar processes, organizations as well as the employees experience an increase in anxiety (Smollan, 2015). Smollan (2015) asserted the change often creates considerable stress for employees. The very nature of technological change can lead to staff uncertainty and job insecurity (Smollan, 2015). Employees often feel insecure and pressured about becoming outdated in their current roles (Smollan, 2015).

Employee stress is an obstacle that can alter the actual execution of the change (Heckmann, Steger, & Dowling, 2016). Hospital leaders may find merger success if they focus on the stress that employees are feeling and are sensitive to worker job security issues (Heckmann et al., 2016). Hospital leaders should also be empathetic to the frustration that staff may feel when spending substantial time implementing change quickly becomes obsolete (Heckmann et al., 2016). Experienced hospital leaders are prudent when implementing change so that leadership input is included in the process (Holten & Brenner, 2015; Smollan, 2015). While hospital leadership is not physically present the entire time during a change implementation, hospital leadership can direct new authorities through an efficient method of instituting change (Smollan, 2015).

Holten and Brenner (2015) asserted that delegating responsibilities was significant because certain change management approaches ensure that the entire workforce is engaged in the process and more readily executing the organization's changes. These assertions also intersect with the teleology model in which respondents moved toward shared organizational objectives (Tabibi, Nasiripour, Kazemzadeh, &

Ebrahimi, 2015). The inclusion of staff throughout the change process, per Holten and Brenner (2015) and Tabibi et al. (2015) is another important point for the successful execution of the change.

All the individual stakeholders concerned should be engaged in an efficient change management process (Tabibi et al., 2015). It is also necessary to understand individual and group dynamics regarding bias that develops because of mistakes in critical thinking, bad decision making, group thinking, and failures in recognition (Cameron et al., 2016). In addition, employees' refusal to accept the change process creates a resistance to change scenario (Cameron et al., 2016). Consequently, it is critical that the directives to the employees should be purposeful, direct, and clear from leadership implementing the process for the change process to be successful (Cameron et al., 2016). In addition, key unofficial influencers must be included in the change process to keep resistance to a minimum (Holten & Brennen, 2015; Cameron et al., 2016).

Key influencers include peer executives, senior executives, and departmental subordinates at the staff level (Cameron et al., 2016). Leadership develops new policies and processes when it comes to the level of recognition that employees understand. Managers set the example; therefore, the level of recognition by leadership of the latest changes could influence subordinates' acceptance or rejection (Hwang et al., 2015). Communication about the change process should be clear and concise.

Communication between hospital leadership and staff during the implementation of the change can be an efficient incentive and instrument of strength (Cameron et al., 2016). It is crucial to transmit clear and timely messages to staff during the

implementation of the change to generate appropriate dialogue and reduce resistance and anxiety (Heckmann et al., 2016). Leadership communicates appropriate dialogue to the staff when stating their own opposition to change and outcomes during obstacles and challenges to the change implementation (Heckmann et al., 2016).

Transition and Summary

Through the results of this study, the larger manager community may have greater knowledge of how to contribute to the success of an organizational merger through improving employee management. Employees who feel their needs are met may continue to be loyal to their managers and contribute to the success of the merger. Understanding the resources available to a manager may allow leaders to manage their employees successfully through a merger. In this chapter I reviewed the history of mergers, classifications of mergers, and the successes and risks associated with mergers. I then discussed the effects of mergers on both organizations and the people. To explore organizations, I reviewed financial impacts, business development, decision making for management, meeting production and goal achievement, and technology requirements. I also discussed the effects of mergers on employees related to training and retention, systems and processes, employee commitment, trust, communication, attitudes and stress, engagement and motivation, morale and performance and production.

This chapter also addressed how human resources personnel can assist the managers with soft skills to manage the employees effectively through a merger. A leader's style will make a difference in how an employee can relate to their manager, especially when a merger is taking place. In Section 2, I outlined the research design and

methodology of the research study. Additionally, in Section 2 is information on the differences in research design, the rational for the chosen research design, and the role of the researcher. I also review how the selection of the participants, confidentiality of the study and interviews, how the interviews were conducted, and the method of analysis. I end the section with a review of the credibility, transferability, dependability and confirm ability of the study. Ethics procedures are included in the chapter to ensure the protection of the participants identified and information collected.

Section 2: The Project

The intent of this qualitative single case study was to explore the strategies of hospital leaders to maintain business office productivity during a merger. This section includes a restatement of the purpose statement, the role of the researcher, participants, method and design, population, and sampling. This section also includes information on ethical research, data collection instruments, data collection technique, organization, and analysis. The concluding subsections include reliability and validity of the study and a proposal summary.

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies of hospital leadership to maintain productivity during the merger process. The target population consisted of leadership in a midsized hospital in the southeastern United States, particularly those connected with hospital business office operations because business office productivity could decrease during a merger. In addition, direct reporting vital hospital staff that are responsible for executing the decisions made by the hospital leadership. The implications for social change include the potential to identify proven strategies for successful mergers that maintained productivity of a midsized hospital. Established merger strategies can lower the risk of hospital closures (citation), thereby ensuring the affected community has proximate access to healthcare.

Role of the Researcher

The role of the researcher was to function as the primary instrument for the data collection and analyses processes to maintain strict adherence to ethical guidelines

(Morse, 2015). I, as the researcher, developed the interview protocol, conduct interviews, collects, organizes, analyzes, and interprets the data (see Arriaza, Nedjat-Haiem, Lee, & Martin, 2015; Cleary, Horsfall, & Hayter, 2014; Hlady-Rispal & Jouison-Laffitte, 2014). Moreover, I did strive to understand, assess, and determine the value of the participants' responses (see Bashir, Sirlin, & Reeder, 2014).

For the purposes of this research, I engaged in all aspects of the study, including data collection, organization, analysis, and interpretation. Berger (2015) posited that a comprehensive investigation is achieved when a researcher is involved in all facets of the research. Cleary et al. (2014) contended that the accuracy of collected information must be assured. Data collection includes gathering information across various sources such as personal observations and interviews (Cleary et al., 2014). My role was to interview the participants, organize, and analyze the responses. Throughout this process, I maintained the privacy of the participants. The member-checking process requires interview respondents to review and correct the researcher's interpretation of interview responses to ensure accuracy (Fusch & Ness, 2015; Noble & Smith, 2015; Yin, 2016). I employed member checking to ensure an accurate interpretation of participant responses.

The *Belmont Report* contains fundamental ethical principles a researcher should abide by when researching human subjects and includes safeguarding the respect of vulnerable populations, avoiding deceptiveness, and providing uniform handling for all participants (U.S. Department of Health and Human Services, 1979). To adhere to the *Belmont Report* protocol, researchers should abide by ethical standards and guidelines for the protection of research participants (Honig, Campel, Siegel, & Drnevich, 2014; Zhou

& Nunes, 2013). I adhered to the ethical principles set forth in the *Belmont Report* and applied the ethics training I obtained from the National Institutes of Health (NIH) (see Appendix A).

Researchers should reduce, and if possible, eliminate bias. Bias occurs when a researcher interprets interview notes through a lens based on preconceived experiences (Bashir et al., 2014; Malone, Nicholl, & Tracey, 2014). Researchers should demonstrate active listening, eschew casting judgment, and remain vested in the responses of each participant (Bashir et al., 2014). I avoided preconceived views from past experiences and remained vested in the participant's responses.

My medical industry experience includes 11 years in hospital revenue cycle management. These duties involved all aspects of the revenue cycle from patient registration through reimbursement. I avoided bias due to my history within a hospital's revenue cycle by maintaining objectivity. I enrolled participants from outside of my immediate department or sphere of influence to ensure research objectivity (Alimo, 2015). In order to accurately and correctly interpret the information, qualitative researchers must strive to study the data with limited bias and maintain a neutral and impartial stance regarding the subject matter (France et al., 2015; Yazdani et al., 2018; Yin, 2017). I used an interview protocol to uphold consistent and accurate processes while rejecting bias throughout the research process

To mitigate researcher bias, I did not conduct this study using known participants. By not using known participants in this study, I avoided involuntarily injecting considerations based on knowledge that could originate from an established relationship.

I avoided representing my personal beliefs and opinions from experiences of working in the healthcare industry and use a well-structured interview protocol (see Appendix B) for maintaining consistency and accuracy while collecting data using interviews. I instituted a structured interview instrument and enhance the quality of the research study by aligning interview protocols in accordance with the study, as recommended by Garvare and Nystrom (2017).

An interview protocol was useful for ensuring impartiality, uniformity, and the quality of probing interviews and was a useful tool to ensure the quality of research results (Kono, Izumi, Kanaya, Tsumura, & Rubenstein, 2014; Platt & Skowron, 2013). Using an interview protocol also allows a researcher to explore unforeseen instinctive responses that participants may provide (Venkatesh, Brown, & Sullivan, 2016). To ensure meaning, interview questions should have an open-ended format to allow for maximum latitude in the response (Venkatesh et al., 2016). The interview structure and open-ended questions creates an environment for a better flow of communication (Anderson, 2017). According to Yin (2014), an interview protocol was important to ensure the data addresses the actual research question. To ensure high quality of research results, I used an interview protocol (see Appendix B) to conduct the interviews in proper order and keep the participants' information confidential.

Participants

The participants for this study consisted of seven hospital leaders (e.g., executives, senior managers) of two midsized urban hospitals in the southeastern United States with experience strategizing approaches to maintain business office productivity

during a merger. The eligibility requirements of participants in this study stemmed from the following criteria: hospital executives and revenue cycle leaders currently involved in a hospital merger with decision-making authority for business office processes in the southeastern United States.

To address the research questions, participants have knowledge and experience with the research phenomenon (Palinkas et al., 2015; Yin, 2017). Participants are commonly more inclined to participate when they have experience and knowledge of the phenomena (Marshall & Rossman, 2015; Pierre-Etienne & Verret Hamelin, 2017).

A working relationship between a researcher and study participants was essential to the success of the study (Hansson & Polk, 2018; Postma, & Roos, 2016; Yin, 2017). A working relationship with participants began with an initial email sent, and a follow up phone call to schedule the interview. Each participant signed a consent form. There was no compensation for participation.

I used purposive sampling, which was a nonprobabilistic sampling procedure, to fit the purpose of my study and the criteria that participants be leaders in a midsize hospital in a southeastern U.S. metropolitan area who were able to maintain business office productivity during a merger. More specifically, I used the nonprobability method know as expert sampling (Patton, 1999). This form of purposive sampling seeks the input of experts in a field to provide data where there is currently a lack of observational evidence (Patton, 1999). Patton (1999) asserted that convenience sampling is another nonrandom nonprobability method of sampling but it is less reliable and has the propensity to be biased. Convenience sampling is used to collect data form participants

who are easily accessible but may not represent the population or be the most informed to speak about the phenomenon being studied (Patton, 2015). For this reason, I did not choose convenience sampling. The purposive sampling method was the best technique for gathering participants needed to collect lived experience data about the research topic (Palinkas et al., 2015; Yin, 2017). Other types of purposive sampling were not appropriate for this study. Other types of purposive sampling include homogeneous, typical case, extreme deviant case, critical case, and maximum variation sampling (Patton, 1999). Researchers use purposive sampling to include or exclude study participants (Emmel, 2015; Palinkas et al., 2015; Patton, 2015). According to Zhu et al (2015), purposive sampling is selective, subjective, and judgmental. Qualitative researchers use purposive sampling to select participants based on who can answer the research question most effectively (Benoot et al., 2016).

Researchers should adhere to a protocol requiring study participants to sign informed consent documents to participate in the study (Broom, Broom, Kirby, & Post, 2018; Chapple & Ziebland, 2018; Levitt et al., 2018). The Walden University Institutional Review Board (IRB) uses the *Belmont Report* as a guide in deliberations to ensure researchers conduct ethical research (see Postma & Roos, 2016). After receiving approval from the Walden University IRB, I sent study participants a consent form via email attachment. Walden University's IRB approval number for this study is 06-03-20-0456992 and it expires on June 2, 2021. I ensured research participants signed and returned consent forms via email before they are enrolled in the study.

