2015

One Hospital's Patient Satisfaction Plans in Response

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2015

Abstract

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to a Changing Healthcare Environment

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MBA, University of Texas at Dallas, 2010

BS, Oklahoma State University, 1986

Doctoral Study Submitted in Partial Fulfillment

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July 2015

Abstract

Recent changes in the Centers for Medicare and Medicaid Services (CMS) reimbursement programs resulted in $1 billion in payments to hospitals based on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Approximately 50% of the 3,000 hospitals currently receiving Medicare supplements may receive increases in reimbursement payments while 50% will receive decreases in payments. This case study explored how one hospital team in North Texas achieved high HCAHPS scores. The primary provider theory, Deming's model of *plan-do-study-act* (PDSA), and disruptive innovation theory framed the study. The data collection process included administrator interviews (n = 7), hospital document analysis (n = 13), and observations of staff conducting care (n = 8). Through method triangulation, themes emerged on the constructs required to achieve high HCAHPS scores. Themes included caregiver-patient interactions, hospital services, hospital environment, hospital technology, and hospital governance. Although this was a single case study, other healthcare leaders may explore the findings to determine how the information contained within might transfer to other healthcare organizations. Improved patient outcomes resulting from education, communication, and technology in the continuum of care might enhance the patient experience and patients' overall health and wellness.

One Hospital's Patient Satisfaction Plans in Response to a Changing Healthcare Environment

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Dedication

I dedicate this study to my parents, who are no longer here in body but will remain in spirit with me always. My parents, through my upbringing, gave me the support, strength, and endurance to achieve my dreams. Additionally, a special dedication to my family members, who have spent the last 8-years supporting and encouraging me while I pursued my academic endeavors.

Acknowledgments

Acknowledgments are due to Dr. Gene Fusch and the faculty at Walden University who supported, encouraged, and guided me throughout the doctoral journey. A special acknowledgment to Dr. Benjamin Nguyen, who was instrumental in helping me complete this study. I would also like to thank all of the participants who shared information with me so that I could complete this study.

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Section 1: Foundation of the Study

Patient-centered care is essential to the success of hospitals from the perspective of patient outcome, patient satisfaction, and hospital financial viability. Moreover, patient-centered care encompasses the provider-patient relationship and the supporting staff creating an environment of care. The Patient Protection and Affordable Care Act 2010 and the Health Care and Education Act of 2010, together known as the Affordable Care Act (ACA), are legislation designed to provide alignment of incentives for hospitals and physicians through structured payment models (Anderson & Wilson, 2011). The payment model, called the v*alue-based purchasing (VBP) program*, includes 12 clinical process measures and one patient experience measure that contains eight submeasures. Centers for Medicare and Medicaid Services (CMS) administrators oversee and implement the VBP, which contains provisions that base 70% of reimbursements on clinical process measures and 30% on the patient experience measure (Anderson & Wilson, 2011). The *patient experience* is synonymous with *patient-centered care*. In a patient-centered hospital, patients achieve positive health care outcomes and experience satisfaction with care, and the hospital team enjoys economic viability. The focus of this study was determining the service plans hospital administrators implemented to achieve the strategic goal of creating a positive patient experience.

Background of the Problem

The evolution of healthcare in the United States began accelerating in 2007. Administrators at the Centers for Medicare and Medicaid Services began requiring hospital administrators to report quality measures through the Hospital Consumer

Assessment of Healthcare Providers and Systems (HCAHPS) survey. HCAHPS measures became transparent when CMS administrators initiated mandatory public reporting of HCAHPS scores. Consumers gained access to information on quality of hospital care and thus the opportunity for informed choice of where to seek care (Niehues, Emmert, Haas, Schoffske, & Hamm, 2012).

Legislators affected additional change in 2009, with the passage of the Health Information Technology for Economic and Clinical Health Act (HITECH). Under the HITECH Act, legislators provided a 10 year, $29-billion incentive payment program for investment in meaningful use of healthcare applied information technology (Buntin, Burke, Hoaglin, & Blumenthal, 2011). The U.S. Congress implemented the HITECH Act to incentivize healthcare professionals to use electronic health records. Legislators followed the passage of the HITECH Act with the Patient Protection and Affordable Care Act (ACA) of 2010.

The requirements introduced by the HITECH and the ACA acts led to disruptive changes in the U.S. healthcare environment, including changes to the Medicare and Medicaid payment systems, and expanded primary care for millions of new patients (Jacobson & Jaskowski, 2011; Kerfoot, Anderson, & Douglas, 2013). To address changes in legislation, hospital administrators likely will develop strategies to ensure that the organization's teams adapt to change rather than decline and become extinct (Cook, Gaynor, Stephens, & Taylor, 2012).

Problem Statement

The administrators at the Centers for Medicare and Medicaid Services (CMS)

oversee and implement the value-based purchasing (VBP) program. The program includes provisions tying almost $1 billion in reimbursement payments to hospitals to patients' perceptions of quality of care (CMS, 2013). CMS administrators predicted that approximately 50% of the 3,000 hospitals currently receiving Medicare supplements would receive increases in reimbursement payments while 50% would receive decreases in payments (CMS, 2013). Many hospital administrators operate hospitals at margins of 5-10%; CMS reimbursement losses of 1-2% could significantly affect hospitals' financial viability (Rauscher Singh & Wheeler, 2012; Volland, 2014). The general business problem is that some hospital administrators do not have explicit plans to improve effectively and maintain quality care (Werner, Kolstad, Stewart, & Polsky, 2011). The specific business problem is that some hospital administrators lack performance improvement plans to achieve high HCAHPS scores (Epstein, Fiscella, Lesser, & Stange, 2010).

Purpose Statement

The purpose of this qualitative instrumental single case study was to determine the performance improvement plans that hospital administrators need to achieve and maintain high HCAHPS scores. Seven hospital administrators from one of the top 10% of HCAHPS scoring hospitals in the Dallas-Fort Worth Metroplex answered interview questions to reveal *what* plans administrators had in place to improve patient satisfaction and *how* the administrators implemented plans to achieve positive HCAHPS performance scores. Hospital administrators can improve business performance by using findings and recommendations from this study to inspire, design, and implement change to increase

hospital HCAHPS scores. The HCAHPS scores reflect the patients' perceived experience and the subsequent revenue loss or gain for the hospital (Fowler, Saucier, & Coffin, 2013). Changes in patients' hospital experiences may lead to positive social impact by improving hospital care quality while securing repeat business for the hospital (Borah et al., 2012; Chatterjee, Joynt, Orav, & Jha, 2012).

Nature of the Study

This study was an instrumental case study containing qualitative methodologies to understand a complex phenomenon in health care institutions. Case study research is a means to observe, explore, and evaluate complex, multifaceted issues in a naturally occurring setting (Crowe et al., 2011; Yin, 2014). An instrumental case study is one in which the researcher investigates and gains a better understanding of a phenomenon in one company (Crowe et al., 2011). The phenomenon of patient satisfaction is complex and multifaceted (Baker, 2011). As such, an instrumental case study in an institution whose patient care teams had achieved positive patient satisfaction scores was appropriate.

Researchers at the leading institution for healthcare research and quality, the Agency for Healthcare Research and Quality (AHRQ), used case study research to explore the success or failure of quality improvement activities in hospitals nationwide (AHRQ, 2013). Following the lead of AHRQ, I incorporated case study methods to (a) observe caregiver behaviors, (b) analyze hospital documentation, and (c) conduct interviews with administrative leaders to learn *what* patient satisfaction programs and activities in a North Texas Hospital resulted in positive patient satisfaction scores.

Furthermore, this study included exploration of *how* the hospital administrators implemented patient satisfaction programs. The behaviors and group dynamics that affected performance emerged during the data collection process.

To quantitatively assess how patients perceive hospital quality, hospital administrators use the HCAHPS survey tool. The intent of this case study design was to determine the performance improvement plans that hospital administrators implemented that resulted in increases in HCAHPS scores for the subject hospital. While quantitative data contain valuable information, quantitative data do not include information to determine *how* a phenomenon occurs. While several types of qualitative research exist, the case study method is a design that can provide information specific to one organization. Case study research involves an examination and exploration of a real-life phenomenon in its natural context (Crowe et al., 2011; Yadav, Shaver, & Meckl, 2010; Yin, 2014). This case study included data sources such as (a) an analysis of observations, (b) performance indicators and hospital documents, and (c) HCAHPS scores. Crowe et al. (2011) asserted that the researcher instrumentally gains broader appreciation of the phenomenon when using multiple sources of information. Through case study research designs, different perspectives emerge, resulting in a deeper understanding of contextual aspects of the business culture. Quantitative studies do not allow researchers to address the how and why questions and thus do not provide the means to glean these perspectives (Yin, 2014).

Research Question

The central question guiding this study was as follows: What performance

improvement plans do hospital administrators need in order to achieve and maintain high HCAHPS scores? In responding to interview questions that mirrored the HCAHPS questions, hospital administrators provided insight into what types of actions they pursued and how the respondents used the identified measures to improve and maintain high HCAHPS scores.

Interview Questions

1. What plans or initiatives do your hospital administrators use to encourage nurses to treat patients with courtesy and respect?
2. How does your hospital administration ensure the nurses listen carefully to patients and explain things to them in ways the patients understand?
3. How does your nursing leadership ensure after the patient pushes the call button, the patient receives assistance as soon as the patients wanted it?
4. How do your physician leaders encourage their physician colleagues to treat patients with courtesy and respect?
5. How do your physician leaders encourage their physician colleagues to listen carefully to patients?
6. How do your physician leaders ensure doctors communicate with patients in a way patients can understand?
7. How do your caregivers improve the patients' perception of hospital cleanliness?
8. What activities does your hospital staff perform to improve the patients' sense of quiet in and around the rooms at night?

9. How have your caregivers enhanced the HCAHPS score pertaining to patients' bathroom needs?
10. How do your caregivers improve the patients' perception of pain control?
11. How do your caregivers share information in regard to medication administration including side effects and the need for medication?
12. What follow-up services, including patient contact after release, do your discharge planning team perform?
13. In regard to patients recommending the hospital, what actions have you taken to increase the likelihood the patient rates the hospital positively?
14. In regard to patients recommending the hospital, what actions have your caregivers implemented to increase the likelihood the patients recommend the hospital to friends and family?
15. How do your administrators ensure caregivers share decision-making with the patient's family on items including follow-up care and personal health management?
16. What other initiatives with regard to patient satisfaction have your administrators implemented?

Conceptual Framework

Current hospital researchers predominantly base research activities on a theoretical framework in which patient satisfaction is an indication of quality care (Beal, 2013; Mosadeqhrad, 2013; Nelson, 2012). While variations in patient satisfaction and quality patient care theory exist, the *primary provider theory* is the essence of patient

satisfaction and quality care. Aragon and Gesell (2003) grounded the primary provider theory on principles centered on the concept that clinical competency alone is insufficient to achieve desired patient care, quality outcomes, and resulting patient satisfaction.

The primary provider theory was applicable to this study in that the purpose of this study was to determine the actions and initiatives caregivers need to take in order to affect patients' perception of care as reported through HCAHPS scores. Through effective communication and interaction with the patient, the caregivers gained insight into the environmental issues affecting patient care (Spence, Murray, Tang, Butler, & Albert, 2011). The HCAHPS question responses result in a measure of patients' perception of care.

In addition to the primary provider theory, Clayton Christensen's 1995 *disruptive innovation theory* supported this study. Over the past few years, hospital administrators have experienced quick and dramatic changes in the healthcare environment. In a rapidly changing environment, researchers have found disruptive innovation theory useful for understanding complex problems (Yu & Hang, 2010). Yu and Hang (2010) used disruptive innovation theory to predict when changes in business or industry caused significant disruption to (a) technology, (b) business practice, (c) business management, and (d) culture. Disruptive innovation theory applied to this research because the federal government implemented regulatory changes that resulted in disruption to healthcare in the United States. Through the ACA and earlier acts, legislators elicited change to the healthcare environment, including requirements for reporting, technology, and reimbursements. Everything known about healthcare is changing, from how and where

patients receive care to success measurements (Kerfoot, Anderson, & Douglas, 2013).

Finally, Deming's 1950s model of *plan do study act* (PDSA) is applicable to hospital performance improvement projects and, as such, was an applicable framework for this study. Stikes and Barbier (2013) asserted that strategic initiatives most often include quality improvement programs with steps for monitoring and measurement to determine success. Some healthcare researchers have used Deming's model for healthcare research (Grant, & Schmittdiel, 2015; Tripathi et al., 2013). As this case study included observable activities to improve patient satisfaction scores and qualitative results, Deming's model was an appropriate element of the study's framework.

Definition of Terms

ACA: ACA is an acronym for the Patient Protection and Affordable Care Act of 2010. U.S. legislators designed the Affordable Care Act to improve the quality of healthcare while lowering healthcare costs (U.S. Department of Health and Human Services [HHS], 2012).

CMS: CMS is an acronym for Centers for Medicare and Medicaid Services. CMS is a government organization designed to represent, protect, and monitor healthcare programs funded by the U.S. Government.

Caregiver: A caregiver is a hospital employee who identifies, treats, or prevents an illness in the hospital setting. Examples of caregivers include physicians, nurses, nurse practitioners, phlebotomists, and pharmacists (CMS, 2013).

Clinicians: Clinicians are members of clinical teams who are trained to carry out the tasks assigned by clinical leadership (Griffith & White, 2011).

HCAHPS: HCAHPS is an acronym for Hospital Consumer Assessment of Healthcare Providers and Systems. HCAHPS is a survey designed to assess patient satisfaction with healthcare (CMS, 2013).

Healthcare teams: A healthcare team is a multidisciplinary team of up to 30 professionals including (a) community nurses, (b) midwives, (c) physiotherapists, (d) social workers, (e) psychiatrists, (f) speech therapists, (g) dietitians, (h) pharmacists, and (i) administrative staff and managers. The team's composition may vary with the patient's needs (World Health Organization, 2014).

Hospital administrator: A hospital administrator is a member of the senior management team tasked with carrying out the integrated strategies developed by the governing board and the hospital CEO. Administrators include (a) vice presidents, (b) directors, and (c) managers (Griffith & White, 2011).

Patient and Family Advisory Council: A patient and family advisory council (PFAC) couples patients and families with members of the healthcare team to provide guidance on how to improve the patient and family experience (Warren, 2013).

Performance improvement plan: Within the context of this study, a performance improvement plan is a plan and execution of initiatives caregivers implemented to improve HCAHPS scores. Hospital administrators base strategies on the objectives, purposes, and goals of the company. The senior leadership team and caregivers carry out major policies and plans for achieving business objectives (Buller, & McEvoy, 2013).

VBP: VBP is an acronym for value-based purchasing. The VBP program is a CMS initiative to reward acute-care hospitals with incentive payments for the quality of

care the hospital team provides Medicare recipients (CMS, 2013).

WHO: WHO is an acronym for World Health Organization. The World Health Organization is an organization whose leadership directs and coordinates global healthcare for the members of the United Nations (WHO, 2013).

Assumptions, Limitations, and Delimitations

Assumptions, limitations, and delimitations are terms to describe the boundaries of a study. Assumptions include items believed to be true that may have affected the study outcome. The limitations are potential weaknesses of the study, or items that limited the study scope. The delimitations include the study boundaries.

Assumptions

The assumptions for this study included the following: (a) hospital administrators accurately reported the patient experience scores to CMS; (b) participants answered the interview questions honestly; (c) during the observation, the caregivers did not change behaviors; and (d) I considered the results of the interviewee responses as representative of the hospital's activities. Another assumption was that hospital documentation contained policies and procedures that staff knew, understood, and followed during their day-to-day activities. Finally, an assumption was that all participants were experts and knowledgeable of the plans and initiatives that hospital administrators needed in order to implement to achieve high patient satisfaction scores.

Limitations

The single case study design was a limit of this study. When a study takes place in one location, the results may not be transferable to other patient populations or other

hospitals (Apekey et al., 2011; Baker, 2011). Hospital culture and environmental design may alter the effectiveness of patient satisfaction initiatives in different healthcare settings (Sinkowitz-Cochran et al., 2011). Patient population demographics including cultural and religious differences may affect patient satisfaction scores (Ghuloum, Bener, & Burgut, 2010; Williams, Meltzer, Arora, Chung, & Curlin, 2011). Demographics of both caregivers and patients may affect HCAHPS scores. The difference in patient-centered care behaviors of the health care providers may change the patients' perception of the caregivers' patient-centeredness and thus the patients' HCAHPS survey responses (Aragon & Gesell, 2003; Guarisco & Bavin, 2008). Each organization has a unique culture with different employee dynamics that may affect caregiver behaviors.

Delimitations

In this study, the participating hospital's team was one that was currently performing well, as indicated by patient satisfaction scores. The hospital had unique characteristics related to location and size that other hospitals may not have. Patient care providers vary from location to location and, as such, the providers delimited the study. Hospital management helps to cultivate a hospital's culture of care, and thus the leadership team delimited the study. The culture in the hospital may have influenced employee behaviors (Sinkowitz-Cochran et al., 2011).

Significance of the Study

Best practices in the field of healthcare are continually changing (Huber, 2013). As best practices change, legislative changes, such those resulting from the ACA (2010), disrupt current practices, and as a result, hospital administrators modify business

activities. Hospital administrators have found that operational procedures require change to improve patient care from the perspective of quality as well as the patient experience (Epstein, Fiscella, Lesser, & Stange, 2010). Hospital administrators who do not have sufficient performance improvement plans to meet the hospital administration's objectives for patient satisfaction may find herein performance improvement plans to implement in other hospital settings. By reviewing the improvement plans herein, administrators may learn how to develop, deploy, and implement strategies to achieve high HCAHPS scores (Epstein et al., 2010).

Contribution to Business Practice

Patients' perceived experience affects how they respond to satisfaction surveys. Patient satisfaction survey responses reflect the conditions of care. Dissatisfaction may indicate (a) an increased length of stay due to HACs, (b) patient anxiety level, (c) elevated heart rate, or (d) sleep deprivation from noise or improper care (Hsu, Ryherd, Waye, & Ackerman, 2012). Liu et al. (2011) noted that an opportunity exists to explore the relationship between patient satisfaction and individual patient experience scores. Epstein, Fiscella, Lesser, and Stange (2010) suggested that although patient-centered care may be in vogue, hospital administrators may have limited knowledge of initiatives needed to achieve high patient satisfaction scores. Successful implementation of activities to achieve high levels of patient satisfaction may have significant influence on the financial success of hospitals in the United States (Davis, Abrams, & Stremikis, 2011). Identification of actions to achieve a positive patient experience has the potential to (a) improve patient health, (b) improve the patient experience, and (c) result in significant

economic impact to the hospital industry (Cliff, 2011; Vest & Gamm, 2010; Zuckerman, 2005). Hospital administrators receive between 35 and 55% of funding revenue from Medicare and Medicaid reimbursements. Hospital administrators will likely implement activities that enhance HCAHPS scores, which in turn will increase the hospital's revenue stream and profitability.

Implications for Social Change

The purpose of the ACA was to drive patient care improvements in hospitals across the United States (CMS, 2013). Medicare costs have been growing at unsustainable rates (Huntington, Covington, Center, Covington, & Manchikanti, 2011). As a result, legislators drafted the ACA both to drive wellness and to reduce cost (CMS, 2013). When hospital administrators create high-performance teams, individuals seeking healthcare and these individuals' families are likely to realize both economic and social gains in respect to personal health (Vest & Gamm, 2010).

A Review of the Professional and Academic Literature

The goal of this case study was to understand the steps that hospital administrators took to maximize HCAHPS scores, which reflect a patient's perception of care during a recent hospital stay. As such, the purpose of the literature review was to explore practical plans for improving patient satisfaction scores and clinical quality measures in the changing healthcare climate in the United States. Through examination of studies covering customer satisfaction, patient satisfaction, and performance improvement, practical initiatives emerged that administrators may implement to achieve higher patient satisfaction scores.

The literature review began with resources from the Walden University Library multidisciplinary research databases, including (a) Academic Search Complete/Premier, (b) ProQuest Central, and (c) Science Direct. The search terms included (a) *CMS*, (b) *HCAHPS*, (c) *healthcare*, (d) *finance*, (e) *patient satisfaction*, (f) *patient satisfaction theory*, (g) *performance*, (h) *strategies*, and (i) *TQM*. Web searches included government and professional association sites. These websites contained information on regulations and information in regard to health care, patient satisfaction, and hospital finance. Web search sites included (a) the Agency for Healthcare Research and Quality, (b) the National Institute of Health, (c) the WHO, and (d) the Centers for Medicare and Medicaid Services. The review included 161 articles, government websites, and books; 85% of the articles were peer reviewed and less than 5 years old from the date of CAO approval.

The patients' hospital experience was the first topic included in the literature review. As the research evolved, the need to address the patient experience evolved as a theme essential to healthcare outcomes and hospital financial viability. The seriousness of the problem revealed a need to understand the history of the problem and to identify possible solutions to the problem. Included in this literature review were articles written by scholars from the early 1970s until 2014. The historical backdrop added to understanding the development of current events in the healthcare environment. The historical backdrop was essential to understanding the evolution of today's hospital patient experience issues and the effects on hospital viability.

The intent of this literature review was to determine how hospital administrators develop and deploy plans and initiatives for improving HCAHPS scores to secure

hospital teams' economic viability in a changing healthcare environment. The literature review began with patient satisfaction theory, patient satisfaction determinants, and the relationship between patient satisfaction and quality care. Business principles bound essential elements of hospital management to the goal of patient satisfaction. These factors included (a) governance and organizational structure, (b) human resources, (c) finance, (d) healthcare technology, (e) quality and performance improvement, (f) laws and regulations, and (g) management strategies. Each hospital department has a role to play in the patient experience, and as such, the first part of the literature review uncovered features related to each division.

Following a review of patient satisfaction literature, a section on customer satisfaction included strategies for satisfaction in various service industries. Industries covered in this section included the hotel industry, the restaurant industry, the Internet services business, and others. The goal of this part of the literature review was to identify customer satisfaction initiatives in the customer service industry that may apply to the hospital setting. The service industry section of the literature review finishes with the plans managers implement to ensure that customers indicate service satisfaction.

Through the literature review, themes emerged that bound customer satisfaction theory with patient satisfaction theory. Analyzing similarities between service industry customer satisfaction initiatives and hospital industry patient satisfaction initiatives resulted in emergence activities that work in both arenas. The literature review concluded with a section on HCAHPS and the topics covered by the HCAHPS survey questions. Fishbone diagrams allowed emergence of themes from the literature review for patient

satisfaction, HCAHPS, and customer service concepts. Neufeld et al. (2013) indicated that themes outside of the construct of HCAHPS questions provide insight into the constructs of patient satisfaction.

The strategy for searching the literature included using search terms related to each of the healthcare management functions. Using search terms resulted in an exhaustive search of the current available research on strategic approaches to patient satisfaction from the perspective of each of the components of hospital management. The literature review included comparisons and contrasts of theoretical points of view in respect to patient satisfaction. The literature review concluded with a summary of best practices in the field of performance improvement and patient satisfaction.

Concise summaries of the literature established the most prominent features of the principles for understanding how to improve business performance based on previous research. Aspects of the theoretical framework for this study linked theory to practice. The plans to address patient satisfaction in the changing healthcare climate emerged through literature-based description of the plans.

Patient Satisfaction Theory

Health care theory has been in existence since the early days of medicine. While many theories exist, patient satisfaction has been of interest for many years (Gill & White, 2009). Early scholars discovered that there were causes and effects of patient satisfaction. Causes included the patients' attitudes and perceptions prior to care; the patients' expectations prior to care, and the quality of healthcare delivery (Gill & White, 2009). Theories have not changed much over the years, as Bjertnaes, Sjetne, and Iversen

(2012); Grigoroudis, Orfanadouki, and Zopounidis (2012); Badri, Attia, and Ustadi (2009); and CMS researchers asserted similar findings.

Expectations of care emerged as secondary to the patients' experience with nursing in a recent study by Bjertnaes, Sjetne, and Iversen (2012). Patients answered a lengthy survey including two questions on patient expectations, 26 questions on the patient experience, and 14 questions on quality of life. Bjertnaes et al. correlated the survey responses to the patients' overall response to whether the perceived patient care was satisfactory during the patients' hospital stay. The results for the survey questions indicated that the patients' experience with nursing services was the primary predictor of patient satisfaction, followed by the patients' expectations of care (Bjertnaes et al., 2012). Similarly, after research on satisfaction attainment, Reinig, Briggs, and Vreede (2009) hypothesized that patients have a goal in mind; patients base satisfaction attainment on their satisfaction with the process and outcome of the medical delivery.

While patient expectations may predict patient satisfaction, patients' healthcare results may affect their survey responses. Grigoroudis et al. (2012) argued that there was a relationship between patient satisfaction and health care outcome. Patients who experienced positive outcomes responded positively to questions on surveys about their satisfaction with care. After investigation of economic indicators, Grigoroudis et al. proposed that patients' satisfaction with healthcare delivery may predict business viability.

April, Dharani, and Peters (2012) concluded that patient satisfaction was a function of personal happiness. Through the distribution of a questionnaire to 115

subjects, April et al. found that people who could change the environment and who had a sense of control reported higher levels of satisfaction than those who did not. The importance of control over received care is a concept that holds true today, as provisions of the ACA were designed to encourage caregivers to engage in shared decision-making discussions regarding treatment goals and methods (Kocher, Emanuel, & DeParle, 2013).

While Bjertnaes et al. (2012), Gill and White (2009), Grigoroudis et al. (2012), and others argued that caregivers can affect patient satisfaction, Fox and Storms (1981) had differing Opinions as reflected by the discrepancy and transgression theory of patient satisfaction. This theory contained the constructs that the patients' culture, knowledge, beliefs, and expectations were predictors of patient satisfaction. Based on the constructs, Fox and Storms (1981) suggested that patient satisfaction is an unpredictable construct. Similarly, Festinger (1957), author of the cognitive dissonance theory, suggested that when a patient's beliefs about the world did not occur, the person felt uncomfortable, and satisfaction was not possible. Gallagher, Holton, McDonald, and Gallagher (2013) purported that in some cases, satisfaction was not possible. While inconsistency in theory exists, hospital administrators today survey patients to determine their level of satisfaction with the hospital's health care delivery.

Through the administration of the HCAHPS survey, hospital administrators strive to measure patient satisfaction, as Grigoroudis et al. (2012) argued that satisfaction is a predictor of patient care quality. The Centers for Medicare and Medicaid Services (CMS) employ HCAHPS scores in evaluating a hospital's standard of care. In 2008, HCAHPS began publicly reporting hospital patient satisfaction scores (HCAHPS, 2013). In order

for hospitals to receive Medicare reimbursements for services, CMS requires the hospital administrators report the hospital's scores. CMS administrators have asserted that the transparency helps healthcare providers improve the quality of care. Similarly, Azmat and Ha (2012) as well as Singh and Singh (2012) proposed that transparency practices protect providers' reputations and help them maintain and attract new customers.

The developers of the HCAHPS scoring system based the system on scholarly research. In one example of such research, Badri, Attia, and Ustadi (2009) found a link between patient satisfaction and patient health. Badri et al. determined that the quality of health care delivery is a predictor of patient satisfaction and that, as such, the HCAHPS survey is an appropriate assessment of patient satisfaction. Similarly, Fowler, Levin, and Sepucha (2011) evaluated the HCAHPS survey and concluded that the HCAHPS survey is an appropriate measurement of quality and safety. Fowler et al. argued that exceptional quality care should not only be medically appropriate, but also desired by informed patients.

Beginning in October 2013, CMS administrators changed hospital reimbursement structures. With the implementation of financial incentives, CMS administrators began urging providers and health care organizations to use the HCAHPS survey to monitor patient perception of quality based on patient goals. CMS administrators use the HCAHPS patient satisfaction score to control as much as 30% of the hospital reimbursement (Zusman, 2012). Healthcare leaders responded to the 30% reimbursement by modifying healthcare practices by focusing on patient satisfaction, along with patient outcomes.

In conjunction with CMS, Aragon and Gesell (2003) argued that the quality of care grounds patient satisfaction. The framework for the nature of this study is Aragon's primary provider theory. Aragon and Gesell asserted that the primary caregivers had the greatest impact on quality of care and patient satisfaction. Aragon and Gesell suggested that the satisfaction with the primary provider, waiting for the provider, and satisfaction with the provider's assistants are the three strongest predictors of patient satisfaction. Both the HCAHPS and Press-Ganey surveys included questions in regard to communication with physicians, communications with nurses, and relationships with other members of staff. Satisfaction with primary providers likely predicted a good patient satisfaction score (Argon & Gesell, 2003). Through patient-provider relationships, including provider protocols, the patients evaluated the quality of care.

Likewise, Hush, Cameron, and Mackey (2011) found that patient satisfaction was a function of patient-provider relationships and the process of care. Hush et al. (2011) conducted a systematic literature review and selected 15 articles for inclusion in a research study. Through evaluation of the preponderance of the research, Hush et al. concluded that interpersonal attributes of providers along with the process of care defined satisfaction. Interestingly enough, treatment outcome was infrequently and inconsistently associated with patient satisfaction (Hush et al., 2011).

Patient Satisfaction Determinants

Through theory, scholars have attempted to explain satisfaction; however, scholars do not all agree on how to determine satisfaction. To ensure patient satisfaction, some scholars focus on hospital environmental aspects, whereas others focus on patient

care provider-patient relationships. The specialists at the Agency for Healthcare Research and Quality (AHRQ) found patients related to the health care environment. Furthermore, patients communicated a personal level of satisfaction based on hospital design features, mediating family interactions, and positive distractions (AHRQ, 2012). Design features included way-finding, lighting, and windows, while positive distractions included nature sounds, music, television, and artwork. Mediating family interactions included social support, shared communication, and confidentiality.

While AHRQ focuses on the environment as a predictor of patient satisfaction, early scholars such as Linder-Pelz (1982) asserted that when caregivers met consumers' expectations, satisfaction followed (as cited in Gill & White, 2009). When the hospital caregivers provided positive interactions and met the patient's expectations, the personal satisfaction level was high. According to Badri et al. (2009), patient satisfaction is an important part of health care. Furthermore, patient satisfaction resulted when the hospital experience met the patients' expectations (Badri et al., 2009). Additionally, the Badri et al. model of patient satisfaction insinuated that qualities of care and provider-patient communication were important aspects of patient satisfaction. Alternatively, scholars such as Reinig et al. (2009) argued that patients assess satisfaction on treatment outcome.

In a literature review of 600 studies, Trochelman, Alber, Spence, Murray, and Slifcak (2012) associated hospital design with clinical outcomes. Furthermore, quietness of the room affected satisfaction in that 23% of the patients commented on the noise levels (Trochelman et al., 2012). Pasani et al. (2015) established a link between noises and sleep deprivation. Pasani et al. suggested that sleep deprivation may have adverse

effects on the patient; furthermore, an association exists between sleep quality and patient healing. Poor healthcare outcomes due to lack of sleep may affect a patient's satisfaction with care.

Whereas patient satisfaction theory evolves, the need for quality health care remains constant. Quality care is significant because patient satisfaction is associated with patient safety and patient outcomes (Palese et al., 2011; CMS, 2013). Aragon and Gesell (2003) based the primary provider theory on quality of provider care. Aragon and Gesell asserted that Press Ganey patient satisfaction scores were one measure of possible patient outcome. Aragon and Gesell grounded the primary provider theory on the following nine principles: (a) patient care requires clinical competency; however, clinical competency alone is insufficient to achieve desired results; (b) desired outcomes require more than clinical competency because providing patient care requires effective communication and interaction with patients; (c) patient-centeredness is a competency that influences the provider's communication and quality of patient care; (d) providers' patient-centeredness influences patient outcomes; (e) providers are responsible for the quality of patient care and the provision of patient clinical expertise; (f) providers who are both clinically competent and patient-centered achieve desired results; (g) patients and families place importance on the patient-centeredness of the patient's providers; (h) the patient-centeredness of the provider is more valuable than the financial objectives of a patient encounter; and (i) patients are the best judges of the patient-centeredness of the providers. If the primary provider theory principles hold true, then positive patient satisfaction scores will result (Guarisco & Bavin, 2008). Guarisco and Bavin (2008)

determined that physicians who modified personal behaviors toward patient-centeredness raised their patient satisfaction scores. The act of identifying and modifying behaviors for healing was an expression of caregiver patient-centeredness (Guarisco & Bavin, 2008). Patient-centeredness resulted in positive patient outcomes (Guarisco & Bavin, 2008). Liu, Squires, and You (2011) validated the use of HCAHPS scores and the use of the Press-Ganey survey as a method for determining patient satisfaction.

Patient Satisfaction and Quality Care

Health equity means attaining the highest level of health for all people and eliminating health care disparities (Beal, 2013). High-quality care impacted communities by (a) improving health, (b) improving the patient's experiences of care, and (c) lowering health care costs (Beal, 2013). The excess rates of disease in people of color resulted in an estimated expenditure of $23.9 billion in 2009; and some projected these costs to rise to $337 billion over the next 10 years (Beal, 2013). Improving health in minority communities through quality and efficiency will play a vital role in controlling the cost of healthcare.

Under the CMS initiative, Medicare administrators based level of payments to the hospital on the HCAHPS scores. Financial incentives were 1% in 2013 and climb to 2% by 2017 (Nelson, 2012). CMS administrators linked quality care to the patient experience scores. Therefore, nurses attempt to drive positive patient satisfaction scores. Driving patient satisfaction scores is necessary for the hospital's financial well-being as many of the uninsured are people of color (Nelson, 2012). Nelson concluded through the ACA, as

more of the uninsured become insured, the need becomes great to improve quality care to the underserved.

Limited literacy resulted in costs the US healthcare system between $50 and $73 billion dollars per year (Tamura-Lis, 2013). Tamura-Lis asserted utilizing the teach-back method of patient education, may improve patient satisfaction and quality care. Many patients have limited literacy in regard to healthcare, and as such, do not understand the patient's role in achieving improved health. Tamura-Lis asserted that caregivers require knowledge of how to teach patients about the patient's role; brochures, illustrations, and patient recall aide in the teaching process. By means of effective communication and education, caregivers may drive down readmission rates, and increase patient satisfaction. Tamura-Lis proposed an essential part of the process be patient follow-up. By calling the patients after discharge to ensure the patients are progressing in personal treatment, the hospital caregivers may avoid repeat admissions, or intervene where needed to help the patient with the patient's needs. Patient follow-up activities may improve patient health and satisfaction (Tamura-Lis, 2013).

While the provisions of the ACA likely produced a change in patient demographics, healthcare leaders should prepare for changing demographics and ensure quality of care does not waver. Meghani et al. (2009) conducted a comprehensive literature review and noted varying relationship between ethnicity and health care services. Meghani et al. observed that in 9 of 27 studies, data collected from 56,276 patient surveys and 1756 provider surveys, reflected that minorities experienced positive health outcomes. Eight studies showed no association between race and health care

outcome, and 10 studies presented mixed findings (Meghani et al., 2009). The results of the Meghani et al. study suggested that there was no significant relationship between demographics and resulting health care outcome.

While hospital administrators in the U.S. find patient satisfaction issues important, worldwide, hospital administrators similarly define patient satisfaction an important construct. In a Greek hospital, scholars utilized the Risser patient satisfaction survey to determine the relationship between patient satisfaction and quality outcomes. Charalambous and Adamakidou (2012) found that the correlation coefficient between patient satisfaction and quality outcomes for 298 cancer patients was 0.78 ($p<.001$). The Risser survey included three sections wherein the patients evaluated the nursing skill level, interpersonal-educational skills, and interpersonal-trust. Charalambous and Adamakidou suggested that the patient satisfaction is a fundamental aspect of the policy of quality of care.

Charalambous and Adamakidou (2012) defined quality of care as a (a) safe, (b) effective, (c) patient-centered, (d) timely, (e) efficient, and (f) equitable administration of nursing care. Flores, Hickenlooper, and Saxton (2013) determined that quality care required quality improvement training, which may be an effective way of improving nursing education in the United States. In 2013, the average age of nursing faculty was 55, and the average age of nurses were 44 nationwide (Flores et al., 2013). With the changing healthcare climate, there is an opportunity for nursing staff to learn how to achieve greater patient satisfaction through quality improvement. Flores et al. (2013) conducted partnership activities among nursing students and practicing nurses to achieve

improvements in medicines reconciliation. Patients realized significant benefit from medicine reconciliation practices and nursing students benefited from recognizing the need for practicing QI as part of daily nursing work (Flores et al., 2013). Additionally, partnering student nurses with hospital unit nurses, created an efficient method to achieve (a) increased safety, (b) care quality, and (c) patient satisfaction (Flores et al., 2013).

In the evolving healthcare environment, aspects of nursing education should include information on quality care and patient satisfaction. Dolansky and Moore (2013) proposed that nursing education that includes systems thinking change the culture from one of an individual care to a system of care. In systems thinking, teams of caregivers involve other caregivers in patient care, and patient handoff between team members becomes seamless (Dolansky, & Moore, 2013). Dolansky & Moore outlined a method to evolve from personal care thought to teamwork and collaboration. In order for hospitals to align with ACOs, hospital staff must display qualities of teamwork and collaboration; aligned organizations exhibited these qualities (CMS, 2013).

Along the lines of system thinking, Turner et al. (2014) determined that the physician continuity of care resulted in lower healthcare cost, but also found insignificant differences in patient satisfaction scores. Turner et al. studied 18,375 hospitalizations, considered the 30-day readmission rates, and correlated readmission rates with HCAHPS top box scores. While discontinuity of care indicated a .9-12% increase in healthcare cost, patient satisfaction top box scores did not reflect a significant correlation with discontinuity of care.

While Turner et al. (2014) did not find a correlation between continuity of care and patient satisfaction, Martinez-Gonzalez et al. (2014) reviewed 27 integrated healthcare care systems and concluded that beneficial effects of system integration and continuity of care included (a) reduced hospital re-admissions, (b) improved adherence to treatment guidelines, and (c) improved patient satisfaction. Turner et al. concluded that there was a significant problem in healthcare in regard to continuity of care. According to Turner et al., additional research in continuity of care is necessary for good clinical and patient satisfaction outcomes.

The results of the extant literature review suggested meeting patients' expectations required hospital administrators focus on patient satisfaction and quality care. Epstein, Fiscella, Lesser, and Stange (2010) argued patient-centered care is in vogue, but hospital leaders have limited knowledge of strategies to achieve patient satisfaction. While expectations, care quality, and provider relationships affected satisfaction, demographics may have played a role in the patients' response to the environment (Ghuloum, 2010; Meghani et al., 2009; Peck, 2011). As such, some researchers have considered demographics as a factor in patient satisfaction.

Demographics and Patient Satisfaction

Aragon and Gesell (2003) framed the principles of the primary provider theory around the patients' relationship with the health care providers. Aragon and Gesell suggested demographics may play a role in the patients' experience preferences. Scholars, including Ghuloum (2010), Meghani et al. (2009), and Peck (2011), asserted similarly, and highlighted the importance of demographic differences in provider-patient

relationships that affect patient satisfaction. When providers administer healthcare, demographic awareness becomes a necessary precursor for provider-patient interaction and resulting satisfaction.

In a review of 175 doctor-patient interactions, Peck (2011) found patients who experienced patient-centered interactions indicated greater satisfaction with provider care than those who encountered lower levels of the patient-centered interaction. Peck observed and recorded physician-patient interactions and determined the physicians' interactions with patients varied depending on patient age and the number of previous physician-patient encounters. Peck also discovered that patients with higher levels of education reported greater satisfaction with care than those with lower education level.

Patient demographics likely are predictors of patient satisfaction both in the US and abroad. In a Qatar mental hospital study, Ghuloum et al. (2010) documented associations between racial demographics and patient satisfaction. Nursing staff administered patient satisfaction surveys in the appropriate language for each patient. The patient responses indicated that there was no significant difference in Qatari and Arab expatriate satisfaction with health care services. However, a significant difference between Arab and Spanish psychiatry patients in all domains of satisfaction emerged (Ghuloum et al., 2010). The findings were not clear whether the quality of care for Spanish patients was different from the quality of care received by Qatari and Arab patients.

Conversely, in a study of patient experiences, priorities and global ratings, de Boer, Delnoij, and Rademakers (2010) established minimum correlations between

demographics and global health care quality ratings. Demographic characteristics in the de Boer et al., study included education, age, and self-observed health. A common theme among patients was the desire for caregivers to treat patients with respect and dignity. For the participants in the de Boer et al. study, the relationship between the caregivers and the patients was the drivers for satisfaction rather than health care outcomes.

In a Williams et al. (2011) study, the relationship between the caregivers and attention to the patient's spiritual needs showed a significant correlation to satisfaction. Williams et al. noted that caregivers who addressed patients' spiritual or religious concerns during hospitalization achieved higher degrees of patient satisfaction than those who did not. Williams et al. concluded that meeting the individual needs of patients increased patients' satisfaction.

Between 2006 and 2009, Williams et al. (2011) administered more than 11,000 surveys to patients about the patient's religious or spiritual encounters while hospitalized. Forty one percent of those patients desired to have a discussion of religious or spiritual nature while in the hospital, but only half had partaken in that conversation (Williams et al., 2011). Additionally Williams et al. noted that the overall patient satisfaction scores were higher when the patient had these discussions with care providers.

Peck (2011), Meghani et al. (2009), de Boyer et al. (2010), and others, indicated that there were various factors to consider that may have affected patient satisfaction. Demographics including religion, ethnicity, and age likely affected survey response (Aragon, 2003; Peck, 2011; & Williams et al. 2011). Whether provider care was similar across patient populations was not clear. Whether the patient's perception of care

impacted the patient's perception of satisfaction was not clear (Aragon, 2003; Peck, 2011; & Williams et al. 2011).

Governance and Organizational Structure

Executive leadership governs the hospital business. The leadership team develops strategies to meet the hospital's mission, vision, and values. In order to ensure effective strategies, leadership ensures strategies are (a) sustainable, (b) result in performance improvement, (c) demonstrate quality, (d) move the business in a defined direction, (e) have focus, and (f) connect with the mission (Zuckerman, 2005). Effective strategies are fundamental to the company's success (Zuckerman, 2005).

One powerful indicator of an organization's patient-centeredness was the senior leadership's level of commitment to the patient experience (Cliff, 2011). A culture wherein cross-functional teams engaged in creating the patient-centered experience produced positive gains in patient satisfaction (Cliff, 2011). Additionally, members of leadership who valued innovation and quality care rewarded this vital aspect of the hospital's culture (Cliff, 2011). When leaders solely focused on patient satisfaction scores, to obtain CMS reimbursement, leaders sent the wrong message to the leadership teams. Instead, leadership focus should surround the patient experience (Cliff, 2011). In addition to hospital employees' engagement in the quality of care processes, Cliff (2011) found that engagement of the patients and the patient's families was essential in improving the quality of care. Cliff (2011) asserted that management at all levels of the company should adhere to basics of plan-do-study-act method of process improvement. Hospital units that operated in siloes were not able to achieve quality improvement in the

changing environment. Utilizing siloed groups in organizational design has been ineffective in eliciting sustainable change (Cliff, 2011).

One way to ensure nurses feel engaged in the hospital care processes is through the *Magnet* journey. Urden & Ecoff (2013) found that relationships with leaders, professional accountability, staff voice, were aspects of the *Magnet* journey that results in hospital care transformation. Nurses indicated that they felt there was advocacy for nursing issues, and they asserted there was a transformation in care due to their magnet journey (Urden & Ecoff, 2013). Similarly Swanson and Tidwell (2011) indicated that the model of shared governance that comes out of the *Magnet* journey results in process changes that improve patient safety.

While nursing engagement results in improved patient safety, physician engagement is also essential in improving patient safety. Manary et al. (2014) concluded that hospitals with collaborative cultures and higher physician engagement tend to score higher in the HCAHPS survey. On average, the hospitals with collaborative cultures score an average of 6.5 percentage points higher in the patient experience scores than non-collaborative cultures (Manary et al., 2014). In hospitals with collaborative cultures, caregivers frequently communicated about patient experience scores in (a) departmental meetings, (b) via e-mail, (c) during leadership meetings, and (d) during patient unit reporting. Manary et al. determined that hospitals with senior leadership who asserted there was a link between the patient experience and patient outcomes, received higher VBP scores.