I ensured anonymity and confidentiality by using alphanumeric indicators P1 through P7 correspondingly for participant names. Allen and Wiles (2015) asserted that pseudonyms can aid in organizing study participants and entities during research examinations. I secured all data collected in a document strong box and on a password-protected computer and will retain it for a minimum of 5-years.

Research Method and Design

Successful completion of a research project depends on selecting the correct research method and design (Yin, 2017). The three types of research methods are quantitative, qualitative, and mixed methods. The method for this study was qualitative. The chosen design for this study was a single case study.

Research Method

The researcher selects the research method centered on the problem statement and the prospective impact of study results to organizational practices (Kozleski, 2017). I used a qualitative research method because I sought an in-depth understanding or explanation of participant's lived experiences within a context (see Vass, Rigby, & Payne, 2017). Researchers employ the qualitative method to interpret the significance of participants' experiences based on collaboration and personal experience (Patton, Hong, Patel, & Kral, 2017; Rich, 2017). It is essential that the researcher be involved with the data when conducting qualitative research. The different patterns or emergent themes detected in the data depend strongly on the integration of varying perspectives (Fugard & Potts, 2015; Patton et al., 2017). Researchers can use software such as Atlas.ti 8th edition to assist with interpreting findings from study interviews (Engle, 2015; Kozleski, 2017).

A qualitative method was an appropriate method for exploring the lived experiences and unique perspectives of study participants (Yin, 2017). Therefore, I used the qualitative method to explore leadership considerations for maintaining hospital business office productivity during a merger. Add summary/synthesis throughout the paragraph to better connect to your study.

Researchers who use the quantitative research method will conduct statistical tests to quantify a problem (Counsell & Harlow, 2017). Quantitative research is different from the qualitative method in that quantitative researchers test and confirm theories, while qualitative research is exploratory and involves theory building (Dasgupta, 2015). Quantitative research involves testing hypotheses regarding relationships between variable (Counsell & Harlow, 2017). Researchers used closed questions and test hypothesis when conducting a quantitative study (Yin, 2017). Researchers using the quantitative method can describe and measure participants' actions; however, they cannot describe the participants' lived experiences (Rich, 2017). Quantitative research was not an appropriate fit for this study since the emphasis of the study was to understand participants' lived experiences and explore themes, and not test hypotheses.

Researchers employ mixed methods research whenever they use more than one research method or whenever they need more time than may be available for a single doctoral study (citation). Mixed methods researchers use both quantitative and qualitative methods to examine more than one context or condition of behavior (Brown, Stickland-Munro, Kobryn, & Moore, 2017: Patton et al., 2017). Researchers can use the mixed methods approach to collect, analyze, and combine quantitative and qualitative data in a

single study (Kachouie & Sedighadeli, 2015; Yin, 2016; Sanchez-Gomez, Pinto-Llorente, & Garcia-Penalyo, 2017). I did not use any quantitative analysis because the qualitative method was sufficient to answer the study questions.

Researchers who conduct mixed methods research use a quantitative method to test a hypothesis. The merits of a researcher employing both quantitative tools and qualitative tools my yield a richer description of a phenomenon (Counsell & Harlow, 2017). A mixed methods study can present challenges to data validity because of a blend of both quantitative and qualitative data. (Brown et al., 2017). Mixed methods research involves measuring the relationships that exist between variables (Sparkes, 2014). A mixed methods approach was not suitable for this study because the emphasis of this study was not testing a hypothesis. The emphasis of this study was to explore strategies and themes. Considering he differences among these three approaches, the most appropriate method for exploring leadership strategies to maintain hospital business office productivity during a merger was the qualitative method.

Research Design

If the researcher selects an inappropriate research design then the data collected during the study may not address the research phenomenon (Yin, 2017). When conducting a qualitative study, researchers have different research designs to choose from such as narrative, ethnography, case study, and phenomenology (Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2017). Researchers can use a variety of research designs to collect, organize, and analyze data in different ways.

For an in-depth study that focuses on a circumstance at a set point in time, a researcher may select the case study research design. The case study research design allows a researcher to narrow the scope of an expansive research field into one researchable area and focus on a circumstance, occurrence, or practice at a given point in time with the intent to capture distinctive perspectives of human experience and behavior from a social perspective or natural worldview (Yin, 2017). Case study design engages in-depth topic investigation and analysis to promote the possibility of further research (Dasgupta, 2015). I selected the single case study research design because this approach allows the narrowing down of the scope of an expansive research field into one researchable topic to capture distinctive perspectives of human experience and behavior with in-depth study.

Researchers should select a research design that effectively addresses the research question and purpose of the study. Rahi (2017) posited a case study design is the preferred model whenever the researcher has little to no control over the events studied. Dasgupta (2015) maintained it is necessary to use the design that is fitting for their research questions and employ the case study design to answer questions of how or why a phenomenon occurs (Dumez, 2015; Tetnowski, 2015; Yin, 2017). I used a single case study design to explore leadership considerations for maintaining hospital business office productivity during a merger.

Carolan, Forbat, and Smith (2016) contended that using the case study design to gather data from numerous sources can aid in strengthening the integrity of the research results. Data collection from multiple sources is a distinctive feature of case study design.

Triangulation means that the researcher is using more than one method to collect data during a study (Leila, Sangeetha, Jepson, & Donovan, 2019). Data triangulation improves the integrity and validity of a case study by improving the reliability of the case study findings through the convergence of information from different sources (Yin, 2017). Researchers use triangulate evidence derived from observations, interviews, and reviewing historic documentation to strengthen a case study when examining real-time events at a set point in time (Creamer & Tendhar, 2016: Yin, 2017). The benefit of employing multiple sources of evidence is the ability to develop converging lines of inquiry (Patton, 1999). I collected data using numerous sources to include relevant hospital business office documents, participant's verbal and nonverbal responses, and participant interviews.

When determining the design for this research study, I considered ethnography, which involves studying people in their cultural context and the ways that culture influences their behavior as individuals or as a group (see Draper, 2015). Armstrong (2015) asserted the use of ethnography design can aid in examining the way social behavior in diverse ethnic groups may differ if observed over a period. Furthermore, Yin (2017) contended that the use of the ethnographic design can cultivate a single narrative that pertains to the entire population. The focus was on the strategies used by leadership to maintain hospital business office productivity during a merger process and not cultures; and therefore, ethnography was not appropriate for this research.

In addition, I contemplated a phenomenological design. Researchers who use the phenomenological design use discussions of experiences in a real-life context (Chan &

Walker, 2015). Phenomenological design aids with studying conscious experiences (Spaulding, 2015). As the emphasis of my study was not on the personal meanings of individual's experiencing a phenomenon, but rather on exploring perspectives and approaches that hospital leaders use to maintain business office productivity during a merger, the phenomenological design was not suitable in my study.

Raeburn, Schmied, Hungerford, and Cleary (2015) posited that the narrative design can be used to research a collection of participant's stories and record the interpretation of the participant's experiences. Raeburn et al. (2015) contended that when using a narrative research design, one communicates facets of a research participant's life story. The narrative design was not a fit for this study because capturing each participant's detailed life experience stories will not address the research question.

Smith (2015) asserted the use of grounded theory research design is to develop a theory. Researchers attempt to develop a theory based on a general abstract theory grounded in the perspectives of the participants (Rohde, Brodner, Stevens, Betz, & Wulf, 2014; Smith, 2015). For that reason, grounded theory research in not applicable because this research was not about establishing a new theory, and I am using a conceptual framework. Add a solid conclusion for the section.

Population and Sampling

The population for this study consisted of seven participants who are hospital leaders (e.g., executives, senior managers) of two midsized urban hospitals in the southeastern United States who have experience strategizing approaches to maintain business office productivity during a merger. A researcher's desired analytic level is a

determinant of the optimal target number of participants in a study (Apostolopoulos & Liargovas, 2016; Tran, Porcher, Falissard, & Ravaud, 2016). A population of management-level persons was appropriate for my research because executives, directors, and managers have a thorough and immediate understanding of business officer merger challenges (Emmel, 2015; Fugard & Potts, 2015). Population criteria are valuable to ensure that selected participants have experienced the phenomenon that is the focus of the research firsthand and can address the research questions (Rahi, 2017). The population supports the central research question because the selected participants for this research have experience and comprehensive knowledge strategizing approaches to maintain business office productivity during a hospital merger.

Emmel (2015) contended that employing a sampling method can aid in ensuring the appropriate selection of participants. The objective is to select participants who have knowledge and experience about the research topic (Emmel, 2015; Fugard & Potts, 2015; Rahi, 2017). Qualitative researchers use purposive sampling to explore and secure the objectives of a research problem and allow transferability of research findings (Marshall & Rossman, 2015; Yin, 2017). I used purposive sampling to select the study participants. I selected hospital leaders (e.g., executives, directors, senior managers) who qualify in two categories: (a) those who have experience developing strategies for maintaining business office productivity during a merger that were willing to share their experiences and (b) those who have experience devising business office procedural strategies.

Sample size indicates the number of participants a researcher will observe for the study (Marshall, Cardon, Poddar, & Fontenot, 2013). A decision about sample size is

critical for ensuring the integrity of the study, the gravity of the data, and the adequacy of the data to address the research topic (Roy, Zvonkovic, Goldberg, Sharp, & LaRossa, 2015). A small sample size is acceptable for qualitative studies (Palikas et al., 2015) and for purposive sampling (Yin, 2017). Use of a small sample size can be warranted for a researcher to realize quality and to gain a full understanding of a study phenomenon (Marshall & Rossman, 2016). Qualitative researchers can accomplish data saturation using a sample size in a range of five to fifty participants (Emmel, 2015). I selected at least seven hospital leaders who meet the requisite experience and knowledge among the total conceivable population of this single case study.

Fusch and Ness (2015) contended that data saturation is achieved when one can no longer uncover new information or new themes, and there is commonality in responses from participants (Fusch & Ness, 2015). Morse (2015) posited that achieving data saturation can aid in strengthening the integrity of qualitative research. Marshall et al. (2015) posited that the composition of sample size, rather than the size of the sample, facilitates data saturation. Saturation is the point in the interview process where the researcher ceases to identify new themes (Morse, 2015). Data saturation occurs when no new themes, concepts, or findings are evident during the data analysis process (Roy et al., 2015). I gathered data by interviewing seven or more participants and reviewing relevant organization documents. The interviews continued until there was no new information obtained and therefore ensure data saturation.

Qualitative researchers may justify their understanding of the data collected from interview responses with participants (Palinkas et al., 2015). Qualified participants can

offer data substantial enough to achieve saturation and to address the requisites of the study (Palinkas et al., 2015). Member-checking is beneficial for achieving data saturation (Fusch & Ness, 2015). Data saturation happens when interview responses begin to be replicated (Elsawah, Guillaume, Filatova, Rook, & Jakeman, 2015). Member-checking is a process by which a researcher follows up with participants to confirm the researcher's interpretations of the participants original responses in order to strengthen the validity and reliability of the study (Noble & Smith, 2015). Consequently, I used member-checking to validate the interpretation of interview responses to ensure no new themes.

Qualitative researchers use interviews to gather data from qualified participants with varying perspectives of the phenomenon being studied (Yin, 2017). I allocated 45 minutes to one hour for facilitating interviews giving reverence to the accessibility of the participants. Researchers use consent forms to safeguard confidentiality and assure participants' rights during the data collection process (Koonrungsesomboon, Laothavorn, & Karbwang, 2015). Participants in this study signed and returned the consent form found in Appendix C. I gathered data from interviews and relevant organization documents that included the hospital's website, the 5 year plan, and the master plan of the respective operating unit.