The rapidly changing healthcare environment created disruption to existing

healthcare models. Disruptive innovation is a way to foster growth with changing technologies (Williams, & Clark, & Gardner, 2012). Disruptive innovation is a competitive strategy, if businesses do not cannibalize internal processes someone else will (Williams et al., 2012). Leaders found survival in a rapidly changing environments required increased bandwidth in the marketplace and marketplace intelligence. Apekey, McSorley, Tilling, and Siriwardena (2011) found a significant relationship between leadership behavior and organizations with a culture of innovation. Apekey et al. (2011) concluded that an organization should include change agents who focus on quality improvement initiatives. Successful leaders, required hospital staff to present a culture of accountability (Kirkland et al. 2012). Leaders with well developed, soft skills achieved success through interpersonal relationships (Gauss et. al. 2012). Leadership ensures the "C" suite and the entire hospital consists of diverse members who match the population's needs. Gauss et al. (2012) asserted strategy should include cultural competency and diversity; these strategies both drive quality. Diversity increased patient satisfaction and supported successful decision making (Gauss et al., 2012). The human resources department may help with developing diverse teams.

Human Resources

The success of an organization is highly dependent on the quality of the people the leaders hire (Aydin, 2013). A strong HR organization can strengthen the business through hiring practices and training, both which affect patient satisfaction (Aydin, 2013). While individuals may be highly skilled, organizational leaders should train and retrain employees on both verbal and non-verbal skills (Aydin, 2013). Aydin (2013)

found that patients perceived physicians with strong non-verbal skills as highly successful. Aydin (2013) concluded the patients' satisfaction levels correlated to physician's level of non-verbal immediacy.

Not only is quality staffing pivotal in the changing healthcare environment, but healthcare leaders should focus on right staffing numbers and a combination of staff (Morrow et al. 2012). Hospital management strategies may require a change in the staffing selection based on care redesign in response to bundled payments. HR in concert with executive leadership may carry out new strategies to hire, train, and retain employees. Morrow et al. (2012) determined delivery strategies, increased employee satisfaction, which in turn affected patient satisfaction.

Some hospital care teams deliver care by encouraging family and patient involvement with choice in the care (Warren, 2013). Hospital administrators hire patient and family advisors to learn the patients' needs and to give options for care (Warren, 2013). Through advisor intervention, caregivers may adjust the care provided based on the patient's individualized needs (Warren, 2013). These advisors are part of the patient and family advisory council (PFAC). Patient and family advisory councils consider the following: (a) philosophy of care, (b) environment and design, (c) personnel practices, (d) information and decision making, (e) patient and family support, (f) charting and documentation, and (g) patients and families as advisors (Warren, 2013). Caregivers adapt care based on patient needs, rather than requiring the caregivers administer one standard of care. Each patient's journey to healing is unique. Warren (2013) concludes healthcare is a journey, not a destination.

Finance

In regard to financial strategies in the evolving healthcare market, one strategy hospital board members considered was remaining independent versus joining another health system. Zuckerman (2005) observed that hospital board members had many options in the model of care delivery. The delivery model options included (a) remaining independent, (b) joining another healthcare system, (c) aligning with various service providers, and (d) expanding current healthcare offerings. The hospital leaders evaluated (a) market share, (b) services, (c) supply and demand, and (d) current payor mix to support the selected delivery model (Zuckerman, 2005). Economic considerations are not only necessary for economic viability, but also for patient satisfaction. Patients may prefer a one stop shop wherein all healthcare needs may be realized at one location (Zuckerman, 2005).

One of the many considerations in the contemporary changing healthcare market is fee structure transparency (Reinhart, 2013). The ACA contains requirements for hospitals to publish, and update annually, prices for standard services (Reinhart, 2013). The ACA, however, does not provide clear guidance on how hospital administrators meet the requirement. While providers await guidance, the providers begin the process of preparing for transparency and planning strategies for addressing fee structure transparency (Reinhart, 2013).

Providers may award financial assistance to various patient populations and ensure p-front transparency about the cost of services. Healthcare providers recognized financial transparency as a conduit towards increased patient satisfaction and healthcare

quality (Honoré et al. 2011). Financial conversations with the hospitals admitting department members, helped patients make informed decisions (Reinhart, 2013). Furthermore, providers who work with patients one on one, tend to secure positive cash flow and financial viability (Rauscher Singh, & Wheeler, 2012). The admitting department may need a strong team of financial advisors to help the patient with options to pay for received services in a timely manner (Reinhart, 2013). With the ACA, hospital administrators expect greater throughput and need an effective way of ensuring a fast revenue cycle to increase profitability (Rauscher Singh, & Wheeler, 2012). Healthcare technology may help leaders with throughput and improving revenue cycle.

Health Care Technology

The Health Information Technology for Economic and Clinical Health Act of 2009 included over $20 billion for HIT (Restuccia et al., 2012). Through the HITECH act, CMS administrators provided incentive payments for hospitals that showed meaningful use of health information technology (CMS, 2013). Eligible professionals received incentives of 44,000 through Medicare, and 63,750 through Medicaid reimbursements for evidence of meaningful use (CMS, 2013). CMS administrators determined meaningful use through demonstrated attainment of 19 of 24 core objectives for incentive payments.

Through empirical evaluation of the hospital compare database, Restuccia et al. (2012) determined hospitals with high levels of HIT had better quality scores than hospitals with low concentrations of HIT. Restuccia et al. concluded that there was clear evidence that patient care quality improves with HIT.

The CMS definition of meaningful use fell into three categories. The first ensured the patient may electronically access personal demographic information, diagnostic results, and procedure information (Miller, 2012). The second and third categories ensured physicians include prescription fulfillment and related medical information in the electronic medical record and required physicians to share information electronically between practices. Additional measures provided for patient-provider interactive communication features (Miller, 2012).

Through information technology, current healthcare models evolved from illness models to wellness models. In the new model, providers ensured patient care through a continuum of care (Murphy, 2011). Care followed the patient from the office or hospital to the home environment. Methods such as health education and follow-up-care take place through information technology. New methods of patient access and communication allow hospital physicians to reach patients in ways never before possible (Murphy, 2011). Through health record sharing, and communications including emails, Facebook, and other means of social media, physicians, hospitals and other healthcare providers improved patient health and wellness (Murphy, 2011).

In a study of Veterans Administration hospitals across the United States, Woods, et al. (2013) found patients declared satisfaction with care after receiving electronic access to health records. Furthermore, Woods et al. concluded the patients who felt involved in their care plan, also sensed empowerment and control over personal care. The patients suggested access to records enhanced communication clarity and subsequent communication with providers (Woods et al., 2013).

While information technology improves the quality of care, Litwin (2011) asserted that an employee involvement in the implementation of technology is critical to its success. Litwin (2011) found that clinics with highly engaged employees enjoyed high levels of employee satisfaction and achieved significantly better results with information technology. Companies, whose leaders included employees early in the IT implementation process, achieved greater success than those who did not engage employees early in the process (Litwin, 2011). Litwin concluded administration should include employee engagement as a business strategy to improve processes and patient satisfaction.

Performance Improvement and Quality

A variety of strategies exists for improving performance in healthcare systems. A few recognized strategies include: (a) implementing high performance work practices (HPWP), (b) hardwiring excellence (sometimes known as the Studer Model), (c) lean six-sigma, and (d) the Baldrige model. While varying methods exist, management may choose the method most compatible with the company's culture (Robbins, Garman, Song, & McAlearney, 2012).

As a result of extensive literature review and analysis of the same, Robbins et al. (2012) suggested HPWP's be implemented in most any business with some degree of success. Using HPWP allowed administrators to reward performance for managers and staff alike. Recognizing managers and personnel for achievements may have provided positive performance outcomes (Robbins et al. 2012). While hardwiring excellence involved engaging passion, lean six sigma means engaging employees through

empowerment and shared purpose. The Baldrige process utilized education and recognition for performance improvement, HPWP's included aspects of each of these popular methods (Robbins et al., 2012). Robbins et al. concluded HPWP's may be successful across a variety of healthcare cultures.

Similarly, Tricco et al. (2012) concluded *pay for performance* based on quality indicators resulted in improved physician performance. Tricco et al. (2012) examined a series of clinical trials and associated patient outcomes. The clinical trials, which included quality improvement indicators, resulted in positive patient outcomes. Physicians, whose business practices included the use of quality indicators, determined that the doctor's patients realized positive healthcare outcomes. Moreover, the physicians received financial rewards for ascertaining positive healthcare outcomes for the patients (Tricco et al., 2012).

While varying techniques exist to address employee performance, customer feedback may be a valuable tool in pinpointing areas for improvement. To ascertain successful performance improvement, physicians worked with patients, and the patient's families to identify areas wherein patients suggest improvement (Stelfox, Boyd, Straus, & Gagliardi, 2013). Stelfox et al. (2013) determined measuring quality of care, based on patient feedback, is the first step in improving patient outcomes. Patient and family values and preferences were paramount considerations in the performance improvement approach to quality care (Stelfox et al., 2013).

Small practices have greater challenges than larger systems in transforming care as the small practice practitioners are often financially strapped. Marsteller, Woodward,

Underwood, Chun-Ju, and Barr (2011) studied small practices and through patient-family-physician teams learned the high cost of IT is often a barrier to performance improvement for small practices. Marsteller et al. (2011) found by posting information, including patient education pieces, staff information pieces, and patient safety practices, communication improved at minimum cost.

While Marsteller et al. (2011) noted the importance of information sharing for performance improvement, Zohar & Polachek (2014) concluded similarly. Zohar and Polachek (2014) conducted an experimental study. The study included two groups, a control group with no manager intervention and an experimental group with manager intervention. Daily, the manager in the experimental group, discussed security and productivity related issues with employees. Zohar and Polachek (2014) concluded employees who received regular communication, displayed safety behaviors, and had fewer safety incidences than employees who did not receive frequent information.

While Zohar and Polachek found communications improves safety behaviors Hwang, Change, La Clair and Paz (2013) concluded integrated delivery system (IDS) models have shown characteristics of quality and safety in care organizations. By integrating care, throughout the continuum of care, including physician services, labs, and outpatient services, patients receive higher quality care for lower cost. Hwang et al. (2013) observed that, in 19 of 21 clinical studies, the clinical effectiveness indicators such as the (a) number of visits, (b) lengths of stay, and (c) medication errors were higher in IDS systems than in non-integrated healthcare systems. Hwang et al. (2013) based conclusions on the health effectiveness data and information set (HEDIS) garnered from

the research. Superior performance in service systems including diabetes care, hypertension, depression, congestive heart failure, and asthma, resulted from strict protocols and care continuity (Hwang et al., 2013).

The Deming approach to performance improvement may contain strict protocols and care continuity processes. Tripathi et al. (2013) used the sequence of plan-do-study-act when assessing the effectiveness of family rounds to affect perception of patient-centeredness. Tripathi et al. (2010) concluded by communication between families and healthcare providers improves with structured family rounds.

Commonly, healthcare quality improvement teams use the Deming cycle to plan care strategies. Parker et al. (2012) found the plan-do-study-act approach of treating patients with attention deficit disorder was effective in improving treatment and patient care. 92 patients responded to surveys with respect to clinical interventions. The results showed the quality improvement measures resulted in improved patient care through improvements in physician performance (Parker et al., 2012).

Performance improvement plans including pay for performance align with the Obama Administration's goals in respect to the ACA (CMSCMS, 2013). Pay for performance was deemed effective both by CMS administrators and researchers including Robbins et al. (2012) and Tricco et al. (2012). Other strategies found effective included the HPWP and the Deming Cycle; other improvement programs resulted in varying degrees of success (Parker et al., 2012; Tripathi et al., 2013, & Robbins et al., 2010).

Laws and Regulations

The Obama Administration established the Affordable Care Act of 2010 to improve healthcare delivery in the United States. The program included value based incentive payment plans or pay for performance. The program administrators reward hospitals for positive inpatient quality reporting measures and disincentives' hospitals for readmissions and hospital acquired conditions (CMS, 2013). The developers of the affordable care act of 2010 designed the act in such a way as to address the needs of the current healthcare delivery system.

Researchers at the Institute of Medicine found that hundreds of thousands of deaths annually resulted from medical errors (Liang & Mackey, 2011). In 2010, healthcare provider medical errors added $19.5 billion to health care costs in the United States; the treatment of medical injuries from these mistakes cost over $6.3 million (Liang & Mackey, 2011). Provisions of the ACA included mandates that top quartile readmission rates for preventable conditions will result in a 20% reduction in Medicaid payments if the readmission is within 7 days and 10% if the readmission is within 15 days (Liang & Mackey, 2011). Additionally, hospital administrators will achieve a 1% reduction in Medicaid payments to hospitals with high rates of medical harm. Medical harm includes incidences of hospital acquired infections, medication errors, and medical errors. The patient experience scores and physician scores, reflected through HCAHPS, will affect reimbursement rates (Liang & Mackey, 2011).

In 2013, hospitals became eligible to receive incentive payments based on how hospital teams perform in 25 core areas. These areas included 17 clinical process

measures based on best practices standards defined by CMS administrators and eight measures based on HCAHPS (Fowler et al., 2013). Hospital administrators can earn points for improvements from year to year in areas such as clinical process improvements, outcomes, patient experiences, caregiver experiences, and rates of admission for certain conditions. In October, 2013, Medicare administrators began determining hospital reimbursements on performance measures, according to rules from CMS. Patient satisfaction determines 30 percent of the incentive payments while improved clinical results decided 70 percent (CMS, 2013).

Accountable care organizations (ACO) administrators began receiving a lump sum payment for services. The ACO administrators, in turn, began distributing the payments to the healthcare providers. Additionally, the ACO administrators began receiving incentive payments for delivering care at a lower cost than benchmark (CMS, 2013). Hospital administrators recognized the need to improve processes, and promote healing and patient care to maximize incentive payments (Davis, Abrams, & Stremikis, 2011). Incentive payments became both socially and financially necessary to ensure both positive patient experiences and the hospital's viability (Rauscher Singh, & Wheeler, 2012; Volland, 2014).

Not only do the HCAHPS scores affect the hospital reimbursement rates, the scores are also are publically available on the internet. With increased transparency, healthcare consumers can make informed decisions based on the patients' view of quality care (Villanueva & McCall, 2012). Transparency encouraged health care providers to improve care. Under the ACO, physicians who effectively collaborate to improve patient

outcomes with other providers will thrive in the new healthcare environment (Kocher et al., 2013).

Through ACOs, current healthcare provider models evolve. CMS administrators created a new model to encourage healthcare providers to focus attention on outstanding patient experiences and shared clinical outcome goals (Kocher et al., 2013). Care organization administrators that redesign care processes for reliability, and who offers the patient higher quality and higher value will reap financial rewards (Kocher et al., 2013). The goal of CMS's value based purchasing plan was to promote a 20% reduction in hospital readmission rates by the end of 2013, thereby potentially preventing 1.6 million hospitalizations and saving the United States government an estimated 15 billion (Kocher & Adashi, 2011).

Management Strategies

While CMS administrators focused on the patient experience score as a metric for measuring quality care, hospital administrators required teams to concentrate on the culture of care rather than on individual scores (McCaughey, Stalley, & Williams, 2013). McCaughey et al. (2013) concluded that culture and leadership were the best predictors of patient satisfaction and not just money spent on operations. After evaluating EVS expenditures and patient satisfaction scores in multiple hospitals, McCaughey et al. observed significant EVS expenditures did not correlate with high patient satisfaction scores. Leadership, cleanliness culture, streamlined processes, and training of the EVS team resulted in positive scores (McCaughey et al., 2013). McCaughey et al. (2013) found newer facilities realized higher EVS scores than older facilities.

While CMS administrators focus on the patient experience score, many hospital administrators do not have a structured plan for promoting the patient experience (Rozenblum et al. 2012). Rozenblum's research team collected 1004 questionnaires to assess the attitudes of clinicians towards hospital management plans in respect to patient satisfaction improvement. Rozenblum et al. (2012) found that 90.4% of clinicians believed patient satisfaction improvement was achievable, only 9.4 % indicated the department leadership had a structured plan to do so. Clinicians who received feedback from hospital management were more likely to state the team had a structured plan to increase patient satisfaction than those who did not receive feedback (Rozenblum et al. 2012). Rozenblum et al. (2012) concluded that achieving high levels of patient satisfaction required a proactive management team and engaged frontline clinicians.

HCAHPS Clinical Measures and Patient Satisfaction

Hospital clinicians measure pain management on a 0-10 numerical scale. Phillips, Gift, Gelot, Duong and Tapp (2013) searched for a correlation between pain management and patient satisfaction. While literature review showed that other researchers found a positive relationship between patient satisfaction and pain management, Phillips et al. found no association between pain intensity score and patient satisfaction with comprehensive pain management. The majority of patients surveyed reported that they were satisfied or very satisfied with personal overall pain management regardless of the patient's pain intensity score (Phillips et al., 2013). Bozimowski (2012) found that by communicating realistic expectations for pain levels, patients reported positive patient experience scores with regard to pain management.

In a study of the HCAHPS database, Day, Hutlzer, Karia, Vangsness, Setia, and Bosco (2013) searched for a correlation between hospital acquired conditions after surgery and patient satisfaction. Day et al. found no significant difference in the mean score for patients willing to recommend the hospital or in the average score for patients' overall satisfaction. The patient population included those with HAC's and those without HAC's. Day et al. concluded that the results indicated factors other than those clinically related to personal care affect satisfaction.

While Day et al. (2013) found no relationship between HAC's and patient satisfaction, Mehrotra et al. (2013) found patients isolated by virtue of the patient's contact precaution status, perceived problems with received care. The isolation patients perceived lack of respect, lack of attention to personal needs, and inadequate care coordination. Mehrotra et al. (2013) concluded isolation patients understand when nursing staff labels the patient's door indicating the patient's contact precaution status, the level of care declines.

The age old theories of Maslow hold true in healthcare today. Jackson et al. (2014) asserted application of Maslow's constructs propels healthcare providers into new levels of care wherein patients recognize holistic care from the healthcare providers (Jackson et al., 2014). Kennedy, Craig, Wetsel, Reimels, and Wright (2013) noted upward trend in HCAHPS scores, in hospitals wherein patients perceived self-actualization along with personal physical care. Kennedy et al. (2013) measured HCAHPS scores after implementing interventions including manager rounding, discharge phone calls, and discharge teaching. Manager rounding provided the opportunity for

nursing leadership to evaluate proactively nursing quality from a patient's perspective (Kennedy et al. 2013). Additionally, caregivers who followed up with patients after discharge enhanced the patient recovery process. Discharge instructions both in writing and through conversation with caregivers improved caregiver-patient communication (Kennedy et al. 2013).

Communication and Patient Satisfaction

Several of the HCAHPS survey questions included caregiver communication with patients. In healthcare, miscommunication could result in serious patient consequences if critical information is miscommunicated or misunderstood. As such, O'Leary, Darling, Rauworth, and Williams (2013) studied issues of hospitalists' communication practice. Before and after the hospitalists attended communication training, patients rated personal satisfaction with their caregiver's communication skills. No significant differences emerged in the HCAHPS patient satisfaction score in regard to physician communication post training (O'Leary et al., 2013).

While O'Leary et al. (2013) found no correlation between hospitalist communication education and patient satisfaction; the HCAPHS scoring system includes opportunities for all patients to assess satisfaction with caregiver communication. Communication with physicians, communication with nurses, responsiveness of hospital staff, communication about medication and discharge information, comprise five of eight measures of the HCAHPS patient experience score (CMS, 2014).

Multidisciplinary rounding is an approach some hospitals use to enhance communication between caregivers and patients. Lown and Manning (2010) found that

multidisciplinary rounds enhanced patient-centered communication, team work, and provider support. Lown and Manning interviewed caregivers to determine their perception of the value of multidisciplinary rounds. Participants in Lown and Manning's study indicated the multidisciplinary rounds enhanced understanding of the various caregivers' roles in patient care. A side benefit, according to participants, was decreased stress and enhanced respect and appreciation for the participants' colleagues (Lown & Manning, 2010).

Nursing huddles, bedside, reporting, and nursing rounds are way nurses enhance communication while improving patient satisfaction. Bernhardt and Misterek (2014) found that the enhanced communication among caregivers through huddles, bedside reporting, and rounding both improved patient outcomes and patient satisfaction. In one hospital, individual nursing units implemented processes to improve communication. Coincidentally, the nurse managers tracked the HCAHPS scores on a scorecard. Bernhardt and Misterek concluded enhanced communication through huddles, rounding and bedside reporting increased HCAHPS scores on units hospital wide.

While communication and enhanced support reduced stress in caregivers, communication and support has also been shown to decrease stress and anxiety in patients. In a study of patients' perception of suffering upon admittance to the emergency department, Body, Kaide, Kendal, and Foex (2013) determined that not all suffering is pain. Emergency room patients reported that information, care and compassion, and treatment resulted in relief of suffering due to emotional distress (Body et al., 2013). Body et al. indicated a friendly face and a smile go a long ways towards relief of patient

suffering.

Pharmacists play a significant role in patient safety as the pharmacist reviews medications prescribed to patients to ensure the combinations of medications work in concert with each other. To enhance physician-pharmacist communication and patient safety, some hospital administrators include pharmacists in physicians' patient rounds. Wilkinson and Couldry (2011) found that hospital teams with pharmacists, who had direct patient contact, realized lower patient readmission rates and higher patient satisfaction. In the Wilkinson and Couldry study, a pharmacist visited with each high-risk patient before discharge to ensure the patients understood their medication regime. The hospital realized improved communication among caregivers and reduced readmission rates (Wilkinson & Couldry, 2011).

Hospital emergency departments receive an abundance of non-English speaking patients. Physicians require licensed interpreters assist in communicating a patients' condition and care plan (CMS, 2013). Not only is licensed interpretation a requirement, interpretation services may result in improved patient satisfaction scores (Bagchi et al., 2010). In a study of 242 emergency room patients whose native language was Spanish, Bagchi et al. (2010) found that the availability of in-person professional interpreter services during emergency room visits improved patient satisfaction with communication.

Patient Satisfaction Fishbone

The results from the extant literature suggest that a patient's degree of satisfaction fell into three broad categories, interactions, services, and hospital design aspects. While

each of these categories included concepts of value to the hospital experience, interactions and services were the primary drivers of a patient's satisfaction. Hospital design did not emerge as a central element of the patient's perception of satisfaction. Nurse/physician-patient relationships including responsiveness and perceived care along with health outcome emerged as the most significant predictors of a patient's satisfaction. Outcome included the idea that the hospital met the customer's expectations.

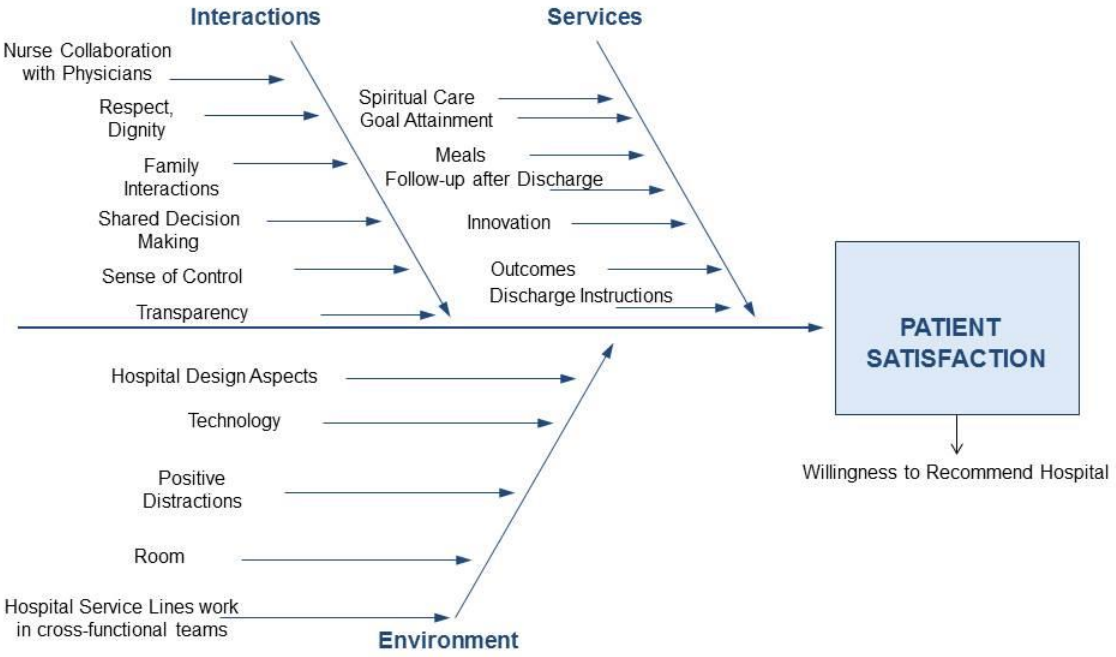

Figure 1. Fishbone structure of constructs of patient satisfaction.

Customer Satisfaction Theory in Service Industry

While hospital administrators strive to achieve positive patient satisfaction

surveys, parallels in other service industries provide guidance to the constructs of customer satisfaction. Weng, Ha, Wang, & Tsai (2012) deduced the constructs of patient satisfaction included reliability, responsiveness, assurance, tangibility and empathy. Weng et al. (2012) asserted the purpose of satisfying the customer is business growth, market share, and repeat and referral business. Customer satisfaction leads to increased profitability (Weng et al., 2012). Client satisfaction occurred when the service providers met or exceeded the client's expectations while consumer dissatisfaction occurred when performance fell below expectations (Weng et al., 2012). Enterprise owners invested resources to understand customer needs, to increase customer value, and to develop products and services which result in customer satisfaction (Weng et al., 2012). Weng et al. (2012) found that customer survey results showed a positive correlation between CI and CV and CS. Innovation in service is a new service concept that requires companies make improvements in customer interactions, service transmission systems, and technology (Weng et al., 2012).

In the restaurant business, Cant and Erdis (2012) established that a clear relationship existed between customer satisfaction, customer retention, and loyalty. To remain competitive in the industry, restaurateurs should focus on rising customer expectations. While customer expectations were important, employee satisfaction was necessary to ensure employees provide superior customer service (Cant & Erdis, 2012).

Customers have many choices when it comes to restaurant selection. One instrument researchers used to evaluate customer service is the Servqual customer service survey. The Servqual survey included five areas for restaurateurs to consider when

evaluating service. Customers answered questions in regard to (a) the restaurant's food quality (hygiene, balance, and healthiness), (b) service quality, (c) physical provision (layout, furnishing, and cleanliness), (d) atmosphere (feeling and comfort), and (e) service received (speed friendliness, and care). Ramseook-Munhurrun (2012) divided the question responses into three categories (a) tangibles, (b) quality-reliability, and (c) assurance-empathy-responsiveness. Ramseook-Munhurrun (2012) established the greatest predictor of customer satisfaction and repeat business was food quality and reliability. Reliability included correctness of the order, timeliness, and accurate billing for products.

Innovativeness is an area of customer satisfaction that Kibbeling, Van der Bij, and Van Weele (2013) argued results in customer satisfaction. Furthermore, Kibbeling et al. (2013) asserted a firm's innovativeness depended on market orientation, and, firm's suppliers drove innovativeness. Market orientation had within firm effects and innovativeness had an impact beyond boundaries of the firm (Kibbeling et al., 2013).

Self-awareness and decision making behaviors may connect a person's sense of responsibility to a person's perceived satisfaction. Pham, Goukens, Lehmann, and Stuart (2010) concluded that self-aware individuals tended to internalize control. Individuals with an internal locus of control attributed satisfaction internally rather than externally. If an organizational leadership ensured the customer felt in control of the received healthcare plan, customers experienced satisfaction (Pham et al., 2010).

Customer satisfaction is the result of perceived value; the level of customer satisfaction determines a company's success (Saeed, Niazi, Arif, & Jehan, 2011).

Outcomes of customer satisfaction included loyalty, retention, and word of mouth. Saeed et al. (2011) concluded that the image, quality, and cost of goods sold had a relationship with customer satisfaction.

Similarly, in a study of a Chinese restaurant, Ryu, Lee, and Kim (2012) surmised the physical environment, the quality of food, and service had a significant impact on the restaurant's image. Ryu et al. (2012) suggested a restaurant's image affected the patron's perception of perceived value; perceived value was a predictor of customer satisfaction. Through integrative modeling, Ryu et al. (2012) found a significant relationship existed between environment, food quality, and service and customer satisfaction.

Customer relationship management (CRM) is a term used by many companies to garner sales and to develop long term customer relationships. One industry that uses CRM as a strategy is the hotel industry. Long, Khalafinezhad, Wan Ismail, and Abdu Rasid (2013) surveyed hotel customers to evaluate: (a) hotel employees' knowledge and performance of CRM, (b) the hotel employee's quality of delivered customer services, (c) the hotel management's ability to develop customer relationships, and (d) the quality of the hotel's information management systems. Long et al. (2013) concluded that quality service includes (a) meeting customers' expectations, (b) providing quality services and (c) handling complaints efficiently. Furthermore, effective customer relationship management includes effective touch point activities such as (a) employee-customer interactions, (b) hotel management's billing practices, (c) customer services, and (d) use of information management. Moreover, Long et al. asserted customer strategy, customer interaction, brand strategy, and value creation strategy makeup the features required for

strong customer relationships and longevity.

Business leaders recognized customer retention was an important aspect of business management that contributed to success (Nitzan & Labai, 2011). Nitzan and Labai (2011) studied customer satisfaction and customer defection. Nitzan and Labai concluded that the level of customer satisfaction correlated with the rate of customer defection. Furthermore, Nitzan and Labai found that (a) the degree to which customers used a product or service, (b) the customer's gender and age, (c) switching costs, (d) negative word of mouth, and (e) promotions by other companies, influence customer defection decisions. Exposure to defecting neighbors also influenced consumer decisions. When neighbors defected, and close ties existed between customer and neighbor, the risk of defection increased (Nitzan & Labai, 2011). Successful businesses thrived on reputation and customer satisfaction (Nitzan & Labai, 2011).

Companies with strong corporate brands and positive reputations may not need the investments in marketing that other businesses need (Ali, Alvi, & Alvi, 2012). In the service industry, a corporation's employees' behaviors towards consumers were essential to retaining the company's customer base. Ali et al. (2012) surveyed cell phone industry consumers to ascertain the qualities consumers valued in a cell phone company. Ali et al. concluded that both the corporation's reputation and the corporation's employees behaviors toward the consumer, correlated with the consumer's response to the corporation. Positive interactions with the customers created loyal customers and resulting repeat business. Loyal customers asserted high levels of customer satisfaction (Ali et al., 2012). Business executives value customer retention and loyalty and consider

customer retention and loyalty essential qualities of successful companies. High, positive corporate reputations improved customer-relationship indicators such as customer satisfaction and loyalty (Ali et al., 2012).

Strategies for Improving Customer Satisfaction

Business leaders create strategies for improving customer satisfaction to ensure business viability. Alidadi and Nazari (2013) surveyed customers to understand what aspects of banking services customers valued. The survey consisted of four categories that included questions in regard to (a) staff training, (b) environmental factors, (c) customer service, and (d) subjective imagination. The results led Alidadi and Nazari to conclude that implementing plans and actions to improve customer service was the most important customer service strategy. Action plans included (a) ensuring service variety, (b) ascertaining service speed, (c) ensuring customers perceived fairness, (d) providing competitive interest rates, and (e) providing electronic services. Furthermore, customers indicated the second most significant factor for satisfaction was the level of employee's demonstrated competence in areas including (a) responsiveness, (b) knowledge, (c) customer complaints, (d) availability, and (e) friendliness. The third most prominent factors included aspects of subjective imagination such as (a) brand management, (b) advertisements, and (c) social responsibility. In a distant fourth, customers placed little value on (a) the environment, (b) facilities, (c) dress of personnel, (d) cleanliness, (e) space, and (f) proximity to transportation (Alidadi & Nazari, 2013).

Hotel industry consumers asserted not only service quality, but also service innovation is an important aspect of customer satisfaction. Ming-Horng, Jih-Lian, Yi-

Chou, and Chung-Lin (2012) discovered that customers value companies with innovative processes and services. Ming-Horng received 433 responses to a 7-point Likert-scale survey, where respondents rated the importance of customer services including (a) service performance, (b) perceived value, and (c) service innovation. In the hotel industry, consumers indicated that innovation in the received services was a competitive advantage (Ming-Horng et al., 2012).

The first step towards achieving process improvement is examination of the customer service value streams (CMS, 2013; Cliff, 2011; Kocher et al., 2013; Saeed et al., 2012; & Weng et al. 2012). Business leaders should identify the processes and service that result in consumer value. Moreover, leaders must understand the interdependencies between the value streams and other business processes (Ming-Horng et al., 2012). The process improvement manager identifies the owner or owners of the various processes, set goals, identify metrics, and put in place feedback mechanisms. Analyzing the cost of each of the value streams and the probable cost of change is a crucial step to prioritize projects (Ming-Horng et al., 2012). Regardless of the industry, value analysis is a significant step towards business viability and success.

Customer Satisfaction Fishbone

Through the literature review of customer satisfaction, the three primary components of customer satisfaction emerged as (a) interactions, (b) services, and (c) the environment. While all three of these areas impacted customer satisfaction, interactions and services emerged as the primary drivers of customer satisfaction. Specifically, quality and reliability, while meeting customer expectations, resulted in customer satisfaction

(Khalafinezhad et al., 2013; Long et al., 2013; Ryu et al., 2012; Saeed et al. 2011). Satisfied customers boosted a corporations' reputation; loyalty and repeat business follow reputation (Alvi et al. 2012; Nitzan & Labai, 2011). Finally, service providers who responded to customer concerns increased customer satisfaction (Ali et al., 2012).

Throughout the literature review, innovative technology emerged as a driver for disruptive innovation, and innovation technology disrupted the customer service industry. In order to remain competitive, companies should effectively use technology for innovation in (a) marketing, (b) services, and (c) customer communication to drive satisfaction (Apekey, 2011; Cliff, 2011; Weng et al. 2012; & Williams et al., 2011). The customer satisfaction fishbone reflects the three primary constructs of customer satisfaction. The services construct includes innovation as theme customers valued.

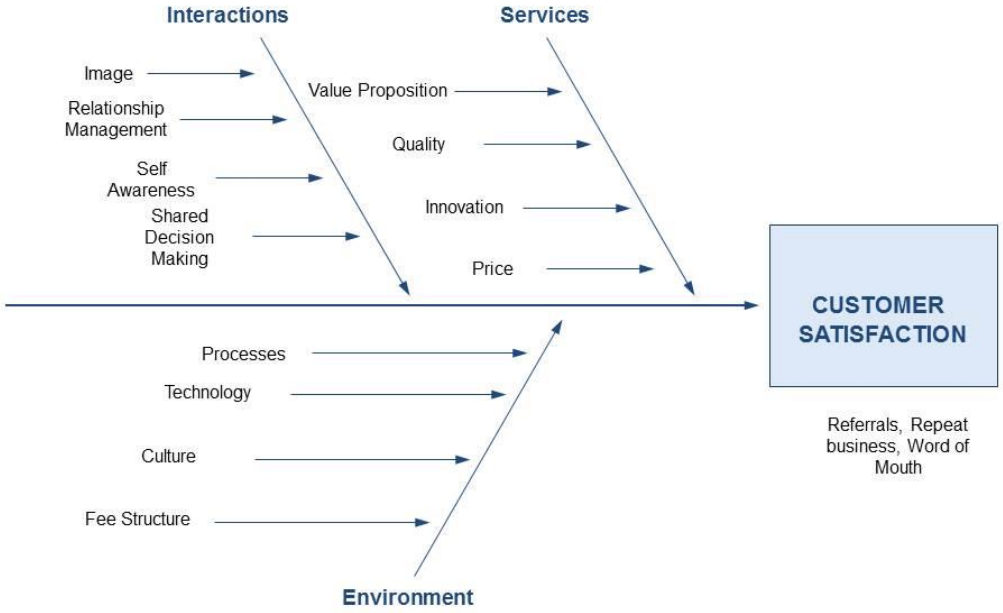

Figure 2. Fishbone structure of constructs of customer satisfaction.

Summary of Patient and Customer Satisfaction

The extant literature review includes theories on plans and initiatives needed to achieve patient satisfaction with the healthcare experience. Furthermore, the literature review contains theories for activities and plans which, when implemented, result in customer satisfaction within service industries. Plans and initiatives for achieving patient satisfaction emerged as similar to the plans and activities service industry business leaders implemented to attain customer satisfaction. The concept of satisfaction in healthcare is of interest to healthcare leadership because of CMS reimbursement based on HCAHPS scores. Through Value Based Purchasing, and the Affordable Care Act, legislators created a structure wherein the patient experience becomes paramount. The next part of the literature review includes information on legislation, the HCAHPS scoring system, and fishbone diagram that may be compared to the diagrams of customer service and patient satisfaction.

Value Based Purchasing and the Affordable Care Act

Disruptive innovation began with the requirement for transparency in 2007 when HCAHPS score reporting became a prerequisite for payment. Through transparency initiatives, the government forced removal of the *shroud of secrecy* (Reinhart, 2013). Healthcare administrators no longer negotiated prices with insurance companies. Instead, CMS began dictating price structure. The next significant step in disruptive innovation was the HITECH act where the government injected subsidies into technology in the healthcare arena. Hospital leaders quickly began implementing electronic medical records

and other technology to take advantage of the influx of funding for these initiatives. Through federal technology subsidies, hospital administrators took advantage of the opportunity to (a) change patient records maintenance, (b) document patient throughput, and (c) communicate with patients. The rapid influx of technology disrupted many organizations; researchers determined hospital culture and resulting behaviors may affect the success of technology implementation (Litwin, 2011; Tyagi, Cook, Olson, & Belohlav, 2013).

Following the HITECH act, legislatures signed into law the ACA of 2010 which created a value-based purchasing (VBP) administered by CMS. Provisions of the VBP program directed CMS administrators to base acute care hospital fee reimbursements 70% on clinical process measures, and 30% on patient experience measures (Liang & Mackey, 2011; Zusman, 2012). Low-performing hospitals received 1% reimbursement penalties in 2013 capping at 2% in 2017 for incidences of harm and poor patient experience scores (Liang & Mackey, 2011). Reimbursement penalties free up financial incentives to reward high performing hospitals on the basis of HCAHPS measure of quality of care. The 1% withholding will increase incrementally to 2% by fiscal 2017 (Kennedy et al., 2013).

Roughly 50% of hospital teams do not meet the standard of care for full reimbursement, and as such, hospital administrators should focus on strategy creation that will demonstrate performance improvement to ensure substantive reimbursements from CMS (Davis, Abrams, & Stremikis, 2011). CMS administrators based reimbursements on 12 quality measures and nine patient experience measures as displayed on the CMS

Hospital Compare website. CMS reimbursements were based on average periodic performance measure scores and score improvement over baseline (Zusman, 2012). The total quality performance score (TPS) consisted of the sum of the scores of each measure. CMS administrators incentivized hospital managers with the TPS. Zusman (2012) surmised that other insurers may adopt VPB program as CMS administrators pressure insurance company representatives to require quality improvement measures in contracts with service providers. The provisions of the new reimbursement model, incentivized hospital leaders to ensure patients record positive scores on the HCAHPS.

The safety-net hospitals' administrators (SNH) may be at risk in the changing reimbursement climate. In a study of 3096 U.S. hospitals, from data gathered off of the hospital compare data base, Chatterjee, Joynt, Orav, and Jha (2012) concluded that safety- net hospitals performed lower on HCAHPS surveys than non-safety-net hospitals. Chatterjee et al. (2012) surmised that the data indicated that there was a gap in the care quality in hospitals serving the most vulnerable of the community. Caregivers at safety-net hospitals treat lower income patients. Many of these patients depend on CMS for insurance coverage. As such, the hospital's accounts receivable teams do not receive significant revenue streams to counterbalance deficits in CMS reimbursements. Administrators in safety-net hospitals will need staff to provide high quality of care to ensure the hospital receive the maximum available reimbursement from CMS (Chatterjee et al., 2012).

While safety net hospital teams struggle with HCAHPS scores, similarly Borah et al. (2012) discovered additional hospital demographic characteristics correlated with the

TPS. The characteristics included the following: (a) profit-status, (b) geographic location, and (c) the total number and types of CPC measures reported. Borah et al. (2012) conducted multiple regression analysis to establish relationships between hospital characteristics and quartile scores as listed on the CMS Hospital Compare website. Through the study of the relationship between hospital characteristics and scores, Borah et al. concluded that hospital leaders may have to make structural changes in ownership and services offered to remain financially viable in a changing environment.

While demographic characteristics played a role in HCAHPS scores, nursing staff may have had the greatest impact the high quality of care reflected by the HCAHPS scores (Wolosin, Ayala, & Fulton, 2012). Wolosin et al. (2012) conducted logistical regression of HCAHPS scores and determined that a positive correlation existed between patient's satisfaction with nursing and overall patient satisfaction. Wolosin et al. found that each 1% point increase in nursing care scores equated to a 4.9% increase in overall patient satisfaction. Secondary to nursing care, physician care, condition of the room, and meals emerged as significant indicators of future HCAHPS scores. The results of the Wolosin et al. healthcare study indicated that individuals throughout the healthcare facility have an effect on the patients' perception of care. Moreover, Wolosin et al. (2012) concluded that candidates for healthcare employment should have (a) strong interpersonal skills, (b) customer service training with reinforcement, and (c) incentives that reward performance to improve patient satisfaction.

Results from studies on value based purchasing, indicated a variety of factors have an effect on HCAHPS scores. Wolosin et al. (2012) found in order to be successful

in the changing healthcare environment; effective human resourcing has a significant influence on resulting HCAHPS scores (Wolosin et al., 2012). Chatterjee et al. (2012) pointed out the influence of quality care throughout the healthcare organization on HCAHPS scores. Finally, Borah et al. (2012) noted the importance of attention to the number and types of CPC measures reported which determine the TPS. Hospital administrators may want to align strategies with the needs or deficits in the administrator's organization to align the business model in such a way to maximize CMS reimbursements.

Strategies for Improving HCAHPS Quality Measures

As a result of the recent changes to the CMS reimbursement structure, hospital administrators may want to align processes and initiatives to ensure patients rate positively the quality of care they received during the patient's hospital visit. Lei and Jolibert (2012) asserted perceived quality of care is an antecedent for patient satisfaction; furthermore, patient satisfaction is necessary to ensure patient loyalty and repeat business. Lei and Jolibert (2012) adapted the SEVQUAL questionnaire to survey patients on the quality of care the patients received during the patient's last hospital visit. Lei and Jolibert concluded that the SEVQUAL patient satisfaction survey reflected the patient's perception of quality. Patient satisfaction mediated the relationship between perceived quality and patient loyalty (Lei & Jolibert, 2012).

The question emerged, how do hospital leaders ensure the patient perceives quality of care? A physician's group surmised (a) access, (b) communication, and (c) information technology were aspects of care patients desired (Friedberg, Steelfisher,

Karp, & Schneider, 2011). Patients answered survey questions in regard to (a) information technology, (b) physician and employee communication skills, (c) workflow characteristics, and (d) wait times. Friedberg et al. (2011) conducted a multiple regression analysis of survey responses and determined workflow improvements and reduced wait times improved customer perception of care. Additionally, patients who asserted physicians and staff communicated well also indicated satisfaction with services. Friedberg et al. (2013) concluded that with (a) the effective use of information technology, (b) efficient effective appointment scheduling, (c) friendly follow-up, and (d) health information availability, physicians may expect positive patient satisfaction scores.

While care during patient visits may affect patient satisfaction scores, physician practice models that include enhanced support through shared decision making may also reap positive financial results. Verrof, Marr, & Wennberg (2013) concluded that enhanced support through shared decision making lowered medical costs by 5.3%. The enhanced support included health coaching through (a) follow up calls, (b) emails, (c) mail, and (d) internet support. Additionally, physician practices with enhanced support models achieved 12.5% fewer re-admissions and performed 20.9% fewer heart surgeries than practices without support models. The results indicated that physicians whose business models included avenues for enhanced support recognized financial rewards.

HCAHPS Fishbone

The HCAHPS scores fall into three categories, interactions, services, and the environment. While all three categories affect the overall patient experience score, the preponderance of the literature indicates that interactions and services have the greatest

impact on patient satisfaction. Quality care and interactions with nurses and physicians emerged as having the greatest impact on patient satisfaction.