Ethical Research

The informed consent process requires explaining to all participants (a) the rationale of the research study, (b) how the research study might be useful to their organization, (c) the process for conducting the study, and (d) the voluntary nature of the planned study (Honig et al., 2014). I gave the potential participants verbal and written

information about the purpose and proposed advancement of the research. At that time, I gave potential participants the opportunity to pose clarifying questions or raise any concerns prior to giving their permission.

Obtaining the participant's consent was necessary to be compliant with informed-consent protocols (Bromley, Mikesell, Jones, & Khodyakov, 2015; Honig et al., 2014). Participants should understand that they can withdraw at any time with no risk of penalty regarding their participation (Honig et al., 2014). I notified study participants of their ability to withdraw their participation at any time. Making direct contact should be done to inform participants of any compensation methods that are applicable to the study (Bromley et al., 2015). There was no compensation for participating in this research.

It was vital that the ethical protection of participants be ensured as ethical challenges are encountered at all stages of research, (Honig et al., 2014). Ethical challenges that some researchers face during a study include confidentiality, anonymity, designing and reporting, and informed consent as well as the researcher's potential bias toward the participants (Bromley et al., 2015; Honig et al., 2014). The three primary areas of ethical concern in a research study where human subjects are involved include (a) justice, (b) autonomy, and (c) beneficence (U.S. Department of Health and Human Services, 1979). Giving ethical protection to participants can be achieved by employing three primary ethics principles stated in the *Belmont Report* (a) justice, which contains conceivable benefits for research participants, (b) autonomy, which establishes the participant's right to participate or not participate in the study, and (c) beneficence, efforts to minimize risk of harm to participants (Honig, et al., 2014; Zhou & Nunes,

2013). I observed *Belmont Report* principles to ensure the ethical protection of study participants. Bias is a significant risk that can distort study results or outcomes (Whiting et al., 2016). Making a conscious effort can aid in eschew biasing the participants (Gittelman et al., 2015). Excluding individual beliefs and opinions based on experience could aid in mitigating bias (Yin, 2017). I excluded my personal beliefs and opinions acquired from working in a hospital business office and evaluated the interview questions with a neutral third party that does not have a stake in the research study to ensure no bias.

It was necessary to consider ethical issues when conducting interviews (Gelling, 2016). Privacy and rights of participants should be protected while gathering data, storing data, and analyzing data (Levitt et al., 2017). At times, participants share concerns regarding confidentiality during the data collection process (Bromley et al., 2015; Marshall & Rossman, 2016). Consequently, I stored all electronic data on a password-protected computer and a strong box for a minimum of 5-years to ensure the confidentiality of study participants. Using electronic and digital formats can aid in preserving the security of research data (Alimo, 2015; Trace & Karadkar, 2017).

During the research process, I converted paper documents to a digital format via scanner as well as store the digital files on a secure external hard drive and shred all paper documents to protect the confidentiality of study participants. Research projects with inadequate quality research designs, weak data analysis, and deficient reporting of the research findings lack ethical backing (Brzezinski, 2016). The Belmont Report was a standard for IRB deliberations to ensure researchers conduct ethical research (Honig et

al., 2014). I conducted this study after requesting and receiving IRB approval from Walden University.

Confidentially preserving the identities of study participants can aid in sustaining anonymity and safeguard the integrity of research (Marshall & Rossman, 2016). Using pseudonyms to distinguish participants and organizations during research helps to maintain privacy, confidence, trust, and anonymity (Zhou & Nunes, 2013). Using alphanumeric categorizations such as P1 and P7 to signify the participants, correspondingly, and BUS1 or BUS2 to reference the hospitals correspondingly, should aid with anonymity and confidentially during the research process of this single case study design.

Data Collection

I was the primary data collection instrument in this research study. The researcher is the primary data collection instrument in qualitative research (Noble & Smith, 2015) because the researcher is directly involved with the research participants by observing the responses and interpreting the data (Marshall & Rossman, 2016; Yin, 2017). Interviews are effective to gather data for study participants with differing perspectives on similar topics (Marshall & Rossman, 2016; Yin, 2017).

A data gathering tool in this research was interviews consisting of asking the same set of open-ended questions to each study participant as recommended by Wilson et al., (2016). Interviews allow the effective collection of data from participants with differing perspectives on a similar subject (Wilson et al., 2016). Participants typically give detailed explanations when answering open-ended questions (Kornbluh, 2015; Yin,

2017). I asked open-ended questions (see Appendix D) while conducting the interviews to explore leadership strategies for maintaining hospital business office productivity during a merger.

The interview protocol for this study consists of identifying study participants, establishing the length of the interview, and concentrating on the participants' experience (Castillo-Montoya, 2016). Due to the COVID-19 pandemic, I did not use face-to-face interviews since this type of research was not considered an essential activity. Instead, I ethically employed video conferencing and phone interviews.

The participants e-mailed a signed copy of the informed consent form confirming their informed consent to participate as an unpaid volunteer. The interview protocol assisted in collecting data for this study and included (a) a reminder to give the participants a consent form if they volunteer to participate, (b) a script of what I said before the interview, (c) a list of interview questions, (d) a script of what I said at the end of the interview, and (e) a reminder to ask the participants if they would like any information pertaining to the interview as recommended by Jacob and Furgerson (2012). The final step of the interview process was data analysis, which involves identifying the themes and codes related to the transcripts from the interview (Castillo-Montoya, 2016).

Using documents can be a tool for collecting data (Marshall & Rossman, 2016; Smith, 2016). In addition, conducting a single case study using organization documentation can provide evidentiary support to the interviews (Kornbluh, 2015; Yin, 2017). I used organization documents such as monthly accounts receivable reports and

five year strategic plan documentation as additional data collection instruments. Archival documents offer historical information and can strengthen the value of a case study (El Haddad, 2015). Gathering data from varied sources can aid in achieving triangulation (Baskarada, 2014; Santiago-Delfosse, Gavin, Bruchez, Rous, & Stephen, 2016). Using triangulation while interpreting research data diminishes the threat to validity (Marshall & Rossman, 2015; Noble & Smith, 2015; Yin, 2017). I accomplished triangulation by using data triangulation.

The combination of member-checking and triangulation increases the reliability and validity of a case study (Baskarada, 2014; Santiago et al., 2016; Yin, 2017). Additionally, data saturation has been achieved when themes become recurrent or have excessive similarity (Kornbluh, 2015; Yin, 2017). I gave study participants a chance to review and modify responses at the conclusion of each interview. Member-checking consists of follow-up discussions that benefit researchers by strengthening the reliability and validity of the study (Noble & Smith, 2015; Yin, 2017). To ensure reliability and validity in the data collection phase, I asked open-ended questions (see Appendix: B) and use member-checking, triangulation, and I monitor themes for data saturation.

Data Collection Technique

After obtaining IRB approval from Walden University, I initiated the process of confirming study participants. Due to the COVID-19 pandemic in 2020 data collection techniques were modified. Interviews were conducted virtually via video conference and phone interview platforms that provide video and audio output, as well as recording functionality and/or transcript generation. These virtual meeting platforms are secure, and

I can digitally record each session. I conducted video conference or phone interviews with the participants at a time and location where confidentiality can be protected. The data collection process involved making initial contact with the study participants by both phone and email, planning and conducting the video conference or phone interviews, and recording and documenting exhaustive notes throughout the interview process. These steps are in accordance with suggestions made by Gergen, Josselson, and Freeman (2015). After the consent forms were signed, I conducted virtual interviews. Participants chose a designated location where they were assured privacy and confidentiality was protected.

Methodological triangulation merges various types of data collection (Ruiz, Martinez, & Bravo, 2016). Qualitative research involves an assortment of data collection methods such as face-to-face discussions, reviews of archived and current documentation, questionnaires, observation, and focus groups (Pasila, Elo, & Kääriäinen, 2017). Using the within-method can assist in achieving triangulation by exercising at least two data collection methods and the same design (Hussein, 2015). I used methodological triangulation to include multiple methods of data collection.

Detailed data collection in a qualitative study includes various research tactics such as survey, document and artifact review, observation, and interviews (Gergen et al., 2015). There are many ways of conducting investigational research when using the qualitative method, but the common types are observations, review of documents, and interviews (Marshall & Rossman, 2016; Yin, 2017). One of the popular forms of data collection for reaching data saturation for qualitative research was interviewing (Cairney

& St Denny, 2015; Fusch & Ness, 2015). Using interviews was a primary method of data collection during a qualitative study (Marshall & Rossman, 2015). Face-to-face interviews are the favored qualitative data collection method (Kornbluh, 2015). Consequently, I used face-to-face or virtual interviews to explore leaderships' strategies for maintaining hospital business office productivity during a merger.

With the respondent's permission, I conducted interviews virtually via video conference or phone interview that provide video and audio output. These virtual meeting platforms are secure, and I can digitally record each session. I used the recorded content of those interviews to enable automated cataloging and analysis (Fredrick, 2015; Patton, 2015). Digital recording and documenting respondent's body language are effectual methods for qualitative data collection (Rosenblum & Hughes, 2017). These virtual platforms can generate transcripts of each session. Transcribing was comprised of interpersonal (the relationship between researcher and participants), experiential (action or event), and interpreting text data (transcribed data) components (Yin, 2017).

Some of the benefits of qualitative researchers using interviews include (a) obtaining in-depth responses from participants, (b) obtaining exhaustive data about the study participant, (c) asking questions in detail (Yin, 2017). Some disadvantages to using interviews could be (a) answers may not accurately reflect the participant's genuine perspectives or opinions and (b) respondents may sense discomfort answering questions in a formal location (Yin, 2017).

Accumulating and assessing organizational documents is included in qualitative studies (Kornbluh, 2015; Marshall & Rossman, 2016; Yin, 2016). Gathering data from

documentation can enhance interviews (Kornbluh, 2015; Yin, 2017). I used archival documentation such as a five year strategic plan to strengthen study findings.

The benefits of using organization documentation include: (a) the researcher can access information that is not available to the public on a hospital's website or CMS.gov, and (b) the researcher has the ability to review information numerous times to ensure accuracy (Kornbluh, 2015; Yin, 2017). Some of the disadvantages of reviewing documentation during a study are: (a) participants may not want to divulge documentation they feel may be confidential, and (b) the documentation could be outdated concerning the topic of study (Kornbluh, 2015; Yin, 2017). Using archival records, physical artifacts, and documentation could aid in triangulating the available data, but the data may be redundant (Yin, 2017). Using organization documents, interview data, and observations are essential to achieving triangulation (Marshall & Rossman, 2016; Yin, 2016). I used methodological triangulation by observing and documenting participant's body language, review company documents, and recording participant's responses to interview questions,

Member-checking refers to the research practice of securing feedback from study participants to strengthen the accuracy, validity, applicability, and credibility of interpreted responses (Emrich, 2015; Nyhan, 2015). Recording interviews can aid in ensuring study participants' responses are accurately captured and described (Yin, 2017). Using a member-checking process, I provided participants the occasion to review and edit my written version of their responses to guarantee accuracy.

Data Organization Techniques

I organized recordings derived from video conference or phone interviews to identify recurring themes. Trace and Karadkar (2017) posited the significance of data organization because researchers may benefit from stored data when they analyze the data to understand developing themes. New themes can become apparent during the coding process (Chowdhury, 2015; Pasila et al., 2017; Yin, 2017). I categorized themes using a coding process. Using digital formats and electronic files can aid in keeping the information safe (Alimo, 2015). Converting paper documents via scanner into electronic files in order can aid in organizing the data (Trace & Karadkar, 2017). I scanned paper records in digital files then safeguard the digital files in a password-protected electronic folder and after 5-years, I shredded the paper files after conversion to preserve confidentiality of data and participants.