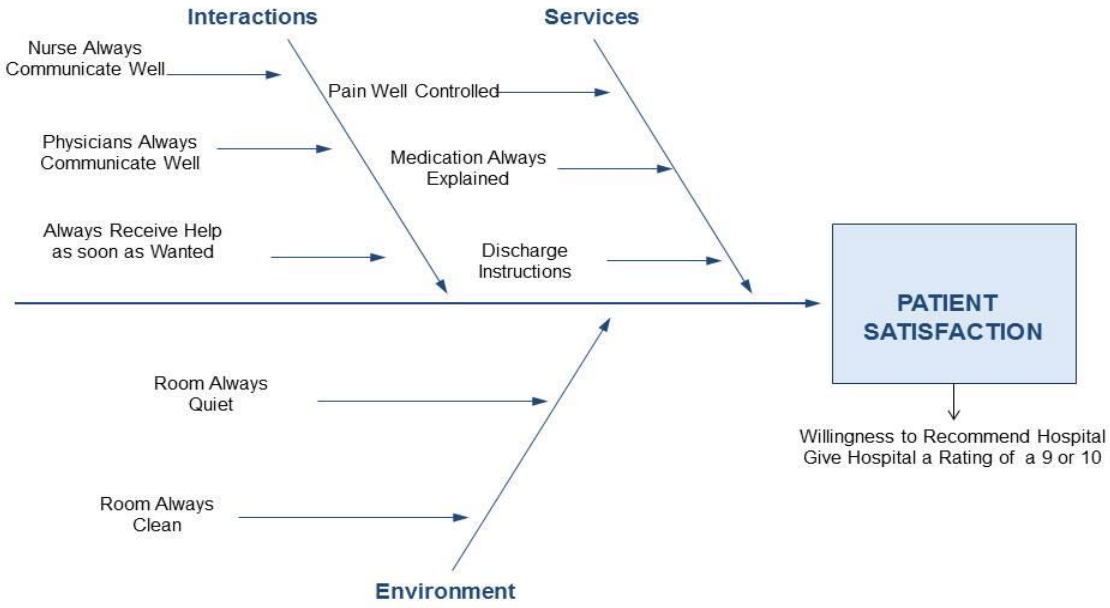

Figure 3. Fishbone structure of constructs of HCAHPS patient satisfaction.

Summary

Review of the literature uncovered key similarities between findings in patient satisfaction and customer satisfaction research. In both realms of customer service, communication and interpersonal relationships between customers and service providers emerged as key indicators of satisfaction. Customers valued shared decision making in service industries and healthcare. Customers valued innovation whether they were customers of retail businesses or healthcare services. In respect to Medicare and Medicaid reimbursements, the HCAHPS survey included aspects of communication,

relationship management, and the environment. The common thread in all arenas was effective communication and positive customer-provider interactions.

Transition and Summary

Section 1 of this study included (a) the foundation of the study, (b) the research questions, (c) the assumptions, limitations and delimitations, and (d) the significance of the study. The literature review concluded Section 1 of the study. The foundation of the study contained the background of the study that included a discussion about the evolution of the healthcare industry and the role that patient satisfaction plays in the hospitals' financial viability. The problem statement and purpose statement included an introduction of the business problem and the case for further research. Covered in the nature of the research was the suitability of case study research to answer the questions posed in this study. Author citations purported that case study research was a both appropriate and insightful approach to qualitative research (Crowe et al., 2011; Yadav, Shaver, & Meckl, 2010; Yin, 2014). The research question section included (a) the research questions, (b) the conceptual framework, and (c) the definition of terms. The definition of terms covered the jargon related to health care research. The assumptions, limitations, and delimitations section included descriptions of the facts assumed true, the potential weaknesses of the study, and features that bound the study. The significance of the research uncovered clear evidence that, in this arena, there were gaps in the research (Cliff, 2011; Vest & Gamm, 2010; Zuckerman 2005). The literature review included evidence that patient satisfaction in the health care setting has a significant economic impact on health care providers (Rauscher Singh, & Wheeler, 2012, Reinhart, 2013).

Rozenblum et al. (2012) agreed that further research may help explain the strategies to achieve patient satisfaction and work in this area will likely address gaps in health care profession.

Section 2 includes a review of (a) the study purpose, (b) the role of the researcher, (c) the study participants, (d) the study methods, and (e) details of the investigation plan. Additionally, Section 2 includes (a) population and sampling methodology, (b) the issues surrounding ethical research, (c) the data collection instruments, and (d) the data collection and organization technique. Section 3 contains (a) the data analysis including the interview questions, (b) the software, (c) the data presentation and interpretation, and (d) issues surrounding validity and reliability. Section 3 also contains the research findings and how the findings relate to professional practice. Additionally, Section 3 contains implications for social change and call for action. Future researchers will find recommendations for further research. Section 3 concludes with a description of how the theoretical framework related to the study's findings.

Section 2: The Project

Section 2 of this case study contains a rich description of the research project plan. The project plan included the research purpose, the role of the researcher, and who would contribute to the study data. The plan incorporated the research process and design, information in regard to the population and sampling, and ethical research considerations. Incorporated in this section is information on the (a) data collection instruments, (b) data collection processes, and (c) data organization techniques. Additionally, residing in Section 2 are the data analysis processes and information as to the reliability and validity of this study.

Purpose Statement

The purpose of this qualitative instrumental single case study was to determine the performance improvement plans that hospital administrators need to achieve and maintain high HCAHPS scores. Seven hospital administrators from one of the top 10% of HCAHPS scoring hospitals in the Dallas-Fort Worth Metroplex answered interview questions to reveal what plans administrators had in place to improve patient satisfaction, and how the administrators implemented the plans to increase HCAHPS performance scores. Findings and recommendations from this study can improve business performance by providing a roadmap for hospital administrators to inspire, design, and implement change and increase hospital HCAHPS scores. The HCAHPS scores reflect the perceived patient experience, and the scores affect revenue loss or gain for the hospital (Fowler, Saucier, & Coffin, 2013). Efficacious change in patients' hospital experience may lead to positive social impact by reflecting improved perceived quality of

care, which, in turn, may increase patient satisfaction and repeat business for the hospital (Borah et al., 2012; Chatterjee, Joynt, Orav, & Jha, 2012).

Role of the Researcher

As the researcher of this case study, I was the primary data collection instrument. My role was to ensure that processes for data collection occurred in an ethical manner per the *Belmont Report* and to ensure that bias mitigation occurred throughout the data collection process (National Institute of Health, 2014). Dalton (2013) suggested that by using the *seven pillars of information literacy* as a research bias mitigation tool, and by using the tools of (a) identify, (b) scope, (c) plan, (d) gather, (e) evaluate, (f) manage, and (g) present, a researcher may limit bias in the data collection process.

I was an *insider*, a member of the leadership team working to improve patient satisfaction in the subject hospital. Three advantages of being an insider are (a) cultural awareness, (b) natural entrenchment, and (c) established intimacy. Unluer (2012) asserted that natural entrenchment in day-to-day activities helps to minimize alteration to the flow of social interaction. Furthermore, by establishing intimacy, a researcher can determine and assert the truth (Unluer, 2012). Unluer determined that a researcher's experience and firsthand observations as an insider result in a deep understanding of existing hospital processes (Unluer, 2012).

My role was to explore plans for increasing and maintaining patient satisfaction in a healthcare setting that realizes high patient satisfaction scores. Patient satisfaction research is necessary with advancements in healthcare; hospital administrators need to understand the environment to catalyze change (Hoybye, 2013). Patients' understanding

of the healing process evolves with the patient's experience during the progression of treatment. The patient's sense of healing changes with the hospital's employees' ability to deliver an experience of homeliness and care (Hoybye, 2013).

Using observations and semistructured interviews, explanation as to how and why patient satisfaction strategies elicited positive scores in the hospital environment emerged. Yin (2009) suggested that with the use of case study research, an investigator may address a broader range of historical, attitudinal, and behavioral issues. As an employee of a north Texas hospital, I found that emersion in patient care afforded the opportunity to gain *profound knowledge* of processes and practices (Torto, 2011). Torto (2011) asserted that researchers' collegial relationships benefit researchers, as colleagues likely will choose to provide insights and perspectives into colleagues' work.

Participants

The participants in this study were members of the senior management team engaged in patient care in a north Texas Hospital. The participants shared information about strategic initiatives they perceived as successful in improving the patient experience. Through interpersonal relationships garnered by means of collegial relationships, participants allowed access (Torto, 2011). Participants for this study included a purposeful sample of seven people over the age of 18 currently working in administration at the hospital under study. As the purposeful sample included administrators who were experts knowledgeable about the plans and actions caregivers implemented in the hospital, a sample of seven resulted in insight into the research question (Thomas & Magilvy, 2011). The study participants consented and allotted time

to answer semistructured interview questions.

A second set of participants was composed of individuals who allowed patient-caregiver interaction observation. The members included a purposeful sample of caregivers who were knowledgeable about patient satisfaction initiatives and who consented freely. The caregivers were knowledgeable to the extent that they worked in a hospital where staff achieved high patient satisfaction scores.

The published study excluded participant identification to ensure confidentiality. All study members gave consent freely and without coercion (National Institute of Health, 2014). The study participants had the mental capacity to understand the consent information (National Institute of Health, 2014). The study group experienced no harm, and the social benefits outweighed the risks, as the patient experience was the paramount concern of this study. The data reside in a locked storage cabinet and will remain in storage for 5 years in both hard copy and on a jump drive until subsequent destruction. Appendix C contains the consent and confidentiality agreement for the interviewed participants, and Appendix D contains the consent and confidentiality agreement for the observed participants.

The study population included a purposeful sample of hospital administrators who direct and/or monitor the patient care initiatives in a North Texas hospital. A purposeful sample is a sample selected because of the individuals' knowledge of the subject matter (Spence et al., 2011). Choosing informed individuals as respondents is typical in case study research (Bailey, Sabbagh, Loiselle, Boileau, & McVey, 2010; Spence et al., 2011). The study participants constituted a purposeful sample accessed because of the depth of

personal knowledge of the strategic initiatives to improve patient satisfaction. Furthermore, the study participants were those who wanted to participate voluntarily; recruitment was without coercion. The participants were able to read and write in English. There were no exclusion criteria; individuals not knowledgeable in the subject matter declined to participate. There was no discrimination based on age, sex, or race. The only discriminating factor was that the participants were able to understand English, as the interviews were in English.

The sample group included seven people selected because of personal depth and breadth of knowledge of plans to improve patient satisfaction. The sample size ensured that there were a sufficient number of interviewees to result in an informed conclusion about the relationship between the actions and outcome. The responses were redundant as the respondents were knowledgeable about the hospital administration's performance improvement programs (Thomas & Magilvy, 2011; Unluer, 2012; Yin, 2014). The emerging themes from interviews, observations, surveys, and articles resulted in evidence of sample size sufficiency.

Research Method and Design

This study was a qualitative intrinsic case study. Through interviews, observations, and hospital documents, answers emerged to the following question: What performance improvement plans do hospital administrators need to achieve and maintain high HCAHPS scores? Method triangulation including the use of (a) qualitative data available from the Hospital Compare website, (b) qualitative observations, and (c) qualitative analysis of hospital documentation allowed validation of the results.

Method

This study was a qualitative research study reflecting the interpretivist paradigm. Within the interpretivist paradigm, knowledge emerges through participant-researcher interactions (Bunniss & Kelly, 2010). The interpretivist paradigm was relevant to this health care case study in that I derived meaning from the participant-researcher relationship.

Qualitative research methods allow investigators to search for meaning through open-ended questions and worldviews (Yilmaz, 2013). The qualitative research method is primarily inductive, wherein the inquirer generates meaning from field data (Yilmaz, 2013). Through semistructured interview responses, the study participants shared (a) the administrators' plans, (b) what initiatives the patients' caregivers implemented, and (c) how the hospital teams achieved high patient satisfaction scores. Through coding of input from study participants, themes emerged that identified strategies to create positive patient satisfaction scores. Through hospital records and data derived from field observations and member checks, the interview results became validated.

Researchers often use qualitative methods in health care settings. Regulatory agencies and health care researchers typically use nonexperimental designs to assess the quality of health care (AHRQ, 2012). This study was a nonexperimental research design. Through qualitative methods, how and why a given hospital achieved high patient satisfaction scores emerged.

Quantitative research methods include examining relationships among variables. Quantitative research is the best approach when the problem calls for (a) interplay

between theory and data, (b) evaluating the effectiveness of an intervention, or (c) understanding the best predictors of outcomes (Braun & Oswald, 2010). While quantitative research methods have a place in healthcare research, quantitative methods do not provide information in regard to sociological experiences that include how and why the situation occurs (Borrego, Douglas & Amelink, 2009). Quantitative methods include testing preconceived hypotheses with closed-ended questions. For the purpose of this study, quantitative methodology was not appropriate, as quantitative methods would not have resulted in *how* answers for the research questions. Furthermore, the qualitative research method enables a researcher to explore what was previously unknown and at times uncover serendipitous information.

Mixed methods research is a composite methodology including both quantitative and qualitative data. When quantitative data or qualitative data alone will not allow the researcher to find answers to the research question, mixed methods research is relevant. For this study, information from qualitative research including interview responses along with the associated data provided sufficient information to answer the research question.

Research Design

This study had a single intrinsic case study research design. A single case study is necessary when the case is (a) unique in nature, (b) representative or a model case, and (c) revelatory in nature (Yin, 2014). Patient satisfaction was the phenomenon occurring in a north Texas hospital. The hospital was unique in nature, in that it was a top-performing hospital and it was a model hospital in regard to sustained high levels of patient satisfaction. The purpose of this study was to identify and explore the plans and

initiatives hospital administrators need to implement to achieve high patient satisfaction scores, and, as such, a single case study design was appropriate. Through case study research, in-depth information with respect to a case or cases emerges (Crowe et al., 2011; Yin, 2014).

This study was a single case study intrinsic in nature. In an intrinsic case study, the researcher chooses the case based on the case's individual merit (Crowe et al., 2011). The Joint Commission recognized the subject hospital as one of the highest rated patient experience scoring hospitals. As such, the hospital administrative team added insight into the research question, and the hospital was an appropriate site for research. Yin (2014) explained that a single case study allows a researcher to explore how and why an event occurred.

In addition to case study, some of the fundamental qualitative designs are narrative research, phenomenological research, grounded theory research, and ethnographic research. Yilmaz (2013) asserted that in narrative research, the researcher explores the life of an individual. In phenomenology, the researcher explores the essence of an experience; in grounded theory, the researcher develops theory from field data; and in ethnography, the researcher interprets and describes the culture of a group (Yilmaz, 2013). The purpose of this study did not require studying the life of an individual, and thus narrative research was not relevant. Nor was the goal of the research a search for theory; thus, grounded theory was not relevant. While company culture might have added insight into the study questions, the purpose of the study was not to study the culture, and, as such, ethnographic research was not an appropriate research design. In this case

study, the responses to the interview questions added insight as to how and why a phenomenon occurred in one North Texas hospital. As such, an intrinsic case study was relevant.

Physicians historically have used case study research in assessing patient response to care and in evaluating the concepts of patient care based on patient experiences and healthcare outcome (Crowe et al., 2011). This case study involved the exploration of methods for achieving positive patient satisfaction scores and for enhancing the patient experience. Case study research requires exploring a real-life phenomenon in the phenomenon's natural context (Crowe et al., 2011; Yadav, Shaver, & Meckl, 2010; Yin, 2014). The researcher instrumentally gains broader appreciation of the phenomenon through case study research (Crowe et al., 2011).

The five components of case study research design are (a) the study questions, (b) the propositions, (c) the analysis, (d) linking the data to the propositions, and (e) the criteria for interpreting the findings (Yin, 2014). The design of this study included semistructured interview questions that reflected the CMS HCAHPS questions designed to determine whether patients perceive care satisfaction. By way of semistructured interviews, research participants provided insights into procedures that the administrators implemented to ensure high HCAHPS patient satisfaction scores. Using open-ended questions ensured that the participants' answers provided insights into the research questions. The propositions included Aragon's theory of the primary providers as determinants of patient satisfaction and Deming's model of planning, implementation, and follow-up action. Crow et al. (2011) asserted that the coding structure must link to

the theoretical framework. The participants answered the interview questions to indicate what initiatives were pursued and how hospital administrators implemented the initiatives; through coding, the response data were linked to the propositions. Methods of interpretation of findings included coding the interview responses to the items that reflected the theoretical framework and linking the coding to the CMS HCAHPS questions. The coding themes that linked to the HCAHPS questions included (a) interactions, (b) services, and (c) environment. Coding methodology provided a means for interpreting the data (Gibbert & Ruigrok, 2010; Yin, 2014).

Method triangulation is a means for comparing data from (a) field observations and field notes, (b) documentation, and (c) interview responses (Gibbert & Ruigrok, 2010). The observation process allows the researcher the opportunity to determine whether staff members demonstrate the behavioral strategies identified by study participants. Gibbert and Ruigrok (2010) asserted that observations create an opportunity for a researcher to triangulate research data. Details of how the members of the organization implemented initiatives emerged. Observation subjects included (a) physicians, (b) nursing staff, (c) senior managers, and (d) ancillary staff. Through observation, information appeared with regard to participants' behaviors that mirrored expected behaviors gleaned from interviews and published policy documents. The hospital policies and procedures reflected the hospital administration's strategic plan for increasing patient satisfaction scores. Information from interviews reflected hospital administrators' perception of activities and processes to achieve positive patient satisfaction score. Subsequently, I reviewed the patient satisfaction data downloaded

from the Hospital Compare website to determine whether the scores reflected the themes uncovered from the triangulated evidence. Yin (2014) asserted that multiple lines of evidence add depth and breadth to a study.

In complex institutions, such as found in healthcare, the contextual landscape can limit the success or failure of change implementation (Baker, 2011). Baker (2011) suggested culture, empowerment, teamwork, and other organizational characteristics alter the degree to which new initiatives become embedded in the organization. By evaluating the interplay of group dynamics with management strategies, and by examining business processes, hospital administrators may discover the organizational features which affect success or failure (Baker, 2011). Yin (2014) asserted the case study design allows researchers to understand small group behavior, and managerial process designs thereby leading to understanding the how and why interventions fail to produce expected results in a particular setting. As such, to identify and explore the strategies hospital administrators may utilize to achieving high levels of patient satisfaction, case study research was relevant.

Population and Sampling

Patients experience varying degrees of attention during the patients' hospital stay (Marang-van de Mheen, 2010). Lack of consistency of care can negatively affect the patients' experience (Frontczak et al., 2011). While inconsistent care is broad in scope, not all hospitals or hospital units experience the problem of inconsistent care to the same degree (Frontczak et al., 2011). Administrators from a hospital in north Texas that received recognition for high patient satisfaction scores constituted the study population.

The participants were hospital administrators experienced in developing, deploying, implementing, and improving plans for increasing patient satisfaction.

The sampling method was expert purposive sampling. The population included administrators experienced and skilled in creating a positive patient experience. Yilmaz (2013) suggested purposeful sampling of individuals with selective skills and experiences results in insightful responses that add depth to the case study. Purposive sampling is a form of non-probability sampling, which consists of volunteers in existing groups reflecting the desired characteristics of participants (Boslaugh & Watters, 2009). Purposive sampling was suitable for this study as members chose to participate freely and without coercion. Borrego et al. (2009) asserted that in single stage sampling, participants provide direct access. In this study, participants provided direct access; therefore, this study design included single-stage sampling.

Seven hospital administrators constituted the sample for this study. The size of the sample was such that approximately 50% of the leadership team, i.e. manager level or above participated. Since the case study contained a single hospital, each administrator understood the strategic initiatives for patient satisfaction and as such, a large sample size was unnecessary. Thomas and Magilvy (2011) asserted that small samples sizes in research where the members consist of elites or experts, six to a dozen participants is adequate to provide insight. Unluer (2012) declared that small sample sizes are adequate when the researcher is an insider. According to Yin (2014), a sample size needs to be large enough so that the researcher finds saturation or redundancy of response. The samples size should be sufficient to identify consistent patterns and leave the researcher

with nothing further to learn (Yin 2014). In respect to hospital strategic initiatives, members of the hospital management were knowledgeable about patient satisfaction strategic plans, I was an insider in the hospital, and thus with a small sample size, the interview response data resulted in data saturation.

Leaders experienced and knowledgeable about patient satisfaction strategies in the study hospital were eligible to participate. Participation in the study was voluntary in nature. Through telephone and email contact, potential participants indicated if he or she wanted to participate. Leaders who wished to participate agreed to a mutually convenient time to answer interview questions. The participants were members of the hospital leadership who were familiar with patient satisfaction strategies and had the knowledge and experience to answer the research questions.

The interview setting was face-to-face which allowed a more personal interaction. The setting was one that created an environment conducive to uninterrupted conversation. Borrego et al. (2009) suggested that the face-to-face meeting allows the researcher to observe the participants' expressions and helps add depth to the interview process. Borrego et al. (2009) asserted that, in the face-to-face interviews researcher can adapt the questions as necessary, clarify doubt, and ensure that the responses are properly understood by repeating or rephrasing the questions.

The observed participants were willing practitioners who consented to the role of members under observation. The participants who consented were experienced in patient care procedures and understood their role as participant remained in confidence. The members agreed that information related to personal behaviors remains confidential and

that there is no risk of disclosure of the participants' identity.

Ethical Research

The steps for assuring ethical research began with approval from the IRB for the subject hospital and the Walden University IRB. IRB approvals assured that respect for persons, beneficence, and justice were integral parts of the research protocol as required by the *Belmont Report* (HHS, 2012). The director of the hospital IRB assigned approval number STU 092014-065 to the study, and the Walden University IRB assign approval number 12-01-14-0312530. After both members of the IRBs, and the hospital approval team vetted and approved the study, the request for interviews and the consenting process began. The U.S. Department of Health and Human Services (HHS) and the code of federal regulations chapter 45 governs ethical research. Information from the HHS and CFR 45 includes guidelines for the ethical treatment of human subjects and outlines the steps required for the consenting process.

Each participant was one who voluntarily agreed to participate in the study. The population did not include any vulnerable subjects. My relationship with the participants was collegial and no participant experienced coercion based on the researcher-participant's professional relationship. The participant's identity was and will be kept confidential before, during, and after the interview. Observed participants' identities remain held in confidence.

Each participant received a consent form which included information on (a) the study background, (b) research methods, (c) the voluntary nature of the study, (d) risks and benefits, (e) payment, (f) privacy, (g) contacts exclusion criteria, and finally, (h)

declaration of consent. Each participant received in depth description of information contained in the consent form. The interview participants verbally consented and agreed to answer the interview questions. Recorded interviews took place in the participant's private office. The interviewee did not provide personal information during the recording process. Observed participants received detailed information of the observation process and consented prior to the observation.