Thomas (2015) posited that qualitative researchers exercise a filing method to preserve confidentiality and strengthen integrity. Multiple copies of the data into different formats and locations such as pen drives, cloud drives, and hard drives may help to recover data should a disaster occur (Madu, 2016; Trace & Karadkar, 2017). Study participants frequently share a concern for anonymity and confidentiality during the data collection phase of a study (Bromley et al., 2015; Marshall & Rossman, 2016). I preserved all electronic data in a password-protected external hard drive and secure the hard drive containing all digital data in a combination strong box for a minimum of 5-years, before deletion.

It is important that qualitative researchers classify stored data (Alimo, 2015; Yin, 2017). Using a coding system can aid in maintaining the integrity, validity, and quality of research (Ingham-Broomfield, 2015; Thomas, 2015; Yin, 2017). I used a coding system to categorize and organize the text into small groups of content, find evidence of the code, and assign the code to a tag. For example, I used specific labels such as P1 to categorize study participants to refer to participant 1 or P7 to correspondingly categorize participant 7. I would label the hospitals as Bus1 and Bus2 respectively.

I arranged the information to ensure that I preserve the confidentiality of the data. I organized data properly when recording the research process, create checklists, and use computer software to store the data (Alimo, 2015). I coordinated research data using Atlas ti 8th edition (Nassaji, 2015; Stuckey, 2015). I used Atlas ti 8th edition for Windows to store the data for the study and use Atlas ti 8th edition's qualitative data organization software to upload and analyze data from Atlas ti 8th edition. Using Atlas ti 8th edition could aid in storing and organizing data within a study (Sarma, 2015; Woods, Paulus, Atkins, & Macklin, 2015). Using password-protected digital files with unique identification numbers could preserve data privacy and confidentiality (Alimo, 2015). To maintain security and confidentiality, I arranged the information in password-protected digital files.

Data Analysis Technique

For data collected from study participants, I performed data analysis using the four stages of the constant comparative method to include: (a) comparing the incident's applicable to each category, (b) integrating categories and their properties, (c) delimiting

the theory, and (d) writing the theory (Vaughn & Turner, 2016). Organizing the data and applying meaning to the data is the beginning of the systematic process when analyzing qualitative data (Vaughn & Turner, 2016). The four triangulation types are (a) data triangulation, (b) investigator triangulations, (c) triangulation of theory, (d) method triangulation, and (e) environmental triangulation (Yin, 2017). Using triangulation could aid in collecting and analyzing data from numerous sources such as interviews and documents (Joslin & Müller, 2016; Spadafino et al., 2016, Yin, 2017). Conducting a case study should include using multiple sources of evidence (Yazan, 2015). I used methodological triangulation to analyze data from each interview and company documents such as annual reports and a 5-year strategic plan. To protect the identities of study participants, qualitative researchers use pseudo coding designations (Cleary et al., 2014; Emmel, 2015). Qualitative researchers use coding to strengthen data analysis, reliability, and validity (Stuckey, 2015; Yin, 2017). I used pseudo coding designations made of alphanumeric categorizations such as P1 and P7 to signify the participants, correspondingly, and BUS1 or BUS2 to reference the hospitals correspondingly to protect the identity of the study participants as well as identify key themes that emerge from the interview process.

Transcribing the data collected and member-checking during the data analysis are essential activities. Employing video conference and phone interview platforms provides automatic transcriptions of each session. Transcribing data is an act of data representation, analysis, and interpretation in such a way that it has a significant influence on the conceptualization of the data (Emmel, 2015). Using a member-checking process, I

used transcribed responses to the interview questions and send to the study participants to ensure that my interpretation was correct. Using member-checking could improve the credibility, validity, accuracy, and applicability of qualitative research by giving participants an opportunity to verify the accuracy of the data collected (Yin, 2017). I started the data analysis process once study participants approve that my interpretation was accurate.

I used Yin's (2017) five phases to analyze the data. These include: (a) compilation, (b) disassembly, (c) reassembly, (d) interpretation, and (e) closure. Qualitative researchers can analyze and transcribe research data using Atlas.ti 8th edition for date storage and organization (Nassaji, 2015; Plamondon, Bottorff, & Cole, 2015; Stuckey, 2015). I entered interview recordings into Atlas.ti 8th edition. Using qualitative software like Atlas.ti 8th edition could aid in sorting, categorizing, and arranging data during data analysis (Stevens, Moser, Köke, van der Weijden, & Beurskens, 2017; Thiem, 2015; Wood, Gnonhosou, & Bowling, 2015; Woods et al., 2015; Zamawe, 2015). I used Atlas.ti 8th edition during the data analysis process to assemble data into a coherent order.

I disassembled the data into smaller sets after compiling the data. Disassembling data means making practical groupings after separating the data (Castleberry & Nolen, 2018). Using coding could protect the data of participants and establish the relationships between the coded information and the phenomenon (Emmel, 2015; Kelsey, Karen, & Hude, 2017). Coding is often used by researchers to disassemble and reassemble data

(Castleberry & Nolen, 2018). After disassembling, I had smaller data sets to create meaningful groupings.

After disassembling the data, I reassembled the information into groups for coding (Castleberry & Nolen, 2018). In a qualitative study, the identification of themes is an important phase (Kelsey et al., 2017). Using coding could establish the relationship between the coded information and the phenomenon being studied (Emmel, 2015). Using thematic analysis, which requires an interpretation and integration of themes, I analyzed the data after reassembly. Interpreting data could aid in identifying themes using thematic analysis involving the abstraction and synthesis of themes (Castleberry & Nolen, 2018; Padilla-Diaz, 2015). Castleberry and Nolen (2018) noted that using the experience of participants could aid identifying the themes and relate themes to phenomena.

Upon arranging the data, analyzing the data broadly, and discovering regularities, I confirmed the conclusions and determine what trends stand out in the data between the responses of the participants. Using quotes from respondents could aid in obtaining credibility (Madu, 2016). Using member-checking could aid in enhancing the validity of research findings (Emrich, 2015; Nyhan, 2015). Oghuma, Libaque-Saenz, Wong, and Chang (2016) referenced correlating the concepts associated with the literature and the theoretical context. Eventually, with the accompanying literature and the analytical context, I compared relevant topics from interviews and relevant company reports. The data analysis results can provide successful strategies for innovation used by hospital leaders to maintain business office productivity during a merger. After concluding the tutorials for NVivo and Atlas.ti software, I decided to use Atlas.ti 8th edition software to

aid in sorting, organizing, and arranging data collected during the study. I based my selection on Atlas.ti 8th edition being a more user-friendly software for coding data analysis to establish themes, and to sort, manage, and analyze the data I collected during interviews, direct observation, and review of documents.

Yin (2018) suggested employing flowcharts to categorize the association between themes. I followed Yin's suggestion. I used reflexivity to evaluate themes I identified in the interview, through direct observation, and other documents. I continued to analyze the data for emerging themes until data saturation was achieved. Where applicable, I used verbatim quotes of participants to support data analyses. The research question is congruent with the aim of the research. The style of the research question is different than the style of the interview questions; as the research questions formulates what I want to understand; whereas, the interview questions are what I ask participants to gain that understanding (Brinkmann and Kvale, 2015). Patton (2015) posited that the hope of the interviewer is to elicit relevant answers that are meaningful and useful in understanding the interviewee's perspective. Inquiry-based questions were used to gain specific information related to the aims of the study (Patton, 2015).

To determine the desired goal for the business office productivity strategies used during the merger, I asked the question most connected to the study's research question, for example: "What strategies did you implement to maintain business office productivity during the merger at the operating unit for which you are responsible?". This question was asked in the middle of the interview after building a rapport with the participant as recommended by Yin (2018).

To determine what the expected outcome of combining the two business offices, I asked: “What was the primary expected benefit of the merger within the business office?” To establish a frame of reference for what would be considered a successful merger of the two business offices, I posed the question: “How did you safeguard against overestimating the expected benefit of streamlining redundant processes that result from combining two business offices?”

By requesting the participant to explain any restructuring of organizational processes to improve service, speed, accuracy, and/or cost performance, I began to establish the procedures employed to maintain business office productivity during and merger, and the reasoning behind them. I attempted to understand the method of evaluating each business offices practices existing prior to the merger by asking “What types of measurement was used to understand the existing practices prior to the merger?”. By asking “How would you describe the personnel interaction or cooperation between the two merging entities during the merger process?”, I gained an understanding of the working culture between the combining offices.

I determined the three challenges to maintaining business office productivity during a merger by exploring the perspectives of participants regarding their respective responsibilities for both the acquiring and acquired business office by inquiring “What strategies did the organization for which you are responsible address the top three challenges to maintaining business office productivity during the merger?”.
I established the units of measurement for successfully maintaining business office productivity during a merger by asking “How did you measure business office

productivity success at the completion of the merger?" By asking "What else would you like to add that we have not yet discussed regarding the strategies used to maintain business office productivity during a merger?", I captured data not specifically requested in previous interview questions. The key focus of this study was exploring strategic knowledge considered by hospital leaders to develop strategies for maintaining business office productivity during a merger based on BPR.

Reliability and Validity

During data collection, ensuring the accuracy and validity of data are equally important (Noble & Smith, 2015). Validity refers to the extent in which the results accurately reflect the data and reliability refers to the validity of the analytical procedures, including differences in personal and analysis methods that may have affected the findings (Noble & Smith, 2015). Reliability, credibility, transferability, and confirmability are the basic criteria for achieving quality and rigor in a qualitative study (Marshall & Rossman, 2016). Such parameters must be established using subjective approaches such as member-checking and triangulation (Noble & Smith, 2015).

Member-checking is the process of reviewing study participant's ideas of confirmation and collecting materials to develop categories (Emrich, 2015; Nyhan, 2015). Reliability and validity were typically characteristic of quantitative researcher studies (Kasim & Al-Gahuri, 2015), but contemplating dependability, credibility, transferability, and confirmability reliability and validity are reconsidered qualitative research criteria (Avenier & Thomas, 2015; El Hussein, Jakubec, & Osuji, 2015). I used reliability and validity criteria to strengthen this study.

A clear reflection of the collection, sampling, and analysis of data can increase validity and reliability (Kasim & Al-Gahuri, 2015). The strategies used to maintain validity and reliability include (a) recognition of personal biases, (b) audio and video recordings of video conference or phone interviews with participants, (c) use of peer reviews for questions or debriefing, (d) use of member checking, and (e) data triangulation (Morse, 2015; Noble & Smith, 2015). Additional strategies such as prolonged engagement, rich description, negative case analysis and external audits aid with conducting proper research (Morse, 2015).

Reliability

It is important to collect data of high quality. Reliability refers to the accuracy of the analytical methods, including personal and analysis process biases that may affect the findings (Morse, 2015; Noble & Smith, 2015). Using objective research information can aid in achieving precision in qualitative studies (Yin, 2017), and if the study data is not biased, achieve reliability (Morse, 2015). Research results that can be repeated have achieved reliability (Noble & Smith, 2015). Case study research is reliable if a future researcher or auditor can draw similar conclusions after repeating the procedures (Yin, 2017). Focusing on achieving reliability could aid in the repetition of the results by future studies ((Noble & Smith, 2015).

Dependability is a concept that means the demonstration of reliability in a qualitative study (Connelly, 2016; Yin, 2017). Dependability refers to the reproducibility of study findings through a transparent process containing limitations and the study's anticipated contribution (Connelly, 2016; Yin, 2017). Ways to improve a study's

reliability include data interpretation, member-checking, transcript review, pilot testing, interview question validations by experts, interview protocol, focus group protocol, and participant observation protocol (Marshall & Rossman, 2016; Yin, 2017). A qualitative analysis allows a researcher to ensure reliability and continuity throughout the research process (Connelly, 2016). Reliability guarantees that the findings of a qualitative study are dependable (Yin, 2017). The use of member-checking in a qualitative study demonstrates the accuracy and quality of the information provided by the participants (Emrich, 2015; Nyhan, 2015).

Using an audit trail process, I can ensure reliability (Connelly, 2016). Marshall and Rossman (2016) determined member-checking as suitable for enhancing academic accuracy. By checking, creating, and maintaining an audit trail of the research process, I ensured reliability. I used an interview protocol (see Appendix B) to create and maintain research notes and adhere to the order of the study. Dependability can be accomplished through a step-by-step process from the collection of data to the final study decision (Connelly, 2016). I used the interview protocol to ensure dependability (see Appendix B). I used consistent data methods to ensure the reliability of this study. Using the same open-ended interview questions and asking questions with each participant in the same order, enhances reliability (Yin, 2017). For each interview, with a least seven respondents, I used the same interview questions before achieving data saturation. By following the interview protocol (see Appendix B), I collected interview data with a set of interview questions and ensure reliability.

Encoding, audio recording, and note taking enhance reliability (Yin, 2017). It was imperative that participants consented to the audio and video recording of the interviews in order to ensure validity and reliability of research (Mitchell et al., 2018; Wright et al., 2018; Yin, 2017). I obtained permission from the participants to audio and video record the interviews to ensure reliability and validity of the study. Member checking is a process involving participants in a review of the interview summary, verifying the emerging themes, and inferences by asking participants to offer reasons denoted in patterns (Birt, Scott, Cavers, Campbell, & Walter, 2016; Nyhan, 2015; Smith & McGannon, 2018; Yin, 2016). Member checking improves validation because it decreased the chance of misinterpreting the data (Carlson, 2010). Employing member checking establishes credibility and reduces internal threats to the study (Bygstad & Munkvold, 2007). I received input from the respondents on my interpretation of the interviews and was assured that there were no misrepresentations

Saturation of data helps ensure the dependability of the findings of the study (Yazan, 2015). Methodological triangulation enhances the results of qualitative research because the data collected comes from different sources (Marshall & Rossman, 2016; Yin, 2017). In a study, triangulation is the way to achieve dependability (Yin, 2017). I achieved methodological triangulation by analyzing relevant company documents, body language of the participants, and connected these to the answers to the interview questions.

Validity

Validity is a measure of truth and honestly when the research results are used to accurately represent the data (Bengtsson, 2016; Noble & Smith, 2015). Qualitative study validity refers to the credibility, transferability, and validity of the findings (Brown et al., 2017). In qualitative research, credibility and transferability are associated with validity, while confirmability is a theoretical viewpoint of objectivity (Kornbluh, 2015; Yin, 2017).

As a follow up to the interview process, I used member checking to enhance reliability and validity of the data instruments in the study. Member checking involves study participants reviewing the researcher's interpretation of data and validation of emerging themes (MacPhail, Khoza, Abler, & Ranganathan, 2016). Member-checking and consistent participant analysis during interviews improve the credibility of research results (Marshall & Rossman, 2016).

Triangulation enhances the reliability and integrity of a case study by improving the research findings' credibility (Kornbluh, 2015; Yin, 2017). There are a wide range of triangulation types, such as information triangulation, investigator triangulation, theoretical triangulation, and methodological (Marshall & Rossman, 2015; Noble & Smith, 2015; Yin, 2017). Methodological triangulation increases credibility (Fusch & Ness, 2015) and supports qualitative researchers in gaining different participant's perspectives during the study.

Data triangulation is a way to explore different levels and viewpoints of the same phenomenon and a way of ensuring the validity of the results of the study (Fusch & Ness,

2015). Wilson et al. (2016) determined researchers use methodological triangulation to explain data and improve the quality of research findings. Theoretical triangulation is beneficial for capturing the shifting role of expertise (Burau & Andersen, 2014). All types of triangulation are useful for the consistency of qualitative data analysis if a researcher is aware of the applicability of the research design to the type of triangulation chosen (Yin, 2017). Methodological triangulation can improve the validity and credibility of a research study because the process includes cross-checking information using two or more methods can give greater credibility (Lodhi, 2016). Therefore, to maintain validity and credibility, I used methodological triangulation. In general, I cross-checked the responses to interview questions, and information from organization documents such as annual reports and a 5-year strategic plan.

Transferability occurs if study readers can agree on the applicability of research findings in other settings (Bellemare et al., 2018; Bryman & Bell, 2015; Korstjens & Moser, 2018; Sinclair et al., 2018). Transferability depends on the decision-makers' judgment (Bærøe, 2018).

I used the same interview protocol for each participant. Transferability can be accomplished by data saturation (Yin, 2017). Failure to achieve data saturation affects the quality of the research carried out and hinders the validity of the content (Fusch & Ness, 2015). Data saturation evidence is important to improve the validity of a qualitative study (Morse, 2015; Noble & Smith, 2015). Data saturations is achieved once no new data is found, no new themes arise, no new coding is necessary and other researchers can replicate the study (Fusch & Ness, 2015). I must ensure the achievement of data

saturation to assist prospective readers and researchers in making decisions about the transferability of the research results.

There is a direct link between triangulation of data and data saturation. Data triangulation is a method of data saturation (Fusch & Ness, 2015). Data saturation occurs when the information gathered for an analysis exceeds a breadth and depth point (Morse, 2015; Noble & Smith, 2015). Saturation of data occurs when the information collected is redundant or repetitive (Fusch & Ness, 2015) and the quality of the interview questions, the extent of the research experience in qualitative research, the methodological understanding of the process, and the use of a guiding conceptual framework are also important aspects of achieving data saturation (Aldiabat & Navenec, 2018).

I used different steps to achieve data saturation, including (a) reading and analyzing interview transcripts and/or recordings, (b) writing each question and synthesizing interview data in one sentence, (c) providing each participant with a copy of the synthesis, (d) requesting input from participants as to whether the synthesis reflects the answers correctly or whether there was additional information, (e) verification and correction of data definitions based on participant responses, and (f) member checking until there was no new data to collect.

Confirmability can be accomplished when the same information can be used by other researchers to collaborate the results (Marshall & Rossman, 2016). Data neutrality and accuracy ensure objectivity and confirmability (Houghton et al., 2013). Achieving neutrality and precision through their theoretical documentation, could aid in reaching a decision (Houghton et al., 2013). In order to achieve confirmability, Bekhet and

Zuszniewski (2012) maintained neutrality and objectivity. Research data should accurately reflect the responses of the participants (Yin, 2017). Researchers can provide quotes from participants to enhance authenticity (Cope, 2014). I must ensure confirmability by being neutral and objective throughout the research process, provide an audit trail, and use quotes. Identifying the conclusions and interpretations of the responses could aid in achieving confirmability (Cope, 2014). I must adhere to the study's purpose of ensuring data confirmability by pursuing the study's goals, using interviews, recording audio and video from video conference or phone interviews, using member checking, and sharing some direct quotations from participants to improve confirmability.

Sample size does not guarantee data saturation (Fusch & Ness, 2015). Even with a limited but sufficient sample, a researcher can achieve data saturation if the sample includes experts in the field of interest (Morse, 2015). Through maintaining a small sample size of seven participants, I can ensure that I achieve data saturation and ensure that all participants have expertise in maintaining business office productivity during a merger. To increase reliability, researchers must prevent bias in their study (Morse, 2015). Researchers must ensure validity of the analysis and the conclusions demonstrated using a qualitative method (Hammarberg, Kirkman, & de Lacey, 2016). To increase the likelihood of accuracy, this study involved verifying the data with participants.

Transition and Summary

In Section 2, I discussed the (a) role of the researcher; (b) participants; (c) research method and design; (d) population and sampling; (e) data collection instruments;

(f) data analysis; and (g) credibility, transferability, dependability, and confirmability. Section 3 contains (a) an overview of the study, (b) the presentation of findings from the research, (c) the professional application of the findings, (d) implications for social change, (e) recommendations for action and future research, (f) personal reflections, and (g) conclusions.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative single case study was to explore leadership considerations for maintaining hospital business office productivity during a merger. Using Hammer's (1990) BPR theory as the conceptual framework, I explored the considerations of leaders from the business offices of two merging hospital systems in the southeastern section of the United States who were successful maintaining business office productivity as they facilitated a merger of the two hospitals. Study participants indicated several considerations that contributed to maintaining the business office productivity, including delivering unified and consistent messaging during the merger. Section 3 includes the presentation of the findings, application to professional practice, and implications for social change. Also included in Section 3 are recommendations for action and additional research, personal reflections, and the conclusion of the study.

Presentation of the Findings

The intent of this qualitative single case study was to answer the central research question: What strategies do hospital leaders use to maintain hospital business office productivity during a hospital merger? To answer the question, I conducted virtual interviews, in compliance with COVID-19 pandemic protocols, with seven hospital business office leaders, comprised of the acquiring hospital referred to as Business 1 (B1), and the acquired hospital referred to a Business 2 (B2), which are both headquartered in the southeastern section of the United States. I also reviewed relevant current and archival documentation. B1 is a midsized urban hospital system with 12

operating units and 25,000 employees. This hospital is a recognized medical industry leader in the southeastern United States and globally. B1 has merged with or acquired several hospital systems between 1995 and 2020. B2 is a smaller 600 bed, three operating unit hospital system with 4,000 employees.

Seven leaders comprised of leaders from B1 and B2 received invitations to participate in the study. The criteria for selecting participants included hospital leaders who worked for both the acquiring hospital's business office and the acquired hospital's business office and were successful in maintaining business office productivity during a merger. Of the seven hospital leaders who received invitations to participate, all seven were available to participate. Of the seven participants, four worked in the business office of the acquired hospital, and three worked in the business office of the acquiring hospital. Study participants positions ranged from manager to vice president, to chief financial officer (CFO). I achieved data saturation and no new themes emerged (see Marshall et al., 2013).

I conducted and recorded the interviews via virtual electronic communication platforms including Microsoft Teams and Zoom. The seven participants responded to nine open-ended interview questions listed in an interview protocol (see Appendix A). Interviews lasted no longer than 45 minutes. Throughout the interviews, each contributor shared personal experiences, perspectives, and anecdotes from their respective positions within the business office regarding the strategies they used to maintain business office productivity during the merger. During this process, I referred to all participants using coded names, such as Participant 1 (P1), Participant 2 (P2), and so forth.

After the interviews, I thanked the participants for their contributions to the study. I then transcribed the recorded interviews and e-mailed the transcripts to the participants with an appeal that they assess the transcripts for accuracy within a week. Next, I conducted member-checking interviews using a virtual electronic communication platform. The member-checking process involved giving the participants one-paragraph interpretations that I created for each of their responses to the open-ended interview questions. The purpose was to confirm my interpretations conveyed what they intended. This process also gave the participants an opportunity to contribute additional material about the research topic, which further assisted me in achieving data saturation.

Case study research includes the use of data triangulation, which involves gathering data from numerous sources (Krichanchai & MacCarthy, 2017). Examples include interviews, participant observations, archival records, and documentation (Yin, 2018). I substantiated the data I collected throughout the virtual interviews by reviewing hospital documents. The documents included the hospital's website, CMS reports on the hospital's performance.

After completing the data collection process, I followed Yin's (2018) five-step process for qualitative data analysis that involved compiling, disassembling, reassembling, interpreting, and concluding. I began this process by transferring all interview data into Microsoft Word where I manually coding and analyzing the data to identify key themes. I then transferred the data into the Atlas ti 8th edition qualitative analysis software program for computer-aided coding, interpretation, and theme development.

I evaluated the themes that developed from my computer-aided and manual data analysis processes. Four themes emerged related to the research topic: (a) leadership presented unified and consistent messaging, (b) leadership shared outsourcing advantages, (c) leadership was purposeful in alleviating staff's fear of the unknown, and (d) leaders were proactive in addressing even potential challenges. Each of the four themes validated common themes from the literature review for this study. Several participant's responses reinforced Cameron et al's. (2016) change management theory, which suggests that resistance to change can stem from the appearance of a neglectful opportunity of leadership to demonstrate an appreciation for the efforts of staff during the transition. Participant 4 reinforced this idea by suggesting that leadership who ignore the efforts of staff to achieve the goals for the business office find a waning enthusiasm for the change and often an overt rebellion toward the change. Most participants reinforced change management theory by emphasizing the need for leadership to deliver consistent messaging about how to view the upcoming changes that will arise because of the merger. All participants suggested that employs who understand their responsibilities, who feel valued, tend to commit to the change and apply themselves to o maintaining business office productivity with a positive attitude. Those employees can serve as personal ambassadors for the merger when speaking with coworkers, and other stakeholders.