As patient-centered care framed this study, and the study took place in a time of increasing emphasis on healthcare regulation, each participant received adequate time to consent. Each participant received a copy of the consent form and interview questions prior to the scheduled interview. If the participant was one who consented to observation, the participant received a copy of the consent form prior to the scheduled observation.

The participants had adequate time to review the questions and consider the consenting process as the participants received documents in advance of the interview or observation. The participants received an in depth description of the informed consent letter to address any questions and to clarify the participants' role in the study. Krumholz (2010) asserted the consent process ensures that participants have sufficient information to make informed decisions. Prior to the interview or observation, the participants verbally consented and kept a copy of the consent form (Appendix C, Appendix D). The confidential nature of the study made withdrawal unlikely. In the event the participants chose to do so, they understood they could withdraw by indicating a desire to withdraw.

The study participants did not receive any incentives for participation in the study. Hard copy data resides in a locked file in a personal residence and will remain there for 5

years to protect the rights of study participants. Soft copy data resides in a file on a password protected computer and was backed up on a password protected drive until subsequent destruction of the data after 5 years. Both the Walden IRB and the hospital research council reviewed and approved the study before commencement to ensure the study conformed to all required ethical research practices. Both Walden University and the hospital under study received a copy of the study results. Nowhere in the write-up does there exist identifiers for the hospital or participants included in this study.

Data Collection

The data collection section includes a discussion of the researcher as the primary instrument and the tools that the researcher used in the data collection process. Both the techniques for collection and organization of data reside in this section. The stepwise process of data collection and the process for data organization reside herein.

Instruments

The researcher is the primary instrument in a qualitative research study that involves semistructured interviews (Pezalla, Pettigrew, & Miller-Day, 2012). Pezalla, Pettigrew, and Miller-Day (2012) suggested that as an active participant in the research process, the researcher's facilitative interaction creates a conversational space where respondents feel safe to share real life experiences. As instruments, researchers should pay attention to potential bias from self-reflexivity when documenting responses (Pezalla, Pettigrew, & Miller, 2012). Denzin and Lincoln (2011) suggested that the researcher facilitates the flow of communication and must be able to identify cues from the respondents to ensure that the respondents are at ease.

As the researcher, I was the primary instrument for this study. The data sources for this study included the (a) interview responses, (b) documents, (c) field observations, and (d) HCAHPS survey data from the Hospital Compare website. The semistructured interview questions consisted of 16 items, selected to ensure the participants provided insights into patient care plans and activities to ensure positive patient responses on the HCAHPS survey. Copies of these questions are included in the semistructured interview protocol in Appendix A. The 16 questions reflect the HCAHPS patient satisfaction survey questions. The questions allowed participants to expound on how the hospital team's plan ensured patients answered positively to the HCAHPS patient satisfaction survey questions. An additional question provided the participants the opportunity to describe patient satisfaction initiatives not included in the interview questions. The questions were qualitative in nature and as such did not include score calculation. Instead, the respondents provided answers to the questions via private, face-to-face interviews. Inter-respondent themes emerged. Publicly accessible HCAHPS survey questions were the basis for the study interview questions. As such, no need existed for permission to use the instrument.

Data for method triangulation emerged from (a) the semistructured interviews, (b) observations, and (c) review of the hospital documents and HCAHPS scores. The interviews took place at different times and included single participants. The observations took place at different times and in different patient rooms and on different patient units. The hospital documents contained data for comparison to observed practice, and perceived practice as indicated through interview response. The data collection and

observation plan was a tool for validating the semistructured interview answers. The plan also included a framework for employee observations and field notes. A final source for triangulation was the HCAHPS scores which reside on the Hospital Compare website. Details of the triangulation instruments reside in Appendix B. Triangulation enhanced the validity, and internal consistency of the data (Denzin & Lincoln, 2011). All data resides either (a) in notebooks, (b) on a password protected computer, or (c) on a password protected flash drive and will be available to the committee by request.

Data Collection Technique

Data emanated from semistructured interviews, hospital documents, field observations, and HCAHPS analysis. Rowley (2012) proposed semistructured interviews provide precision and reliable answers when the researcher wishes to find answers to specific questions. Data saturation results when multiple respondents provide the same data, no new themes emerge, and the study becomes replicable (Denzin & Lincoln, 2011). When interview response data became, repetitive the data became saturated, and the requirements for additional data no longer existed. Denzin and Lincoln (2011) proposed that collecting data from multiple respondents add to the rigor of the research. The data collection process for this study included data collection from multiple participants and multiple lines of evidence.

The first step in the interview portion of the data collection process was to schedule interviews with study participants. Through telephone and/or email contact, potential study participants indicated a willingness to answer interview questions. Through email, the study members received the set of interview questions prior to the

scheduled meeting so members could prepare and become comfortable about the interview. Rowley (2012) suggested that providing questions ahead of time help alleviate the interviewees' concerns about interview preparation. Additionally, interviewees received an informed consent form via email before the meeting; the interviewees received a detailed explanation of the informed consent at the time of the interview. At the time of the interview, the study members received (a) a recap of the study purpose. (b) a recap of the informed consent process, and (c) consented to the interview. The interviews took place in the respondents' private offices. After the interview, I interpreted the transcripts and took my interpretation to the participants for member checking. The participants confirmed the interpretation affirming the findings reflected the participants' views. The participants' responses reside in password protected files on a password protected laptop computer. A password protected flash drive contains a copy of the responses. The semistructured interview protocol is in Appendix A.

The second step of the data collection process involved gathering data such as policies and procedures that contain information about the hospital's day to day activities to achieve patient satisfaction. During the interview process, the participants provided insight into the documents that supported the participants' assertions about patient satisfaction. The policy and procedure documents reside on the hospital team's intranet site; additional hardcopy documents emerged from file storage available to hospital employees. Gibbert and Ruigrok (2010) stated that through document analysis, patterns and themes should surface that match the interview responses. Through the participants' answers and research on the hospital website, pertinent documents added breadth to the

information garnered through the interview process.

Information emerged from the interviews and data collection that helped shape and update the observation plan. The hospital documentation and interview responses included information that allowed enhancement of the observation plan. Reviewing the interview answers and documentation enabled finalizing the observation plan and allowed creating a plan for proceeding to the next step in the process.

The third step in the data collection process was to observe hospital personnel behaviors and create field notes as to the observed behaviors. Prior to embarking on the observations, the hospital research council approved the case study research plan and data collection technique. Various hospital employees responded to emails suggesting individuals who had the information necessary to complete the observation. Through phone calls, emails, and face-to-face contact, I was able to arrange the observations necessary to finalize data collection. The hospital staff participating in the observation process consented to take part in the study and the participants' identities remain confidential.

During observations of caregivers and auxiliary staff conducting patient rounds and interacting with patients, I created field notes. I observed staff behaviors to determine if the demonstrated behaviors matched policy, and if staff followed procedures and expectations disclosed during the semistructured interviews. During observations, conversations occurred, and the conversations allowed me the opportunity to understand the employees' perception of strategic patient satisfaction initiatives. Yin (2014) suggested observations serve as a source of evidence in case study research.

Observational evidence helped me understanding the caregiver's perception of behavioral expectations in regard to patient care. Furthermore, through observation, caregivers demonstrated compliance with the hospital patient satisfaction initiatives. The steps subsequent to observations and the collection of the field notes included (a) entering the notes into a journal, (b) summarizing the notes, and (c) searching for themes. The journal resides securely in a locked file storage cabinet.

The fourth step in the data collection process was to review and record the HCAHPS scores located on the Hospital Compare website for the subject hospital. With the information from the Hospital Compare website, qualitative observations emerged from the HCAHPS data. By comparing the data to the information garnered through interviews, observations, and hospital documentation similarities emerged that indicated the HCAHPS data accurately reflects the hospital teams focused actions towards patient satisfaction. HCAHPS, interview data, observations, and hospital documentation included information with which to draw conclusions about the nature of patient care initiatives in the hospital under study. CMS (2013) suggested HCAHPS scores reflect the patient experience.

Data Organization Techniques

Tabbed notebooks contain the catalogued data organized by data tier. The notebooks have four tiers: (a) tier one includes participant interviews; (b) tier two includes hospital records; (c) tier three includes observation notes; and (d) tier four houses the HCAHPS scores for the participating hospital. Tier one includes (a) subsections tabbed by participant number, (b) the hard copy interview transcription, (c)

consent documentation, and (d) notes. Each participant's data file contains notes identifying any confounding effects that could affect study outcome. Tier two includes information in regard to the hospital documents and handwritten notes in regard to these documents. Tier three includes observational notes and comments staff shared about patient satisfaction initiatives. Tier four includes HCAHPS scores, and data analysis of the same, notes and summaries. The information and data remain in a locked filing cabinet for 5 years. Soft copy data reside in password protected files on a password protected personal computer for 5 years.

Data Analysis Technique

The data analysis consisted of (a) interview coding, (b) document coding, (c) observation and field note coding and analysis, and (d) reviewing the HCAHPS data. The interviews were the primary sources of data. The secondary sources included (a) hospital documents, (b) observations and field notes, and (c) the HCAHPS scores. Yin (2014) suggested the major strength of case studies exists in the opportunity to use multiple sources of data to support conclusions.

The first step in the data analysis process was to review the completed interviews; Appendix A includes the semistructured interview protocol. The next step was to code the interviews, and look for themes. The themes included *interactions, services, and the environment* as gleaned from the fishbone diagrams for patient and customer satisfaction. Additional themes emerged including *governance* and *technology*. Technology was a sub-theme of the environment in the literature review. Subthemes from the interactions included patient-provider communication, both communication behaviors and methods.

Successful coding resulted in topics that aligned with the theoretical constructs of the study including (a) aspects of patient-provider communication, (b) provider interactions with patients and families, (c) innovation and services, and (d) Deming's model of PDSA. Crowe et al. (2011) and Yin (2014) asserted successful coding ties responses to the theory.

The second step of data analysis was to review the hospital documents. By means of hospital record data mining, policies, procedures, and directive documents, data emerged which aligned with the strategic initiatives outlined by the study participants. Terms, coding and themes, in the hospital records that matched interview terms enhanced the interview method triangulation.

The third step in the data analysis process was to review the observational records and determine if the observations matched the codes from the interviews and the expected behaviors and processes as outlined in the hospital documentation. The data aligned and supported the interview responses. If the data did not align, nonalignment would have defined opportunities for further exploration analysis. To triangulate the data, comparison of interview responses, hospital documents, and observations with the theoretical study constructs occurred. Inconsistencies in the data did not become apparent and as such did not define opportunities to uncover deeper meaning from additional sources. Crowe et al. (2011) and Yin (2014) proposed the use of multiple sources of data in case study research allows an investigator to address a broad range of behavior patterns.

From CMS HCAHPS Hospital Compare website, I accessed the scores of the

hospital under study. The hospital's scores for the various questions were higher in the areas wherein the hospital has clear performance strategies. Through qualitative analysis, it became apparent the questions with high scores reflected areas where the hospital team focuses the greatest effort, and as such had the largest influence on TPS. The scores aligned with strategic initiatives. Consideration and analysis of the HCAHPS data helped complete the chain of evidence and verify the findings.

Through data analysis, themes emerged that are similar to the constructs of patient satisfaction, customer satisfaction, and HCAHP patient satisfaction as emerged from the body of literature. In alignment with the themes, activities surfaced that reflected the framework of the patient provider theory, disruptive innovation, and Deming's PDSA, performance improvement model. Explicit plans and actions materialized that other hospital administrators may implement to garner similar results. A table of best practices is located in Appendix I.

Reliability and Validity

In this study, through semistructured interviews, hospital administrators were expected to share information that allowed development of a database of plans and activities that promoted an environment wherein patients scored positively to questions on the HCAHPS patient satisfaction surveys. My analysis of the interview question responses, when compared to (a) hospital documents, (b) the observed behaviors, and (c) HCAHPS scores, considered the extent to which the interviews illustrated how patient satisfaction occurs in the study hospital. Gibbert and Ruigrok (2010) suggested that through observations and document analysis, additional data emerges that allows

triangulation of the study findings. Themes emerged from all data sources which added to the validity of the study.

Reliability

Reliability refers to the degree to which a perceived phenomenon occurs by more than one observer (Gibbert & Ruigrok, 2010). Through recordings, and careful transcription of interview responses, the study participants' understanding of what measures caregivers implemented and how caregivers implemented actions to improve patient satisfaction emerged. During observation and field note taking, recordings included whether and how caregivers showed the patient satisfaction measures that participants identified. The interview responses and observed behaviors indicated links in the chain of evidence. Yin (2014) posited that the reliability of a case study becomes strengthened through the strength of the chain of evidence. The chain of evidence includes multiple forms of data that when linked, build the chain of evidence (Yin, 2014). Furthermore, my review of the HCAHPS scores provided indication of whether the scores from the subject hospital resulted in high patient satisfaction and whether the scores reflected practice. The patient satisfaction scores, therefore, added links in the chain of evidence.

When many respondents answer similarly to questions, the data demonstrate reliability (Gibbert & Ruigrok, 2010). Data saturation occurs when multiple respondents provide similar responses, no new themes emerge, and the data become replicable (Gibbert & Ruigrok, 2010). Through member checking, the members indicated whether they understood the questions, and whether the coding reliably reflected the interview

respondents' thoughts. Review of the responses indicated similarity between study members' perceptions of care.

Gibbert and Ruigrok (2010) purported that reliability may increase when the detailed field notes, transcribed and coded, reflect the themes revealed through coding of the interview responses. For this study, coded field notes reflected evidence of the themes stemming from coded interview responses. Gibbert and Ruigrok purported that when both sets of data result in similar themes, the research is deemed *reliable*.

Dependability refers to the degree to which a third party may explain and audit the research methods (Gibbert & Ruigrok, 2010). An audit trail may include (a) describing the purpose of the study to the auditor; (b) discussing participant selection; (c) discussing the study time frame and how the data collection took place; (d) explaining the data analysis procedure; and (e) discussing data interpretation (Thomas & Magilvy, 2011). For this study, the physician chair at the hospital under study reviewed and audited the research study's design and the design's implementation. The review process included (a) describing the purpose of the study to the physician chair, (b) discussing why the participants were selected to participate, (c) discussing the translation and transcription of their interviews, and (d) discussing the interpretation. The chair confirmed the findings.

Validity

Qualitative researchers use credibility, transferability, and confirmability to validate the study. Thomas and Magilvy (2011) suggested that credibility, transferability, and confirmability bring an element of *truth* to qualitative research. Furthermore, Thomas

and Magilvy asserted that the credibility is the feature that enables others to understand the experiences through the interpretation of a participant (Thomas & Magilvy, 2011) . Through member checking, the participants ensured the *credibility* element of this study.

Participants validate the research project when the participants deem the results as correct or credible; the data are transferable, and the findings align with the conceptual framework (Yilmaz, 2013). To enhance validity, Crowe et al. (2011) suggested respondent validation occurs when study participants review findings and confirm the results reflect the participants' intended meaning shared during the interview process. Through member checking, members verified the interpretation of responses to the interview questions. Through thick description, the participants understood the process of arriving at themes, and the members shared how responses aligned with, or did not align with the different themes. If the participants indicated the answers did not align with the different themes, the participants subsequently clarified personal responses. Crowe et al. suggested that through participant review of transcribed data, including confirmation of accuracy and interpretations, members check validity. Member checking helps fill any gaps that may occur between data collection and transcription. When the results of this study logically followed the constructs uncovered by previous scholars, and study participants verified findings through the member checking process, the study gained credence. In the event new constructs emerged, the constructs became new themes in the body of knowledge.

Confirmability occurs when the auditor confirms findings (Yilmaz, 2013). The physician chair, who is an expert in the field of both the patient care process and patient

satisfaction initiatives in the hospital under study, verified interview interpretation accuracy. As an auditor, the physician chair strengthened the dependability of the study findings through the interpretation review.

Throughout the data collection and analysis processes, checking and rechecking the data and emergent themes helped confirm consistency of data. Recording the interviews allows the researcher to check and recheck the data interpretation (Yilmaz, 2013). Storing copies of documents and field notes allowed data confirmation. Furthermore, documenting the processes for checking the data allowed ease of confirmation by a third party. I reinterpreted the data a few weeks after the original interpretation and came up with the same conclusions during the rechecking process.

Transferability occurs when the data can be transferred to similar setting or location (Yilmaz, 2013). Thomas and Magilvy (2011) suggested transferability is the extent to which the finding of a particular inquiry may apply in other contexts or with other subjects. In respect to patient satisfaction, the activities to achieve positive patient satisfaction scores are actionable by other hospital administrators. Thomas and Magilvy (2011) asserted that the experiences in one setting may be applicable to other settings by evaluating the attributes in one setting that can help practitioners build on existing experiences in other places. Processes and policies that are duplicable enable transferability among locations. Furthermore, practitioners in other contexts may find the information useful and may be able to use the findings in similar contexts. Future researchers may decide the transferability of this information for the purposes of application to new studies (Thomas & Magilvy, 2011).

Validity refers to the degree to which a researcher's investigation reflects the objective of the researcher's intended study, i.e. the extent to the accuracy of the observed purported phenomenon (Gibbert & Ruigrok, 2010). This study included examination of the means and methods to achieve patient satisfaction. Through method triangulation, the degree of accuracy of the methods to achieve patient satisfaction became apparent. Method triangulation included interviews, observations, document review, and HCAHPS score review. Multiple forms of data resulting in similar conclusions supported the conclusion for data validation.

For this study, the fishbone diagrams included terms that emerged from the literature review. The idioms aligned with the concepts of customer satisfaction, patient satisfaction, and HCAHPS. Gibbert and Ruigrok (2010) suggested that through diagrams and description among, variables and results, and pattern matching, similarities between collected data and prior data provide a means for verifying research findings. Through coding and pattern matching among the three types of data, I validated results against prior works.

Triangulation is another process for ensuring studies' validity. Denzin and Lincoln (2011) suggested four categories of triangulation: (a) data triangulation, (b) investigator triangulation, (c) theoretical triangulation, and (d) method triangulation. For this study, theoretical triangulation, and methodological triangulation occurred. This study did not include investigator or data triangulation. Investigator triangulation refers to the participation of more than one researcher or more than one coder (Denzin & Lincoln, 2011). As this study was a doctoral study, investigator triangulation was not appropriate.

Data triangulation refers to comparison of data from multiple participants taken at different times. Denzin and Lincoln (2011) asserted when the researcher uses multiple participants, select different times for data collection, or selects different places for data collection, the study findings gain credence. In this study, while various participants answered a set of questions; observations occurred at different times, and observations occurred at different locations in the hospital, the primary method of triangulation was between methods.

Theoretical triangulation occurs when the researcher applies multiple theories to explain the same phenomenon (Denzin & Lincoln, 2011). For this study, triangulation occurred through the application of three theories, the primary provider theory, the disruptive innovation theory, and Deming's plan-do-study-act model for performance improvement. During the interview coding process, data emerged that reflect the theoretical constructs included in this study. Additional data collection and observations and field notes, resulted in data supporting the theoretical framework for this study.

Method triangulation may be *within method* or *between methods*. Between-method triangulation refers to use of dissimilar methods to explore the same case, and within method refers to applying many techniques for data collection and analysis (Denzin & Lincoln, 2011). This study included between-method triangulation that occurred through the use of interviews, observations, document analysis, and HCAHPS scores. The triangulation resulted in the expansion of the depth and breadth of the means and methods to increase patient satisfaction. Together, the verification strategies of data, theory, and method incrementally contributed to reliability and validity assurances and

thus study rigor.

Transition and Summary

Section 2 of this study contained a summary of this study's purpose, the role of the researcher and the study participants (CMS, 2013; Hoybye, 2013; Hwang et al., 2013; Unluer, 2012). Section 2 contains (a) definition of the population, (b) sampling methods, (c) sample size, (d) study participants' consent, (e) eligibility criteria, and (f) justification of the population, sampling methods, and sample size (Bunniss & Kelly, 2010; Crowe et al., 2011; Yin, 2014). The research method and design materials allowed justification of the appropriateness of the qualitative design and specifically for addressing the research question. The research quality indicators included (a) ethical research, (b) data collection instruments and technique, (c) data organization technique, and (d) data analysis (Crowe et al., 2011; HHS, 2012; Yin, 2014). Section 2 concluded with a description of plans and activities for assuring the study's reliability and validity (Gibbert & Ruigrok, 2010; Yilmaz, 2013).

Section 3 includes presentation of the findings and the application of findings to professional practice. Section 3 contains this study's conclusions with implications for social change and a call to action and presents recommendations for further studies. Section 3 closes with reflections on the experiences in designing, developing, implementing, and analyzing patient satisfaction research and resultant data.

Section 3: Application to Professional Practice and Implications for Change

Subsequent to the ACA, hospital administrators began seeking to improve hospitalized patients' experience (Kennedy et al., 2013; Phillips et al., 2013). A hospital's financial viability became contingent upon healthcare outcomes and the patient experience (Honoré et al., 2011; Rauscher Singh & Wheeler, 2012; Reinhart, 2013). The purpose of this study was to determine the performance improvement plans that hospital administrators need to achieve and maintain high HCAHPS scores. To understand the plans and initiatives required to achieve high HCAHPS scores, I conducted an instrumental qualitative case study in a hospital where the hospital teams had successfully achieved and sustained high HCAHPS scores.

From interviews with hospital administrators, hospital document analysis, and observations of hospital caregiver behaviors, themes of care emerged that exemplified the constructs of how one hospital achieves high patient experience scores. The themes included caregiver-patient interactions, which included the behaviors and methods of interactions between caregivers and patients. Hospital services emerged as an important aspect of care and encompassed care received from (a) nursing staff, (b) pharmacists, (c) auxiliary service members, (d) chaplains, and (e) social services personnel. The hospital environment surfaced as important in regard to the patients' first impression of the hospital. First impressions included (a) interactions with guest services, (b) perception of cleanliness, and (c) hotel-like amenities. Hospital technology emerged as an important aspect of care and as an enhanced service to the patients. Finally, hospital governance

surfaced as an aspect of how the caregivers interacted with each other and how governance led to performance improvement and a sense of staff empowerment.

Caregivers indicated that quality care requires hospital administrators to ensure that each member of the caregiver team has the opportunity to provide input into hospital care processes. Furthermore, a culture of continuous improvement and innovation ensures that the hospital team provides consistent, high-quality care. Finally, patient care does not begin and end in the hospital, but is a continuum of care before, during, and after the patient's hospital stay.

Presentation of the Findings

The overarching research question for this study was the following: What plans and initiatives do hospital administrators need to achieve high HCAHPS scores? To answer the research question, I conducted interviews with seven hospital administrators, gathered data from hospital documents, and conducted observations of caregivers administering care in the case study hospital. Throughout the observation process, staff members, patients, and family members added to the data through candid comments and anecdotes about the hospital experience. I followed up with hospital administrators with a couple of questions that emerged during the data collection process. The data analysis process resulted in categorical themes emerging from multiple data sources. The themes provided a framework for the case study hospital teams' story in regard to the patient experience.

The themes that surfaced through method triangulation included (a) caregiver-patient interaction, (b) hospital services, (c) hospital environment, (d) hospital

technology, and (e) hospital governance. Intertwined within the themes were the constructs of (a) communication (both caregiver-patient and caregiver-caregiver communication), (b) the hospital culture, (c) measurement and feedback mechanisms, (d) technology, and (e) training and recognition for caregivers. Together, the themes include actionable steps hospital administrators may take to improve HCAHPS scores.

Theme 1—Caregiver-Patient Interactions

The first theme, caregiver-patient interactions, includes subthemes of (a) behaviors and (b) methods. The subtheme of behaviors refers to *how* the caregivers communicated with patients, *when* the patient-provider interactions began, and *what combinations* of caregivers communicated with patients either individually or in groups. The method of communication refers to the *form of communication.* Forms of communication included (a) written communication, (b) verbal communication, and (c) the use of technology or interpretation services to communicate with the patient.

Behaviors. How to communicate with caregivers emerged as a primary focus of the hospital care team. The constructs of *how* included (a) courtesy and respect, (b) calling the patient by name, (c) using simple language, (d) listening to patients, and (e) using the teach-back method of communication. The *when* refers to the continuum of care including interactions with physicians and their staff before hospital admission. The *what* combinations included (a) physician-resident rounds, (b) physician/pharmacist rounds, (c) multidisciplinary rounds, (d) care coordinator communication, (e) nursing handoff/bedside reports, and (f) nurse manager quality rounding.

How caregivers interact with patients emerged as subtheme of behaviors. A predominant theme that emerged from interviews with administrators was the constructs of courtesy and respect (PI 1; Physician 3; Nurse Mgr. 4; Physician 5; Nurse Mgr. 6; Physician 7). The interview responses included eight incidences in which administrators mentioned the hospital's culture, which contained the construct of courtesy and respect. In line with the interview responses, predominant terminology contained in the hospital administration's guiding documents for employees included (a) *respect*, (b) *confidentiality*, (c) *kindness*, and (d) *concern* (Mission Statement; Care Commitments; PACT cards; & the video "What If You Were Taking Care of You," 2014). Other items such as website postings, letters to staff, and quality initiatives incorporated terms such as (a) *attentiveness*, (b) *courtesy*, and (c) *empathy*. Through observation, I noted that the caregivers demonstrated the constructs of courtesy and respect by (a) acknowledging the patient, (b) calling the patient by name, (c) using simple language, (d) introducing the care team, (e) giving the patient information about care timeframes, (f) allowing the patient to ask questions, and (g) thanking the patient when leaving the room. Caregiver-patient interactions and the resulting subtheme of courtesy and respect emerged from the administrator interviews, the hospital documents, and the observations, in alignment with the body of literature. Feinberg (2014) asserted that the patients' interaction with the care providers is as important—and, in some cases, more important—than the quality of received treatment. Hays et al. (2014) determined that communication with providers has a strong correlation with the patient experience, $\alpha = 0.93$; and office staff courtesy and respect have a correlation with the patient experience $\alpha = 0.80$. In concert with this

finding, Kennedy et al. (2014) suggested that the doctor's interpersonal skills are arguably the most important to clinical outcome and patient experience. Aragon's primary provider theory contains the construct that patient-centeredness is a competency that influences the provider's communication and the quality of patient care (Aragon & Gesell, 2003).

The hospital's physicians and nurses used the teach-back method of communication, which demonstrated how providers interacted with patients to ascertain effective communication about the patients' individual care plans. During the participant interviews, the participants indicated that the use of the teach-back method effects clear provider-patient communication (PI 1; Physician 3; Nurse Mgr. 4; Physician 7). Hospital documents also contained the constructs of communication as an essential part of patient care (CQI Training, About Us; Satisfaction Award, On-Boarding Packet, 2014). When I accompanied physicians on rounds, I observed the physicians using the teach-back method of communication with patients. Amin et al. (2014) asserted that the teach-back method of communication is effective in ensuring that the patient understands the diagnosis, the prognosis, and the self-care requirements. Further, discharge teaching is part of routine postoperative care and includes instruction by means of the teach-back method of communication (Darcy, Murphy, & DeSanto-Madeya, 2014). Aragon and Gesell's primary provider theory contains the construct that patient provider communications require more than clinical competency because providing patient care requires effective communication and interaction with patients (Aragon & Gesell, 2003).

In the case study hospital, the care teams understood the concept of continuum of care and the *when* the caregiver-patient relationships begin. Both physicians and nurses indicated that provider-patient relationships begin with the patients' first phone call to the physician. A physician study member explained, "our clinic ensures the individual answering the phone reflects happiness and positivity" (Physician 7). The documents for clinics contain information on patient-provider interactions and the need for teamwork in ensuring patient satisfaction (CQI Training; Satisfaction Award; On-Boarding Packet, 2014). During my observations, I noted the manner in which staff members answered phones and demonstrated courteous interactions. Long et al. (2013) accentuated the need for effective touch-points that begins with the first contact with the customer. In the current healthcare environment, the framework for administering care is transforming from single points of care to a continuum of care linking wellness, outpatient care, and inpatient care (Bodenheimer et al., 2014; Hwang et al., 2013; Murphy, 2011). Consonant with the primary provider theory and the construct of continuum of care, patients and families place importance on the patient-centeredness of the patient's providers (Aragon & Gesell, 2003).

Setting expectations *before* surgery emerged as a construct of patient satisfaction. Physician 7 indicated that if a patient's expectations are set prior to surgery on issues such as pain and the patient's expected healing regime, the patient will be more satisfied than those patients whose physicians did not set expectations. Setting expectations aligns with the skill, quality, and educational aspects of the hospital documents. I observed physicians setting expectations with patients during rounding where physicians set

expectations for healing and care. Setting expectations as a means toward patient satisfaction is in line with the body of literature (Bjertnaes et al., 2012; Gill & White, 2009). While setting expectations does not specifically align with the primary provider theory, providers are responsible for the quality of patient care and the provision of patient clinical expertise (Aragon & Gesell, 2003).

In what combinations the caregivers administered care to the patients emerged as a tertiary theme of patient caregiver interactions-behaviors. Physician administrators indicated during interviews the importance of rounding with interns as a teaching opportunity, and with pharmacists for medication support. Hospital documents contained statements supporting teamwork as essential to quality care. I observed physicians and interns rounding on patients. I observed physicians rounding with pharmacists in the ICU. Additionally, family rounds constituted one of the care processes caregivers implemented to ascertain shared decision making among physicians, patients, and patients' families (Dept. Dir. 1). Family-rounds referred to the time that a multidisciplinary team of caregivers visited with patients and the patients' families to share information about the patients' healing progress and to answer questions about the patients' care. During my observation of physician rounding practices, I noted that the doctors and caregivers used the rounding opportunity to understand the needs of not only the patient, but also the family in terms of follow-up care. Tripathi et al. (2013) concluded that family rounding was an effective means of improving the quality of healthcare delivery. The physicians, nurses, and other caregivers include the family in shared decision making and care to the extent that the patient allows (Physician 7). Patient satisfaction and reduced costs result

when caregivers engage in shared decision-making discussions regarding treatment goals and methods (Kocher et al., 2013; Verrof et al., 2013). CMS found that effective communication reduces patient anxiety, increases adherence to treatment protocols, and results in better patient satisfaction and healthcare outcomes (CMS, 2013). In alignment with the primary provider theory, the hospital team demonstrated through care processes that the team understands that both the patients and the patients' families value patient-centeredness.

In addition to multidisciplinary rounds, the hospital employs patient care coordinators to act as liaisons between patients, nurses, physicians, and other members of the care team, which further enhances communication (Dept. Dir. 1, Physician 3). During administrative interviews, the participants disclosed that additional multidisciplinary rounds included nurse-nurse bedside reporting. Furthermore, both physicians and nurse managers indicated that nurse manager quality rounding affords the patient the opportunity to discuss issues with care providers, which is another step in ascertaining quality care. Through observation, I noted that multidisciplinary rounds of many types occurred in the case study hospital. Lown and Manning (2010) found that multidisciplinary communication enhanced care and patient satisfaction. Bernhardt and Misterek (2014) found that the enhanced communication among caregivers through huddles, bedside reporting, and rounding both improved patient outcomes and patient satisfaction. Consonant with the primary provider theory, the constructs of patient-centered care emerged as necessary for patient satisfaction. Providing patient care requires effective communication and interaction with patients (Aragon & Gesell, 2003).

Methods. Methods of communication with patients and interdisciplinary communication emerged as a primary focus for the hospital care team. The methods of communicating with patients included (a) written—white boards, picture boards, progress reports, care plans, medication sheets, and binders with contacts; (b) verbal—progress reports, care plans, and medication information; (c) technology; and (d) interpretation services. The methods for interdisciplinary communication emerged as essential to ascertain consistent caregiver-patient communication. The interdisciplinary communication methods included (a) physicians and residents comparing rounding notes, (b) interdisciplinary team meetings, (c) health literacy assessment, (d) bed-board meetings and huddles, and (e) communication through EMR.

Physicians and other caregivers in the case study hospital use white boards, written materials, and pictorial materials to enhance communication with patients. From a nurse manager interview, I learned that with patients who are not able to communicate due to cognitive sensory impairment, caregivers may use picture boards to enhance patient-provider communication (Nurse Mgr. 6). The nurse managers who participated in the study indicated that the nurse asks the patients for feedback about the patients' goals for the day and incorporates the goals into the care plan (Nurse Mgr. 4; Nurse Mgr. 6). I observed a caregiver making written changes to the white board in a patient's room. Additionally, I observed during rounding that the physicians provided both written and verbal progress reports to the patients. CMS recommends communicating in simple language in multiple ways with patients, including picture boards and both verbal and written communication (CMS, 2013). With a visible, written care-plan, both the patient

and the patient's family will see the schedule for the day. Marsteller et al. (2011) indicated that multiple forms of communication, both verbal and written, enhanced patient satisfaction. Requesting feedback on the plan is consonant with the patient satisfaction research of April et al. (2012). April et al. indicated that patients who feel in control of their care will be satisfied. While the hospital documents and the primary provider theory do not specifically address forms of communication, through theory, Aragon and Gesell purported that patients are the best judges of the patient-centeredness of the providers. Potentially, without multiple forms of communication, patients may not judge the provider as patient-centered.

Communication with patients in multiple languages emerged as a necessity for quality care. For patients for whom the primary preferred language is not English, the hospital caregivers provide licensed interpretation services (PI 1; Physician 2; Physician 3; Nurse Mgr.4; Nurse Mgr. 6). Hospital policy requires that licensed interpreters converse with patients whose primary language is not English. During physician rounding, I observed a physician calling for an interpreter to enhance communication between herself and a patient. Bagchi et al. (2010) determined that interpretation services enhanced a patient's satisfaction with communication. Enhanced television technology was a method of communicating with patients of various primary languages.

Other methods of communicating with patients of different languages included technology and behaviors required due to cultural nuances. The television technology in the case study hospital contains a means for literate patients to communicate with caregivers in a variety of languages (Nurse Mgr. 4; Nurse Mgr. 6). Education pieces and

opportunities for the patients to communicate with staff over the television technology emerged as a means to enhance the quality of care. Beyond verbal communication, one interviewed participant, Physician 7, noted that it is important to understand cultural nuances in communication. I did not find hospital documents, nor did I observe any special behaviors due to cultural nuances during the observation period of my study. However, in the literature review, CMS indicated that communication should occur both verbally and nonverbally and that personal space requirements vary between cultures (CMS, 2013). Aragon and Gesell (2003) asserted that desired outcomes require more than clinical competency because providing patient care requires effective communication and interaction with patients.

Interdisciplinary communication emerged as a necessity to ensure caregivers communicate consistently with patients and share the same information. Comparing notes between physicians emerged as a method to ascertain effective communication with patients. Two of the four physicians indicated that to establish effective communication, physicians and residents round on patients both separately and together (Physician 3; Physician 7, 2014). Subsequently doctors and residents compare notes about what they heard from the patients. While no hospital documents address comparing notes, I observed during rounds, the attending physician and the resident took turns communicating with the patient and providing care (Physician Obs. 2; Resident 1). I observed the practice of comparing notes when a team of doctors and residents discussed what each caregiver had learned through patient-provider interactions (MDTM). Consistent with the literature review findings, while individuals may be highly skilled,

organizational leaders should hire individuals based on both verbal and non-verbal skills (Aydin, 2013). McCaughey et al. (2013) concluded that culture and a physician's leadership style were essential to achieving positive patient satisfaction. Comparing notes did not specifically emerge through the literature review, the hospital documents, or the primary provider theory, but was a best practice in the case study hospital. Comparing notes loosely correlates with Deming's model of PDSA as constructs of measurement and evaluation are important aspects of the model.

Physician leaders facilitate multidisciplinary communication through daily multidisciplinary team meetings. The physicians, dietitians, care coordinators, physical therapists, nurse manager, and other members of the patients' care team meet to discuss each patient's condition to ensure the care team members effectively shared information (MDTM, 2014). Teamwork is a construct included in multiple hospital documents (PACT cards; CQI training: Patient Satisfaction training, 2014).I observed a daily team meeting where members actively discussed the various patients, each patient's condition, and further actions necessary for care. Cliff (2011) indicated a culture that includes effective communication between cross functional teams enhanced care. Interviewed nurse managers indicated that multidisciplinary communications occur through nursing huddles at each shift, daily bed board meetings, and bedside reporting; these venues are ways nurses enhance communication with each other and with the patient (Nurse Mgr. 4; Nurse Mgr. 6). I attended a bed-board meeting and observed both a daily huddle and bedside reporting where caregivers communicated with each other and with the patient. Bernhardt and Misterek (2014) found that daily huddles and bedside reporting were

processes that improved patient satisfaction and healthcare outcomes. Multidisciplinary care and the team approach emerged through the documents as a step towards saving patients' lives (Website article, 2014). The primary provider theory highlights the importance of communication. While the theory does not specifically include the term multidisciplinary communication, Aragon and Gesell (2003) purported that providers are responsible for the quality of patient care and the provision of patient clinical expertise. Multidisciplinary communication is a way to provide quality care and clinical expertise.

Health literacy assessment tools help the caregivers identify not only the preferred language of choice, but also the patient education level. During the interview process, administrators revealed that shortly after admission, clinical care coordinators assess the health literacy of each patient (PI 1; Physician 2; Physician 3). While I did not find a hospital document that included the construct of health literacy, the hospital administrators indicated that the health literacy assessment is a part of standard hospital care processes. Tamura-Lis (2013) indicated that limited literacy costs the healthcare system billions of dollars each year and assessment is a necessary step in care. Vargas, Chuang, and Lee (2014) asserted health literacy affects patient participation, compliance, and outcomes. As conveyed by all of the interviewed participants, the physicians in the case study hospital strive to use simple language to ensure the patients understand the message the physician is trying to convey. Aragon and Gesell's (2003) primary provider theory highlights the importance of effective communication between the care-giver and patient.

As mentioned by each of the 7 interviewed participants, and as observed during floor rounding, nurses, physicians, pharmacists, and all of the care providers enter notes in the electronic medical record as another means of internal communication. While the hospital documents did not include information on the EMR, during interviews, nurse managers indicated the electronic medical record enhanced communication between nurses and physicians. I observed physicians and nurses entering information in the EMR. Murphy (2011) asserted that through enhancements in technology that improve caregiver communication, patients may experience improved health and wellness. Hospital leaders benefit both from improved communication and financially for the installation of EMR as CMS reimburses hospital for effective use of information technology (CMS, 2013). As healthcare has evolved, so has the need for technology. Over the last couple of years the case study hospital has added the EMR, replaced the nurse call system, and added interactive television and thus the construct of disruptive innovation theory is applicable to the use of the EMR.

The case study hospital administrators' HCAHPS scores are consistent with the study findings that patient communication is a primary focus of patient care. Review of the Hospital Compare website and the HCAHPS scores confirmed that in regard to patient interactions, the case study hospital scores well (85%) in patient-provider communication, and the highest score (89%) was that patients would definitely recommend the hospital. The HCAHPS scores add to the method triangulation that patient-provider communication is essential to achieving patient satisfaction.

Theme 2—Hospital Services

Hospital services emerged from the interviews, the observations, the hospital documents, and the literature as primary themes towards achieving patient satisfaction. The theme hospital services includes the services caregivers and auxiliary teams provide the patient: (a) patient assistance, (b) pain management, (c) medication management, (d) room service, (e) chaplain services and (f) follow-up services. The hospital services are those services outside of the constructs of medical diagnostic care.

Patient assistance. While recovering in the hospital, patients require responsive care. Advanced nurse call technology and hourly rounding emerged as initiatives caregivers implement to ascertain responsive care. Nurse call technology is a means for expedient communication between the patient and the care team, which contains diagnostic capabilities for documentation and measurement (Nurse Mgr. 6). By reviewing reports from the nurse call system, nurse managers can determine how much time it takes from the time the patient pushes the call button until the nurse responds to the patient (Nurse Mgr. 4; Nurse Mgr. 6).In one of the hospital documents, the chief nursing officer (CNO) commented on the advanced technology as care enhancement. I observed the use of the nurse call system by both nursing staff and the health unit coordinator (HUC). In concert with the body of literature, innovation in service is a concept that requires companies make improvements in customer interactions, service transmission systems, and technology (Weng et al., 2012). The measuring and monitoring of service is consonant with Deming's model of PDSA.

While the use of technology enhances care, nurses check hourly on each patient to provide timely, individualized care (Nurse Mgr. 6). Regular rounds circumvent the patient's need to call for help. The nurse's goal is to anticipate the patient's needs so the patient does not have to call for help (Nurse Mgr. 6). The hospital administration's care commitments document highlights the construct of anticipating the patients' needs. Regular nursing rounds align with Friedberg et al.'s (2011) conclusion that workflow improvements and reduced wait times improved customer perception of care. Additionally, regular rounds align with patient-centeredness which is the primary construct of the patient provider theory.

Pain management. Physicians in the case study hospital asserted that the most important construct of satisfaction in regard to pain management is to set the patients expectation in regard to pain (Nurse Mgr. 6; Physician 7). Patients who believe they will have no pain and then have pain will not be satisfied. Patients who believe their pain level will be a 3 or 4 on a scale of 1 to 10 will be satisfied if their pain rating is a 3 or 4 (Nurse Mgr. 6; Physician 7). While setting expectations did not emerge from the hospital documents or observations, setting appropriate expectations for pain control is a measure consistent with Bjertnaes, Sjetne, and Iversen (2012) findings. Bjertnaes et al. concluded that meeting the patient's expectations of care is an important step to ensure the patients perceived a positive experience. Weng et al., (2012) concluded that client satisfaction occurred when the service providers met or exceeded the customer's expectations while consumer dissatisfaction occurred when performance fell below expectation. Frequent communications between the patient, the doctors, and the members of the care team is the

way one hospital manages patients' perception of pain. Body et al. (2012) indicated patients' perception of suffering decreased with compassionate care and communication. The hospital also has doctors who specialize in pain management in the event the attending physician wishes to consult with a specialist in regard to pain (Physician 2). Measuring and monitoring patients' pain levels are consonant with Deming's model of PDSA and Aragon and Gesell's construct of patient-centeredness.

Medication management. While medication management is an essential part of healthcare, the method for medication management is what sets health systems apart (CMS, 2013). The Centers for Medicare and Medicaid Services included medication management and discharge instruction as two of the eight patient experience measures in the HCAHPS survey (CMS, 2013). In the case study hospital, pharmacists are an active part of the care team (Dept. Dir. 1). The pharmacists review each patient's medication regime to ensure appropriate doses and to ensure patients are not over or under medicated (Pharmacist 1; Pharmacist 2; Physician 3; Physician 7; Dept. Dir. 1). Wilkinson and Couldry (2011) indicated that including pharmacists in patient care lowered patient readmission rates and improved patient satisfaction. While in the ICU, pharmacists round daily and on some floors pharmacists round with physicians, additional pharmacists rounding may enhance medication safety (HUC 1; Physician 2; Physician 5; Physician 7; Pharmacist 1; Pharmacist 2). Pharmacists also review discharge medications with patients, especially with patients who have multiple medications due to complicated conditions (DOP 1). Through observations and discussions with pharmacists and a follow-up with the pharmacy director, I confirmed the processes for rounding and

medication management. While the hospital documents did not reveal information about pharmacist-patient interactions, pharmacist-patient interactions are in line with the primary provider theory as acts of patient-centeredness.

Room service. A service which patients enjoy in the case study hospital is room service; the patients order their meals off of a menu. Meal times are flexible based on the needs and desires of the patient (FS 1). The patients can select their choice of food from a menu to the extent that their diet allows (FS 1). Dieticians are available to help patients with food selections. The patients can order up specialty coffees from the café, or snacks and room service responds to meet the patient's schedule (FS 1). Hospital patient manuals included information on food service. I observed food service employees providing room service to the patients' rooms. Furthermore, food quality is a predictor of satisfaction (Ramseook-Munhurrun, 2012; Ryu et al., 2012). Room service is also an innovative way to provide patient meal service and aligns with the constructs of disruptive innovation theory.

While the patients appear satisfied with food services, patient family members are not always satisfied with food availability (Patient 1). A food services manager indicated the hospital receives high scores on the Press-Ganey survey for food services (FS 2). Two patient family members reported that after 2:00 and on weekends food was not readily available (PFM 1; PFM 2). After discussing the situation with a food services employee, I determined the family members were not aware they could order up food trays when their loved ones ordered trays (FS 1). Through document review, I verified that the case study hospital's team has received multiple awards from Press-Ganey for performance (XYZ

Wins PS Award; XYZ Wins Two National PS Awards). Aragon and Gesell's (2003) primary provider theory address the construct of patient-centeredness which correlates loosely with food services.