Theme 1: Leadership Presented Unified and Consistent Messaging

All participants remarked that the unified and consistent messaging provided by hospital leadership enabled the employees to maintain focus on achieving the

productivity goals established throughout the merger (see Table 1). Hospital leadership must establish unified and consistent messaging when communicating with employees about processes, goals, expectations, and appreciation related to business office productivity. The best way for hospital leadership to develop unified and consistent messaging to employees is to prioritize employee comprehension (Al-Ali et al., 2017). The study outcomes indicated that hospital leadership who adhered to a unified and consistent messaging during the merger, inspired staff to maintain focus on productivity to the hospital's benefit.

Table 1

Coding of Participants' Responses Related to Themes

Themes	Participants[a]	Responses[b]
1. Unified and Consistent Messaging	7	7
2. Openly Shared Outsourcing Advantages	7	8
3. Alleviating fear of the unknown	7	9
4. Proactively address potential challenges	7	9
Total (duplicated)	28	33

Note, [a] Number of hospital leaders who contributed responses linked to the themes. [b] Number of interview questions for which participant responses linked to the themes.

Participant 1, Participant 3, Participant 4, and Participant 6 suggested that a unified and consistently delivered message established by hospital leadership reinforced the notion that the business office of the acquiring hospital and the business office of the acquired hospital should begin to see themselves as one combined entity. For example, Participant 4 emphasized that a mantra of "no separation" was repeatedly vocalized by hospital leadership during collaborative meetings of both entities business office personnel from the initial stages of the merger. Participant 3 added that even lower level staff would

begin to volunteer the “no separation” messaging on their own during the meetings. Although there was still uncertainty surrounding the future state of the combined business offices, Participant 3 said staff appreciated the reassurance that the combined entity was view as one team. Participant 3 also explained that many employees at both B1 (the acquiring hospital), and B2 (the acquired) hospital business offices were initially uncertain as to whether they would be view differently than their counterparts on staff with the other operating unit’s business office. Participant 3 said the reassurance allowed staff to maintain focus on achieving productivity standards. Participant 1 described how the removal of ambiguity in expectations bolstered employee retention during the transition because the consistent messaging increased the staff’s comfort level with the merger process. Hospital documentation confirmed participant’s assertions regarding a unified and consistent messaging.

The findings of this study support the peer-reviewed sources in the literature review. Hospital leaders who provide a unified and consistent messaging can augment the employee’s morale, and productivity (Al-Ali et al., 2017). As staff labor to maintain business office productivity during the merger, they appreciate hospital leadership removing uncertainty by being unified and consistent in the messaging regarding the merger (Tabibi et al., 2015). Unified and consistent messaging such as “no separation” and “address the issue before it becomes a problem” can fortify employee’s commitment to the organization’s goals (see Tabibi et al., 2015). The findings of this study also bolster the conceptual framework, BPR theory, as consistent messaging regarding the processes set forth, leads to employee’s ability to adapt to change and focus on priorities (see

Hammer, 1990). Being deliberate about messaging is one strategy that leadership can use to maintain hospital business office productivity during a merger.

In addition to repeating consistent messaging in a unified manner, hospital leaders have identified the significance of delivering on the promise of those messages. Participant 7 offered that treating staff as one unit after proclaiming there was "no separation" between the two combining business offices, created buy-in to the culture change and process modifications during the transition. Participant 5 and Participant 4 both identified key components of the messaging to be developed during the merger, including positive affirmations, admonishments, and process descriptions.

Participant 2 also cited the importance of habitual messages of employee appreciation as a priority for hospital leadership. For example, during daily huddles, business office leaders were tasked with finding someone to celebrate in front of their peers; thereby reinforcing the message that effort will be recognized and rewarded. Equally important to habitually appreciating employees in front of their peers is having the messaging to show appreciation to employees individually. Participant 2 indicated that if an employee consistently met their productivity goals, they as a leader was diligent to send a message of appreciation for the effort.

These findings corroborate the literature on resistance to change. Hospital leaders who deliver unified and consistent messaging can assuage resistance to change that is a characteristic recognized in employees during mergers (Hornstein, 2015). Hornstein (2015) posited that consistency is a significant component of effective messaging because employees who receive repeated unified and consistent messaging from leaders are more

likely to remain engaged and focused. In addition, hospital leaders acknowledge the benefit of a consistent message of appreciation, admonishment, or direction (Hornstein, 2015). Unambiguous messaging benefits the organization by enhancing employee's ability to withstand the uncertainty of the future state of an organization experienced by employees during a merger (Hornstein, 2015). Employees who can defy that uncertainty can focus on maintaining productivity standards (Al-Ali et al., 2017). Add summary and synthesis throughout the paragraph.

Another aspect of unified and consistent messaging involves hospital leadership being transparent in their messaging. Participant 4 said that consistently vocalizing appreciation for employees' efforts has been a great way for leaders to incentivize employees to not only achieve their productivity goals, but to exceed them. Employees who feel appreciated by their leaders are more likely to buy-in to the changes being made during the merger and apply maximum effort for the duration of the transition (Kirrane et al., 2017). Even seemingly trivial messaging, such as a "good job" in passing has improved employee's determination to achieve productivity standards during the business office merger.

Theme 2: Leadership Openly Shared Outsourcing Advantages

Participants noted the willingness to share information typically not shared regarding outsourcing and leveraging established relationships with respective outsource vendors alleviated burdensome processes and released employee capacity to engage other areas of responsibility that contributed to business office productivity. Employees who were able to transfer time consuming or tedious responsibilities to vendors who already

managed those responsibilities for their counterparts, were able to address other areas of productivity (Eaton & Kilby, 2015; Osarenkhoe & Hyder, 2015). All seven participants mentioned how instrumental the application of outsourcing was to the success of the merger, and how it was leveraged was in maintaining business office productivity during the merger.

Hospital leaders created capacity for employees to focus on the task of revenue collection which was measured using productivity standards. Six of the 7 participants explained how employees were able to concentrate of working high dollar accounts and collecting high balances when the lower balance accounts, that require excessive effort and produce little revenue, were outsourced to vendors. Participants 3 noted that when an employee had the newly added capacity to work higher dollar accounts, they were able to meet their collections productivity standards more easily.

Participant 3 added that employees often can own management of their own areas of business when they have the capacity to devote the necessary time to achieving their productivity expectations. Employees feel a greater ability to focus when they know they will not be inundated with low dollar, high effort accounts for which they are responsible for collecting balances. Both Participant 3 and Participant 4 agreed that employees generally appreciated not being overwhelmed with high effort-low yield productivity responsibilities and appreciated that hospital leaders were actively looking for ways to remove barriers to their achieving productivity standards. These findings are consistent with the literature, noting that employees perform worse when saddled with mundane or unrewarding repetitive tasks (Eaton & Kilby, 2015; Osarenkhoe & Hyder, 2015). The

findings of the study also support the conceptual framework, as redistributing capacity can give employees the ability to efficiently learn and execute new processes (Hammer, 1990).

Hospital leaders also enabled the business office employees to maintain productivity standards by using outsourced vendors to continue business office operations while employees were unable to work accounts due to the process of physically relocating their respective offices to a new shared location. Participant 3 said that the physical office move resulting from the merger neutralized employees for nearly a month. The dismantling of one office, the physical move, and the reassembly of the offices in the new shared space prevented employees from optimal contribution to business office productivity for nearly a month. This supports the notion that outsourcing certain business functions can lessen the operational risks resulting from outside factors preventing employees from executing their responsibilities (Anderson, 1988; Krantz, 2006; Ladewig & Hecht 1993). Hospital leaders who employ the services of outsource vendors to perform a portion of productivity-based responsibilities, while employees are busy with the logistics of moving their offices, aid the business office in maintaining the productivity standard set by the organization (Anderson, 1988; Krantz, 2006; Ladewig & Hecht 1993).

Hospital leaders also leveraged the establish relationships that already existed with one operating unit's business office to generate similar advantages for the joining business office. Because of the ability to offer outsourced vendors increased volume due to the addition of the new business resulting a merger with a new business office, hospital

leaders were able to negotiate more favorable rates in the outsource contracts. That financial savings allowed hospital leaders to redirect funds toward resources to enable employees to do their work. Participant 4 stated this availability of funds helped procure resources like software and equipment that helped employees do their work more efficiently and maintain business office productivity during the merger. This sentiment supports the literature such as Cameron et al. (2016) that leaders can leverage existing resources to remove barriers to employees executing the change that results from a merger.

Theme 3: A Concerted Effort to Alleviate Fear of the Unknown

Employees have a greater aspiration to achieve productivity standards when they are not preoccupied with the fear and uncertainty that can accompany mergers (Holten & Brenner, 2015). Leaders who are purposeful about alleviating the uncertainty that accompanies mergers increase the likelihood of employee retention during a merger (Diab, Safan, & Bakeer, 2018). Approximately 77% of study participants acknowledged that employee anxiety about pending merger changes would have disrupted operations. Participant 7 conceded that hospital leadership and employees benefitted from a concerted effort and comprehensive strategies to not add to the uncertainty. Participant 7, along with Participants 1, 2 and 4, cited the hospital business office's daily meetings, huddles, and briefings as one strategy for fostering improved morale and predictability among employees.

Participant 1 noted that the daily meetings, huddles, and briefings typically covered productivity related topics such as problem accounts, collection projections, and

contractual procedures. Although some external speakers contributed to these meetings, employees were given opportunities to develop their own leadership skills by facilitating portions of the meetings. Hospital leaders acknowledge that direct participation in the facilitation of the meeting increased employee's confidence and fostered a sense of trust and inclusion in the newly combined business office entity. The inclusivity bolstered employee retention which helps to maintain business office productivity during the merger. Hospital leaders also encouraged employees with previously underutilized competencies to take a greater role and increased responsibilities in the pursuit of the business office goals. Participant 1 indicated that in many cases, leaders needed to increase their own comfort level with relinquishing control to subordinates.

Hospital leaders also challenged employees to expand their skillset. Participant 2 expressed that employees who were continually challenged were less likely to become complacent in their roles and more likely to remain engaged. Occupational challenges also positioned employees for advancement opportunities within the business office that had not previously been afforded to them. The confidence gained from addressing those challenges gave employees a comfort level with the pending changes of the merger. Participant 3 indicated that hospital leaders were continually thinking about succession planning to backfill positions of employees who were advanced because of improved skillset. Participants 1 and 2 corroborated this perception, adding that hospital leaders typically aim to promote from within before seeking talent outside of the organization. Participant 3 expressed that employees appreciated having greater opportunities within the hospital's business office to advance from their existing roles to roles that have more

impact on the combined organization's productivity. Participant 4 said that employees with the most seniority especially appreciated having advancement opportunities because of the merger after having been stagnant in their career trajectory for a time. Participants noted that employees felt accomplished when they were continually learning and not stagnant in their current position. Hospital documents supported the focus on profession development. For example, the hospital's website continually indicated that because business office employees continually participated in professional development courses, they were more likely to grow within the business office and not leave the hospital for more fulfilling employment. The hospital's organization development website also highlighted the business office leadership team's focus on coaching employees to acclimate them to their new responsibilities.

These findings confirmed the research from the literature review. Diab et al. (2018) posited employees feel more engaged and willing to work harder when they are provided opportunities for career development. Zuckerman and Golden (2015) also suggested that employees feel more connected to their work when they receive appropriate mentorship. Hospital business office leaders who offer growth opportunities show that they appreciate their employees having the knowledge, skills, and abilities required to succeed for the duration of their careers (Shah & Gupta, 2018). This strategy for leveraging the offer of professional develop opportunities to strengthen the resolve of employees to maintain or exceed acceptable productivity standards during a business office merger aligns with the conceptual framework, BPR theory, as investing in

employee's professional development was one way to foster a favorable outlook in how employees view the hospital business office's productivity goals.

Theme 4: Leadership Was Proactive in Addressing Potential Challenges

Study participants indicated that employees were better positioned to maintain business office productivity during the merger because of a concerted effort to address obstacles before they disrupted operations. A proactive approach to addressing challenges was vital to identifying and addressing obstacles before they can disrupt productivity (Cameron et al., 2016). Study participants explained that hospital leadership fostered an attitude of continuous improvement in operations during the business office merger. Hospital documents, specifically the hospital's website, reinforced that promoting continuous improvement motivated employees to surface productivity obstacles and address them immediately.

Participant 4 identified the adoption of continuous improvement as a high priority concept defined by Lean Six Sigma (He & Goh, 2015). From a perspective of standard work for all employees, leaders were able to leverage the concept of continuous improvement business office- wide. For example, Participant 1 and Participant 3 noted that business office leaders establish, encouraged, and rewarded employees across the business office to compel them to seek out and surface obstacle to maintaining productivity so the obstacles could be resolved. Four participants also cited the business office daily dashboard reports as a valuable tool for keeping the workforce informed and on the lookout for obstacles and challenges. The dashboard highlights key information such as issues with safety, methods, equipment, supplies, or staffing. These participants

also alluded to the importance of communicating the accepted resolution to the raised obstacles that were surfaced by the employees. Participant 1 noted that as the employee's confidence grew that their perceived obstacles would receive the appropriate attention and were resolve in an expedient manner, the employees were more proactive in identifying obstacles. This focus on proactively addressing obstacles to productivity supports the literature review. Multiple researchers have explored the importance of leveraging internal communication means to update and level set employees (Karanges et al., 2014; Korzynski, 2015; Nadim, 2015)

From an oral communication perspective, hospital leaders leveraged in-person meetings to foster open dialogue and increase opportunities to detect obstacles to inherent in processes or barriers hindering the employee's workflow. All the study participants noted that each department within the business office conducted weekly meetings focused on removing barriers and resolving issues that were obstacles to achieving the productivity goal set for that department. Among the meeting discussions were current workloads, opportunities for improvement, problem-solving, and the sharing of best practices. Although some employees were unable to attend meetings due to being at a different physical location, Participant 4 described how employees could attend via Zoom to be connected. This team meeting strategy supports the literature, as Seymour and Geldenhuys (2018) posited that team dialogue can have a positive effect on employee engagement with organizations. In addition to facilitating team meetings, leaders regularly engaged in weekly one-on-one meeting with employees. Participant 3 said that while weekly team meetings were beneficial, one-on-one meetings enhanced the

opportunity to identify issues that may have been missed in group discussions. Participant 3 noted that these encounters allowed employees to drive the agenda and share more detailed descriptions of challenges and needs. Participant 2 also developed the routine of spontaneously rounding on employees to observe and confer about their activities and concerns. Participant 2 added that leaders efforted to foster an atmosphere of open communication to optimize the opportunity to surface issues. Contributors expressed that each of these interactions furthered collaboration, which heightened the opportunities to both surface challenge to productivity and resolve those obstacles.

Regarding day-to-day communication, about 71% of respondents said that they consistently engaged employees in person versus relying on email. This outlook aligns with research conducted by Men and Hung-Baesecke (2015) and O'Neill et al. (2015), who discovered that employees feel most unified when leaders communicated with them face-to-face. Participant 6 remarked that employees tended to feel a personal connection when communication was more intimate. Conversely, Participant 6 noted that employees could easily misconstrue impersonal communication from leadership as being uninterested in their perspectives on issues. Participant 1 and Participant 6 also emphasized the need for employees to be able to speak openly with each other to resolve challenges and remove barriers to workflow.

Some notable outliers developed from the research data regarding hospital leadership communication practices and tools. After emphasizing some of the business office's strengths, Participant 4 acknowledged that the merged business office still has openings to be even more efficient. For example, Participant 4 noted that business office

leaders might benefit from establishing a self-service instant message network that allows customers of the hospital to communicate instantly with the business office employees via a virtual chat feature. Participant 4 added that customers could use this technology to inquire about billing, pay their bills online, and request records. Participant 4 acknowledged that utilizing this type of technology could free up significant capacity, enabling employees to exceed productivity standards. Participant 4 expressed there are still opportunities because of the newly combined business office still working on separate computer platforms. Participant 4 noted that the dual computer platforms being used has led to some communication-related inefficiencies.

Participant 1 and Participant 4 noted that business office leaders must model the behavior that they seek from their employees. Participant 1 and Participant 2 stated that they continually worked accounts just as their employees. This meant business officer leaders were also responsible for meeting productivity requirements. Because they were doing the same work they could empathize with employee's concerns. Participant 4 noted that business office leaders did not place blame on others when a mistake occurred, and they did not demand employees maintain a productivity standard that they themselves were not willing to accomplish. Leaders doing the day-to-day work lead to employees feeling inspired, unified, and valued. The literature corroborates this concept, as Ong and Yaqiong (2018) stressed that leader's behaviors directly influence staff's satisfaction, attitudes, and commitment to the organization.

Participant 1 and Participant 4 noted that leaders found it beneficial to contour messaging to specific tasks that contributed to overall productivity. Participant 1

explained that they developed separate specific strategies for maintaining productivity in billing, and follow up, and Denials. This meant that the strategy to maintain productivity for billing was different than the strategy to ensure follow up productivity was maintained. The strategies for each respective area were developed with consideration of the process necessary to carry out a complete cycle of each. Once the process was mapped and measured, business office leaders would consider each contributing component of that process and a strategy to optimize those components individually. The theory was that if incremental improvements to the contributing factors were made, the improvements would result in an improved overall process. Participant 5 expressed appreciation for an approached that allowed leaders to focus on smaller issue rather than the nebulous concept of productivity. The literature supports this notion. Hammer (1990) posited that the whole could be improved by improving each of its individual parts.

Findings Related to the Conceptual Framework

I used Hammer's (1990) BPR theory to explore the leadership considerations for maintaining hospital business office productivity during a merger. The core principle of BPR is systems thinking and an emphasis on removing all processes that do not create value for the organization. The theory is based on leadership's ability to map the processes of a particular organization and assign measurable units to the steps in those processes, monitor those units, diagnose issues and challenges within those processes, suggest improvements, and continuously monitor performance based on those redesigned processes (Hammer, 1990).. This theory is consistent with the research included in this study. For example, when leadership redesigned existing hospital business office

practices to better align the processes of the two combining business offices, productivity was maintained during the merger. Understanding the threats to maintaining suitable productivity within the components of the revenue cycle and the connection between those contributing components can enable hospital leadership to respond appropriately (Vasilaki, Tarba, Ahammad, & Glaister, 2016; Zhang et al., 2015).

Study participants substantiated BPR theory. Participant 3 and Participant 4 noted that when leaders were able to consider incremental improvements to the components contributing to overall productivity, employees were able to focus on delivering better performance in their specific area of responsibility; which resulted in optimal overall productivity. Participant 1 noted that rearranging how work queues were organized allowed employees to focus more on high dollar accounts and thereby achieve the cash collection productivity goal more easily. All four themes delineated in this study exemplify strategies used by hospital leaders used to maintain business office productivity during a merger: (a) leadership presented unified and consistent messaging; (b) leadership openly shared outsourcing advantages; (c) a concerted effort to alleviate fear of the unknown; (d) leadership was proactive in addressing potential challenges. Hospital leaders employed these tactics and were successful in maintaining the productivity of the business office during the merger. Participant 7 and Participant 4 added that the implementation of these strategies have been integral in fostering a desire amongst employees to dedicate the appropriate effort to maintain productivity.

Applications to Professional Practice

The specific business problem for this study was that some hospital leaders lack strategies for maintaining business office productivity during a merger. The results of this study reveal the strategies that hospital leaders at midsize urban hospitals in the southeastern U.S. use to realize this aim. The findings are applicable to maintaining business office productivity during a merger because they include specific suggestions for using the principles of BPR to improve the processes of two combining business offices in order to maintain productivity as they merge into one newly formed business office.

The results of this study incorporated the resulting suggestions for hospital leaders to improve business office practices where achieving a required productivity was the focus: establish a unified and consistent messaging for processes and expectations, and convey those messages at every opportunity. Other suggestions included exploring ways outsourcing and existing outsourcing relationships can benefit each business office during a merger, and how combined business office volume can command better rates than either entity experienced individually. Other significant recommendations involved frequent team meetings and huddles consisting of leadership transparency in communication and both routine group and routine individual daily engagements to foster robust communication. Additional proposals included adopting and developing an atmosphere of continuous improvement among all personnel, promoting the practice of anticipating obstacles and aggressively confronting those obstacles before they can disrupt productivity.

These findings are pertinent to improved business processes as they exemplify strategies that other researchers, in Hammer (1990), Karanges et al. (2014), and Yin (2018) have expressed are important to maintaining business office productivity during a merger. Various researchers acknowledge a connection between how organizational leaders strategically develop processes and improve effect on productivity (Cameron et al., 2016; Al-Ali et al., 2017). Employees who feel valued tend to perform better which contributes to higher productivity (Seymour & Geldenhuys, 2018; Karanges et al., 2014). The findings of this study can guide hospital leaders who struggle to maintain business office productivity during a merger. Following the suggested approaches can aid hospital business office leaders experience a success merger by improving processes that lead to a sustained productivity (Angwin & Meadows, 2015; Georgalis et al., 2015).

Implications for Social Change

Using the findings from this study to maintain hospital business office productivity during a merger could lead to positive social change by helping hospitals, individuals, and communities succeed. From a hospital perspective, combining business offices that can maintain productivity will experience successful mergers (Al-Ali et al., 2017). Hospital leaders with merging business offices that can deliver unified and consistent messaging experienced a more focused employee outlook and stronger commitment to achieving established goal (Tabibi et al., 2015). Enhancing employee focus during a hospital merger can influence the ultimate success of the merger.

From an individual standpoint, effort to enhance leadership engagement with employees through transparency, better communication, assembling frequently

proliferates opportunities for employee professional development (Eaton & Kilby, 2015; Osarenkhoe & Hyder, 2015). Employees who have an opportunity to sharpen skills and add competencies can solidify commit to the organization and improve retention during a merger (Diab, Safan, & Bakeer, 2018). Employee retention during a merger fosters stability which enables an organization to focus on productivity (Garmon, 2017). Merging hospitals with successfully integrating business offices will be able to continue to provide proximate healthcare to surrounding communities (Cascardo, 2018).

Hospital with efficiently functioning business offices secure adequate operating revenue and are more likely to have the resources to benefit society through delivering patient care (Angwin & Meadows, 2015). More hospital leaders are acknowledging the importance of efficient processes regarding their business practices (Boyd, 2017; Cleven et al., 2014). Hospitals that experience successful mergers can maintain profitability and therefore can provide stable healthcare to communities that would be deprived if diminished productivity during the merger, caused the merger to fail or even hospital closure ((Dobrzykowski, McFadden, & Vonderembse, 2016).

Recommendations for Action

In this qualitative single case study, I explored leadership considerations for maintaining hospital business office productivity during a merger. The findings can benefit hospital leaders who wish to compel employees to appreciate that it was essential to focus on performance in every area that was measured in efficiency and yield (Ku, Frogner, Steinmetz, & Pittman, 2015). The recommendations from this research study may benefit (a) hospital leaders who are in the midst of a merger with another hospital

that may be experiencing a decline in business office productivity, (b) business office leaders who are having issue with consistent communication with their employees, and (c) leaders and employees who lack the competency, information, or determination, to accomplish the organizations productivity goals.

Four recommended steps for action include the following: (a) identify effective unified and consistent messaging that appeals to employees, (b) establish practices to evaluate outsourcing opportunities that will compare and contrast the costs and benefit, (c) develop and identify initiatives that will confront and alleviate fears inherent in the uncertainty of mergers, (d) seek methodology that operationalizes an aggressive proactive approach to confronting potential issues. Hospital leaders would benefit from pursuing these incremental advances by setting attainable goals with a realistic timeframe for accomplishing them. Continuous monitoring, reassessment, and adjustment will determine if the initiatives are producing the desired result.

The first recommendation is to identify effective unified and consistent messaging that appeals to employees. Hospital leaders could initiate this by educating and reinforcing the goal and "what right looks like" with all stakeholders. Once the direction is made clear, hospital leaders can find consensus on the exact wording of effective messaging that will be uniformly adopted by all. Examples range from how messaging was conveyed in group meetings, to one-on-one scripting for individual encounters, to written messaging disseminated for instruction, education, encouragement, or admonishment. Hospital leaders could request input from employees to ascertain what

kinds of messaging and communication methods are effective to them and then create the messaging in conjunction with their feedback.

The second recommendation is to establish practices to evaluate outsourcing opportunities that will compare the costs and benefit. A feasible way to establish this practice is to develop a standard tool that measures outsourcing opportunities based on agreed upon fixed criteria with which all opportunities will be evaluated. Hospital leaders can empower employees to evaluate the effectiveness of outsourcing on a business office responsibility; as the employee, who is the authority closest to the task, plausibly has the best understanding of what the task requires. From a cost standpoint, hospital leaders can evaluate if the, in a merger situation, the return on investment is worth increasing the business given to an outsource vendor to drive down rates, to maintain current levels, or discontinue use of a vendor altogether.

The third recommendation involves developing and identifying initiatives that will confront and alleviate fears inherent in the uncertainty of mergers. Hospital leaders can anticipate employees having fears inherent in any merger processes and be purposeful in doing what is necessary to alleviate the fears that are within their control. During a merger, hospital leaders can alleviate merger fears by ensuring employees feel they are valued by organization. Hospital leaders can be transparent about future-state plans regarding locations, positions, and responsibilities expected post-merger. Hospital leaders would benefit from creating opportunities to listen to and respond promptly to the concerns of employees. This transparency and responsiveness during the merger process

can soothe anxieties of employees which can become disruptive to productivity if not addressed properly.

The fourth recommendation involves seeking methodology that operationalizes an aggressive proactive approach to confronting potential issues. For hospital leaders to realize this recommendation, a culture change must occur. Hospital leaders must create an atmosphere where all stakeholders have a consistent desire for continuous improvement. Hospital leadership would benefit from demonstrating, modeling, and encouraging a relentless pursuit of improvement to each component of a total process. In addition, hospital leaders could develop a practice of spontaneously inspecting processes and questioning what have employees noticed that could improve the steps of a process. Equally as important, leadership can inquire what both leaders and employees are doing to improve a process at any given time.

Participants in this study will be given a two-page synopsis of the study's findings via email. Plans also include publishing this study in the ProQuest Dissertations and Theses Database. I will also identify opportunities to present the research finding in industry meetings and other applicable forums.

Recommendations for Further Research

I conducted this qualitative single case study was to explore leadership considerations for maintaining hospital business office productivity during a merger. Researchers should conduct further studies to address a couple of key limitations of this study: geographic location and sample size. The study participants I interviewed worked with hospital business office operations from both an acquiring hospital and the acquired

hospital in a merger headquartered in the southeastern portion of the United States. Future researchers could extend the geographical location to other hospital systems merging in other areas of the United States, as hospital leaders in other areas may have unique merger characteristics worth investigating. In addition, the findings of this study might not apply to all hospitals, business offices, or business office employees. Future researchers could conduct case studies using other departments within medical facilities that is productivity based.

I suggest that future researchers adhere to some of the delimitations of this study. For example, they could continue exploring leadership's considerations for maintaining hospital business office productivity during a merger, as opportunities continuously present themselves to gain new knowledge on this phenomenon. Researchers could also employ purposeful sampling to identify hospital leaders who can effectively address the topic. However, future researchers might contemplate using mixed-methods or a quantitative approach to incorporate empirical data on the topic. They could also collect data from a hospital's personnel via focus groups or surveys to ascertain employees' perspectives on strategies to maintain productivity during a merger. Gathering data from employees can help validate or refute perspectives from hospital leaders.

Reflections

When I embarked on this journey, I was excited to increase my understanding and knowledge of doctoral-level research. I aggressively studied topics related to research designs, research methodologies, qualitative validity and reliability approaches, and data collection techniques. Although the entire process was educational, I found the most

fulfillment by undergoing the process firsthand and experiencing the challenges, frustrations, and successes that accompanied each phase of the journey. Achieving milestones such as arriving at a research topic, refining a problem statement and research questions, finding the case study organization, and collecting and analyzing data required comprehensive preparation and perseverance. I have greater appreciation and respect for the strategic and critical thinking and attention to detail required to design, conduct, and present sound research.

All researchers have preconceived ideas, values, and personal biases that could sway their data collection and analysis. I abated my own biases by using strategies such as conducting interviews in neutral environments. In addition, I used an interview protocol (see Appendix A) to preserve consistency during my dialogue with study participants. I also conducted member-checking interviews with participants to corroborate my interpretations of the data I collected.

The interview activity was particularly fulfilling for me, as leaders appeared to be humbled by the opportunity to discuss their strategies for maintaining business office productivity during the merger. I was equally humbled after seeing how much the hospital leadership respected their employees and the challenges they faced during the course of executing day-to-day responsibilities during the uncertainty of a merger. The strategies I learned are worth sharing with colleagues and applying throughout my career.

Conclusions

Maintaining business office productivity during a hospital merger is vital to the success of the merger (Al-Ali et al., 2017). However, some hospital leaders lack

strategies to effectively maintain business office productivity during a merger (Sapkota, Ivanov, Bachman, Vermillion, & Goyal, 2019). The purpose of the qualitative single case study was to answer the research question "What strategies do hospital leaders use to maintain hospital business office productivity during a hospital merger?" Seven leaders at a recently merged hospital business office in the southeastern section of the United States participated in interviews to address this question. I complemented the interviews by examining hospital documents, including the hospital's social media data, and website. Four themes emerged following data collection and analysis: (a) leadership presented unified and consistent messaging; (b) leadership openly shared outsourcing advantages; (c) a concerted effort to alleviate fear of the unknown; (d) leadership was proactive in addressing potential challenges. The findings indicated that hospital leaders who leverage these strategies can maintain business office productivity during a merger.

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Appendix A: NIH and CITI Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Scott Hughes** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 12/20/2013

Certification Number: 1346302

CITI PROGRAM

Completion Date 27-Apr-2020
Expiration Date N/A
Record ID 36443600

This is to certify that:

Scott Hughes

Has completed the following CITI Program course:

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Student's (Curriculum Group)
Doctoral Student Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w7e7d60d8-50c1-4a4d-bec7-670002c7f7b4-36443600

Appendix B: Interview Protocol

The guiding research question for the study is as follows: What strategies do hospital leaders use to maintain hospital business office productivity during a hospital merger?

The following interview protocol contains the questions used to explore the central research question.

Interview Protocol	
Due to the COVID-19 pandemic in 2020 data collection techniques were modified to be compliant with social distancing protocols to prevent spread of the Coronavirus. CDC guidelines suggest people remain at least 6 ft apart. For that reason, interviews were conducted via video conference or phone interview, that allow 2-way communication in the form of video and audio. These video conference platforms are secure, and I can digitally record each interview session. I conducted interviews with the participants via video conference or phone at a time and location where confidentiality can be protected.	
What I did	**What I said—script**
Introduce the interview and set the stage—often over a meal or coffee or at a private location.	Good morning or afternoon I want to first thank you for taking the time to participate in this research study. The purpose of this qualitative study is to explore the strategies hospital leaders in a southeastern U.S. market use to maintain business office productivity during a merger. The outcome may produce an understanding of how Healthcare leaders going through a merger may be able to use the findings of this proposed study to maintain business office productivity during the merger. As the researcher, I wanted to assure you that the information provided will be kept confidential as indicated in your signed consent form. The qualitative research data are collected using virtual interviews to understand the experiences and processes from the perception of the participant. These questions are presented in an open manner to encourage you to answer as openly as possible.

	The virtual interview will last approximately 30 to 60 minutes with an additional 20 minutes at an established date to meet again virtually to review the synthesized summary of data captured during the initial interview. Before we proceed are there any questions concerning the intent of this study or anything that I have stated?
• Watch for non-verbal queues • Paraphrase as needed • Ask follow-up probing questions to get more in-depth	1. What was the primary expected benefit of the merger within the business office?
	2. How did you safeguard against overestimating the expected benefit of streamlining redundant processes that result from combining two business offices?
	3. What strategies did you implement to maintain business office productivity during the merger at the operating unit for which you are responsible?
	4. Please explain any restructuring of organizational processes to improve service, speed, accuracy, and/or cost performance.
	5. What types of measurement was used to understand the existing practices prior to the merger?
	6. How would you describe the personnel interaction or cooperation between the two merging entities during the merger process?
	7. What strategies did the organization for which you are responsible address the top three challenges to maintaining business office productivity during the merger?
	8. How did you measure business office productivity success at the completion of the merger?
	9. What other insights would you like to add regarding the strategies used to maintain business office productivity during a merger?

<table>
<tr><td>Wrap up interview thanking participant</td><td>This concludes the interview and I wanted to thank you again for your participation.</td></tr>
<tr><td>Schedule follow-up member checking interview</td><td>The follow-up video conference to discuss the synthesis of the information interpreted from each question, should last approximately 20 to 30 minutes. What date and time frame would you like to be scheduled?</td></tr>
<tr><td colspan="2">Follow–up Member Checking Interview

Member checking involves the process of checking with research participants whether the identified concepts and codes summarized fit one’s personal experience (Carson, 2010).</td></tr>
<tr><td>Introduce follow-up interview and set the stage</td><td>Thank you for this follow-up member checking video conference meeting to review for validity that the synthesized summarized data represent the correct answers. If I missed anything or you like to add anything, please feel free to add that information as we review.</td></tr>
<tr><td rowspan="6">Share a copy of the succinct synthesis for each individual question

Bring in probing questions related to other information that you may have found—note the information must be related so that you are probing and adhering to the IRB approval.

Walk through each question, read the interpretation and ask:</td><td>Question and succinct synthesis of the interpretation</td></tr>
<tr><td></td></tr>
<tr><td>1.

Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed</td></tr>
<tr><td>2

Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed</td></tr>
<tr><td>3

Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed</td></tr>
<tr><td>4</td></tr>
</table>

Did I miss anything? Or, Is there anything you would like to add?	Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	5 Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	6 Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	7 Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	8 Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	9 Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	If there is no additional information that you would like to add, this concludes the follow-up video conference or phone interview. Thank you for your contribution of time and knowledge to this study.

Appendix C: Interview Questions

1. What was the primary expected benefit of the merger within the business office?
2. How did you safeguard against overestimating the expected benefit of streamlining redundant processes that result from combining two business offices?
3. What strategies did you implement to maintain business office productivity during the merger at the operating unit for which you are responsible?
4. Please explain any restructuring of organizational processes to improve service, speed, accuracy, and/or cost performance.
5. What types of measurement was used to understand the existing practices prior to the merger?
6. How would you describe the personnel interaction or cooperation between the two merging entities during the merger process?
7. How did the organization for which you are responsible address the top three challenges to maintaining business office productivity during the merger?
8. How did you measure business office productivity success at the completion of the merger?
9. What else would you like to add that we have not yet discussed regarding maintaining business office productivity during a merger?