Chaplain services. The hospital team offers chaplain services for patients desiring spiritual support while recuperating in the hospital setting. One of the physicians interviewed mentioned the importance of having both chaplain services and a chapel in the hospital setting to meet the spiritual needs of patients (Physician 7). The patient guide, which is located in each patient room, includes information about chaplain services. I observed chaplains rounding on patient floors. Sinclair and Chochinov (2012) found that spirituality has a positive effect on subjective and emotional aspects of a patient's health, including quality of life, wellbeing and distress. Failing to address spiritual needs impacts patient wellbeing, satisfaction with care, perceived quality of care and is associated with higher healthcare costs (Sinclair & Chochinov, 2012). Aragon and Gesell (2003) addressed the construct of patient-centeredness in the primary provider theory but did not specifically mention chaplain services.

Follow-up services. Each patient admitted to the case study hospital receives an assigned care coordinator (CC 1). The care coordinator's responsibility is to ensure the care team provides services unique to each patient (Nurse Mgr. 4). Each patient has individual needs in regard to after care, whether it is equipment needs, physical therapy, hospice care, or transportation to healthcare appointments (Warren, 2013). The care coordinators begin the discharge planning process as soon as a patient enters the hospital (CC 1). Some patients have a strong family support system of individuals who will

provide home care, while others may need additional home care support (Physician 7). Social workers help arrange care for the patient after the patient leaves the hospital (SW). Hwang et al. (2013) asserted that by integrating care, throughout the continuum of care, including physician services, labs, and outpatient services, patients receive higher quality care for lower costs.

Follow up services are an important aspect of patient care that can ensure a patient heals without incident or need for readmission (Physician 2; Physician 3). Patients must have a follow up appointment within 30 days of discharge (CMS, 2013). On the day of discharge, the patients meet with their care coordinators to ensure the patients understand their discharge instructions (PI 1; Nurse Mgr.4, CC 1). The patients receive discharge instructions both verbally and in writing. Kennedy et al (2013) determined that discharge instructions both in writing and through conversation with caregivers improved caregiver-patient communication and resulting outcomes. During rounding, I observed care coordinators and social workers complete the discharge planning process. The patient navigator arranges for follow up appointments to ensure the patient has the follow up care needed for successful recovery (Nurse Mgr. 4). The care coordinators ensure the patients have needed medications and that family or friends are available to take them home (Physician 7). Friendly transporters take the patients to the valet stand where the patient meets with their loved ones to go home (Observed transporters in action, 2014).

Follow up phone calls a day or two after discharge is an effective means of ensuring the patient has the home care they need (Nurse Mgr. 4). Tamura-Lis (2013) indicated that by calling the patients after discharge to ensure the patients are progressing

in personal treatment, the hospital caregivers may avoid repeat admissions. The third party provider feeds information back to the hospital teams which creates an environment for continuous improvement. The practice of using a third party to follow-up with patients is a step to ensure care quality and is in line with recommended practices found in the literature review. Eggenberger et al. (2013) noted that caregiver-patient relationships develop through discharge phone calls, and the discharge phone calls increase the likelihood of successful healthcare outcomes. Furthermore, discharge phone calls result in improved patient perception of the hospital experience which may result in repeat business (Eggenberger et al., 2013).

Follow-up services are in concert with the construct of patient-centeredness identified in the primary provider theory. Additionally, throughout the service themed data, Deming's model of *PDSA* emerged as an essential part of ensuring the caregivers met the patients' needs (PI 1; Physician 3; Nurse Mgr. 4; Nurse Mgr. 6). Through HCAHPS scorecards and nurse call system reports, managers and directors monitored and measured performance (PI 1; Physician 3; Nurse Mgr. 4; Nurse Mgr. 6). Pharmacists act as a quality control through medication review for backup assessment and measurement of physician prescriptions (Dept. Dir. 1; Pharmacist 2; Physician 7). Follow-up third party phone calls were another way of measuring performance so that hospital administrators can assess any deficiencies in services as indicated by all interviewees.

Through the data collection process services emerged second in frequency to interactions. The HCAHPS scores reflected second place as the scores were about 10

points lower than the scores related to patient interactions. The always score for hospital services was 75%. The hospital documents contain information on the importance of quality service and as such, the scores reflect quality service (Mission Statement, Care Commitments, PACT cards, & Video "what if you were taking care of you"). The data collected as part of this study only secondarily addresses hospital services and thus the HCAHPS scores align with hospital practices. Hospital services align with the primary provider theory construct that patients and families place importance on the patient-centeredness of the patient's providers (Aragon & Gesell, 2003).

Theme 3—Hospital Environment

The third theme hospital environment refers to the built environment and the amenities the patients and the patients' families experience outside of the hospital room. The themes include: (a) guest services (b) cleanliness, (c) noise/sleep protocols, and (d) additional amenities. When a patient enters the hospital, the emotional tenor and cellular feelings that emerge may be engaged through the environment. Consistent with the findings of the AHRQ, the hospital environment plays a role in patient satisfaction (AHRQ, 2012).

Guest services. In regard to hospitality, hospital administrators described the case study hospital as having a welcoming environment. Friendly faces, and skilled, compassionate, courteous caregivers create an environment that attracts patients to the hospital for care (PI 1; Physician 2; Nurse Mgr. 4; Nurse Mgr. 6). Body et al. (2013) found friendly faces and compassionate care go a long ways towards relieving patient suffering. From the valet services, to the welcome desk, to the care coordinators, the

experience upon arrival creates a *hotel like* atmosphere (Physician 2). During the observation phase of the study, I observed guest service personnel in action and displaying hospitable behaviors. Guest services personnel escort patients are from the lobby to the surgery floor where each patient is greeted by another guest services attendant (GPS 1). The patients then wait to be called back for surgery. The surgery staff greets the patients and families with friendly compassionate demeanor (Observed in the pre-surgery waiting area). Hospital documents contained the constructs of friendly service as a part of the environment of care. The primary provider theory includes the construct that patients are the best judges of patient-centered care.

Cleanliness affects the patients' perception of the environment. The environmental services team ensures the lobbies and elevators are clean to create a positive first impression (EVS 1). When the patient arrives in the room, they receive a welcome card from the housekeeping staff that details the cleaning schedule and provides the name of the housekeeper and contact number (EVS 1; Observed the cards in clean rooms). McCaughey et al. (2012) determined that environmental cleanliness was a predictor of satisfaction. The room also contains a concierge binder with the list of hospital services and contact numbers (Nurse Mgr. 6). If a housekeeper services a room when the patient is out for care, the housekeepers leave a *sorry we missed you* card that details the services that took place while the patient was out of the room (EVS 1; Observed the cards in rooms). Hospital documents include the constructs of hospital cleanliness as an important part of patient care (Mission Statement; Commitment to Patients). Commitment to cleanliness corroborates with the primary provider theory.

Noise/sleep protocols enhance care. Through interview responses it was apparent that caregivers understand the importance of noise control to ensure the patient experiences a quiet healing environment. Additionally, the hospital team's care commitments include the construct of providing a quiet healing environment. The hospital administrators indicated that the hospital had a healing environment committee that addresses issues related to noise in the environment. Observed protocols included evening clustered rounding, door signage to indicate do not disturb patients during certain hours. The hospital team placed stoplights on each nursing unit that light up when the noise is exceeding pre-determined acceptable levels.

The hospital teams focus on noise was consistent with finding in the literature review. Trochelman, Alber, Spence, Murray, & Slifcak (2012) associated hospital noise with patient satisfaction. Basner et al. (2010) established a link between noise, sleep deprivation, and adverse effects on the patient. The actions of the hospital staff are consistent with Deming's PDSA in that through recommendations from the healing environment committee, various nursing managers implemented protocol changes to determine if the actions affected the patients' ability to sleep and resulting HCAHPS scores. Commitment to quiet on the nursing units reflects the construct of patient-centeredness found in the primary provider theory.

Other amenities enhance the patients' perception of the environment. Other amenities include aspects of the waiting rooms, food availability, parking services, and access to technology. The intensive care unit waiting rooms include books, games, computers, televisions, and vending machines. The waiting areas for the intensive care

units as well as the individual floor waiting areas include computers and computer access. The entire hospital contains WIFI service. The hospital administration makes amenities available to help the patients' family members pass the time. The patients' rooms contain a sofa that converts into a bed where the patients' family may stay overnight (Observed during physician rounding). The amenities are in alignment with the AHRQ that purports patients communicated personal level of satisfaction based on hospital design features, mediating family interactions, and positive distractions (AHRQ, 2012). The hospital environment included family rooms, and family waiting areas where there are books for the family members to read and games that family members may wish to play (Observed the waiting areas). Positive distractions help ascertain patient satisfaction (AHRQ, 2012). Guest rooms are available to the more discerning families (Physician 2). There is a cafeteria, a coffee bar, and vending machines that patient families may enjoy while waiting for their loved ones to heal (Physician 2; Observed amenities). The hospital provides a chapel and chaplain services for patients and family members to use for comfort and respite (Physician 2). Chaplain services are an important service in healthcare; Williams et al. (2011) determined attention to the patient's spiritual needs showed a significant correlation with satisfaction. The many amenities in the hospital environment align with the construct that hospital patients and their families are the best judges of patient-centeredness (Aragon & Gesell, 2003).

The HCAHPS scores for the patients' perception of the hospital environment including cleanliness fell into the 75% range. The scores support the hospital team's focus on hospital cleanliness. Hospital documents included the construct of cleanliness as

an important aspect of the hospital environment. Hospital documents included the construct of innovation in service and care as a construct which sets the hospital apart (Mission Statement; Care Commitments, 2014).

Theme 4—Hospital Technology

The fourth theme hospital technology emerged as necessary tools to carry out patient care. While the HCAHPS questions and the study questions do not directly include questions about technology, technology emerged as significant determinants of *how* to achieve patient satisfaction. Hospital technology includes: (a) EMR, (b) Nurse call technology, (c) Interactive cell phone technology, (d) Skylight interactive television, and (e) WIFI.

The interviewed caregivers commented that the hospital teams provide excellent care and that technology is useful for communication and improved care (Nurse Mgr. 4; Nurse Mgr. 6; Physician 5; Physician 7). While the administrators interviewed indicated that technology, such as the EMR, enhanced care, several administrators indicated there is room for system improvement (Physician 2; Physician 3; Nurse Mgr. 4; Physician 5; Physician 7; Pharmacist 2; LT 1). Restuccia et al. (2012) concluded that there was clear evidence that patient care quality improves with HIT. Beech et al. (2013) suggested communication affects coordination of care and communication between practitioners is essential to quality care. Physicians desire compatible technologies to facilitate information sharing; an important step is in integration of the EMR with various hospital technologies (Beech et al., 2013). Litwin (2011) found that clinics with highly engaged

employees enjoyed high levels of employee satisfaction and achieved significantly better results with information technology.

Nurse call technology and integrated cell phone technology speed communication between patients and caregivers. By shortening response time, patient satisfaction may increase. Innovation in service is a new service concept that requires companies make improvements in customer interactions, service transmission systems, and technology (Weng et al., 2012). Installing new nurse call technology is in line with the disruptive innovation theory that indicates healthcare providers should change with the rapidly changing healthcare environment.

In the case study hospital, patient rooms included enhanced television technology (Nurse Mgr. 4). The technology allows the patients to not only watch television, but also the patients can receive an alert requesting the patient watch an education piece outlining the patient's medical condition (Nurse Mgr. 4; On-line interview with CNO). Advanced technology is a predictor of customer satisfaction as supported by Ming-Horng et al.'s (2012) research study. Customers indicated they value companies with innovative processes and services (Ming-Horng et al., 2012).

The case study hospital's interactive television technology allows physicians the option of contacting the patients through the television technology (On-line interview with CNO, 2014). New methods of patient access and communication allow hospital physicians to reach patients in ways never before possible (Murphy, 2011). The technology used in the environment of care supports the assertion that *disruptive innovation* is an appropriate framework for this research.

The televisions contain an array of channels including music channels, nature scenes, religious channels, and information about the hospital (Noted during observation of unoccupied room). The video technology also includes gaming features (Noted during observation of unoccupied room). The patients may choose from an array of games to play remotely from the bed. Technology in the case study hospital is expected to drive customer satisfaction and patient outcomes (On-line interview with CNO). Consistent with the preponderance of the literature, in order to remain competitive, companies should effectively use technology for innovation in (a) marketing, (b) services, and (c) customer communication to drive satisfaction (Apekey, 2011; Cliff, 2011; Weng et al. 2012; Williams et al., 2011). Newnham et al. (2015) found that using television video to education patients on their diagnosis, medication, and post discharge plans resulted in patient recall of the information and positive satisfaction with care.

The television technology includes technology where the patient can request services from the housekeepers, the nurses, the facilities team, and food services (Nurse Mgr. 4). The patients cannot only order services, but rate the service received right on the television (Nurse Mgr. 4). Immediate feedback to staff allows the opportunity to rectify timely any issues the patients identify (Nurse Mgr. 4). Ali et al. (2012) found that providers who responded to customer concerns increased customer satisfaction. The patients' access to medical records, to request prescriptions, and to contact the physicians' on-line enhances communication between patients and caregivers (Nurse Mgr. 6; On-line interview with CNO).

The installation of advanced technology keeps the case study hospital current with the disruptive innovation necessary to provide cutting edge patient care. The hospital took advantage of the HITECH act to ensure the hospital caregivers had the latest technology to perform top quality care (CFO). The care includes technology for patient communication as well as technology for medical care and services. The hospital administration's guiding documents for employee's included terminology such as (a) innovation, (b) quality, and (c) safety (Mission Statement; Care Commitments; PACT cards; Video "what if you were taking care of you"). Documents such as website postings, letters to staff, and quality initiatives incorporated terms like (a) continuous improvement, (b) innovation and (d) quality care. The responses of leaders are in concert with the literature review, the hospital documents, and the disruptive innovation theory. Furthermore, the installation of technology is in line with patient-centered care.

Theme 5—Hospital Governance

Hospital governance emerged as a significant part of creating an environment for success. The culture in the case study hospital is one that suggests the administrators use the framework of patient-centeredness, and the framework of PDSA to conduct and evaluate patient care. Additionally the use of many forms of technology is in line with the disruptive innovation theory. As such, the administration has a framework for hospital operations. The strategies for carrying out the hospital administrators' identified framework included forms of communication and feedback from staff. Hospital governance included employee engagement through: (a) performance improvement

committees, (b) the magnet journey, (c) training and retraining staff, (d) matching skills to tasks, and (e) employee/team recognition.

Physicians are involved in performance improvement committees that result in process changes to enhance patient safety while improving physician's sense of control in the care arena (PI 1; Health literacy initiative). Rozenblum et al. (2012) concluded that achieving high levels of patient satisfaction required a proactive management team and engaged frontline clinicians. The case study hospital includes physicians in higher level roles (Physician 7). According to Physician 7, by participating in the hospital's governance, physicians can deliver a higher standard of care. "There are differences in the thought processes of physicians and nurses; an institution's administration is wise if it exploits both" (Physician 7). In follow-up discussions with physicians, Physician 7 indicated there was additional opportunity for physician involvement in governance. Similarly Physician 2 indicated there was opportunity to enhance physician participation in hospital process improvements. Stelfox et al. (2013) and Robbins et al. (2012) asserted performance improvement strategies are important constructs to achieving patient satisfaction and quality outcomes.

While bed-board meetings, daily nursing huddles and multidisciplinary caregiver meetings emerged as methods for increased inter-caregiver communication, these same tools played a role in hospital governance. At the meetings the teams decide how, and through what methods patients receive care. While meetings and huddles generally allow administrators to provide a forum to discuss patient care, these meetings also created a forum to discuss caregiver processes and opportunities for improvement. Bernhardt and

Misterek (2014) found that the enhanced communication among caregivers through huddles, bedside reporting, and rounding both improved patient outcomes and patient satisfaction.

Nursing managers indicated that the *Magnet* journey changed the culture in such a way that the front line nurses were able to evoke process changes (Nurse Mgr. 4; Director 9). According to the nursing managers, changes in equipment and processes created an environment that was safer for both patients and caregivers (Nurse Mgr. 4). The *Magnet* journey was a step towards employee engagement that created a nurse centric environment of care (Nurse Mgr. 4). Urden & Ecoff (2013) found that relationships with leaders, professional accountability, staff voice, were aspects of the Magnet journey that results in hospital care transformation. Litwin (2011) concluded administration should include employee engagement as a business strategy to improve processes and patient satisfaction. While the *Magnet* journey was a conduit for nurses to share opportunities for improved processes, some believed it would be beneficial for the hospital to facilitate participation by improving meeting scheduling and back-up staffing so the nurses could participate during their regular working hours (Director 9; Clinic 10; Nurse Mgr. 11).

Hospital administrators implement methods to ensure employees remain focused on the hospital's culture and framework of care. Two of the methods include the on-boarding process and training and re-training of employees. The hospital administrators discussed the on boarding process and hospital employee training (Nurse Mgr.4; Nurse Mgr. 6). Similarly, the hospital administration's onboarding document included education on the constructs of patient care. A nurse manager indicated to reinforce appropriate

caregiver-patient interactions, hospital administrators ensure all employees, regardless of the employee's role in the hospital setting, receive AIDET training to reinforce the culture and to provide a consistent framework for customer relationships (Nurse Mgr. 6). AIDET stands for acknowledge, introduce, duration, explanation, and thanking. The hospital administration's on-boarding documents listed AIDET training as required for all new employees. According to Aydin (2013), organizational leaders should train and retrain employees in both verbal and non-verbal skills. By ensuring each employee understands the constructs of customer service; hospital administrators asserted the patients may experience consistency of care (Director 8). During rounding, physicians, nurses, care-coordinators and other staff emulated the AIDET principles. Similarly, Aragon and Gesell (2003) indicated the care provider interactions with patients were essential in predicting satisfaction with care.

The housekeeping director indicated that the environmental services team members provide regular input into processes to improve hospital cleanliness (EVS 1). The housekeepers who are more customer-focused are assigned to patient room cleaning, while the housekeepers who are not comfortable with patient interactions receive *back of house* assignments (EVS 1). McCaughey et al. (2013) concluded that culture and leadership were the best predictors of patient satisfaction and not just money spent on EVS operations. Employee involvement in decision making enhances employee satisfaction and resulting performance (McCaughey et al., 2013). Cant and Erdis (2012) indicated that while customer expectations were important, employee satisfaction was necessary to ensure employees provide superior customer service.

In order to triangulate EVS employees' involvement in the cleaning process, I asked an employee if she felt involved in cleaning process improvements. One EVS employee indicated that the main challenge was when the hospital was completely full; there is not adequate time to clean rooms and to complete checkouts (EVS 2). EVS 2 asserted that process improvements in the location of equipment to flex between room cleaning and terminal clean may enhance the cleaning process. Hospital documents included evidence that administrators value a clean environment (Care Commitments). Aragon and Gesell's primary provider theory does not address cleanliness; however patients may construe cleanliness as an act of patient-centeredness.

The case study hospital had a framework for governance. The administrators provided a strategy for care that included continuous improvement through employee engagement. The primary constructs included in the hospital administrator's guiding documents included caregiver-patient interaction and hospital services. The care commitments included the constructs of the environment as one which was peaceful, healing, and clean. The culture in the case study hospital was one of mutual respect between all members of the care team from physicians and nursing staff, to members of the EVS and food services teams.

Summary

The framework of care, as determined by hospital governance, the patient experience as determined by interactions, services, and the environment, and the available tools for care including technology are integral parts of patient care. While the framework, the experience, and the technology are necessary, a hospital team's

reputation, specialty services, and marketing plan are parts of a successful business enterprise. In order to remain competitive, companies should effectively use technology for innovation in (a) marketing, (b) services, and (c) customer communication to drive satisfaction (Apekey, 2011; Cliff, 2011; Weng et al. 2012; & Williams et al., 2011). Figure 4 includes the constructs of one successful business enterprise. While the business enterprise is successful, each organization has room for improvement. Caregivers commented on the need for increased staff engagement in process improvements, the need for additional employee recognition, the need for enhanced inter-caregiver communication, and the need for modifications to electronic medical record (Nurse Mgr. 4; Physician 5; Physician 7; Director 9; Clinic Mgr. 10; Nurse Mgr. 11). While patients may perceive excellent care, there are innate aspects of the hospital that exist beyond what the patients see that allow opportunities for enhancements to care. The hospital has a reputation where skill and compassion are the foundations of care. Reputation is a predictor of business success (Ali et al., 2012; Nitzan & Labai, 2012). The hospital's culture is one where the caregivers display courtesy, respect, and compassion for each and every patient (PI 1; Physician 7). The interactions, services, and environment provide a place where patients go can go to experience skilled care in a quiet, peaceful, and healing environment (PI 1; Physician 3; Physician 7).

Figure 4. Framework for hospital governance including the constructs of patient satisfaction and the external forces affecting the hospital.

Applications to Professional Practice

The findings of this study contain detailed action plans and initiatives hospital leaders may explore in order to achieve high HCAHPS scores. Additionally included herein are tools one hospital care team uses to achieve high HCAHPS scores. Appendix I contains a table of best practices that surfaced as part of the study findings. The findings are both relevant and proven to improve business practice. CMS has linked the patient experience to patient outcomes (CMS, 2013). Hospital administrators can improve business performance by using findings and recommendations from this study to inspire, design, and implement change, to increase hospital HCAHPS scores. The HCAHPS scores reflect the perceived patient experience and the scores affect revenue loss or gain for the hospital (Fowler, Saucier, & Coffin, 2013). Efficacious change in patients' hospital experience may lead to positive social impact by reflecting improved perceived quality of care, which in turn, may increase patient satisfaction and repeat business for the hospital (Borah et al., 2012; Chatterjee, Joynt, Orav, & Jha, 2012). As such, hospital

administrators may wish to implement some of one hospital's proven strategies for improving the patient experience.

Hospital administrators may wish to remember that patient care neither begins nor ends in the hospital environment. Patient health and wellness is a continuum of care from when the patients family environment, through the patient-physician relationship, into the hospital environment, through follow-up care and back to the patient's home environment (Physician 7). Verrof, Marr, & Wennberg (2013) concluded that enhanced support through shared decision making lowered medical costs by 5.3%. The enhanced support included health coaching through (a) follow up calls, (b) emails, (c) mail, and (d) internet support. Figure 5 includes a diagram of the continuum of care. Health and wellness is not a single point of care, but a continuum of care.

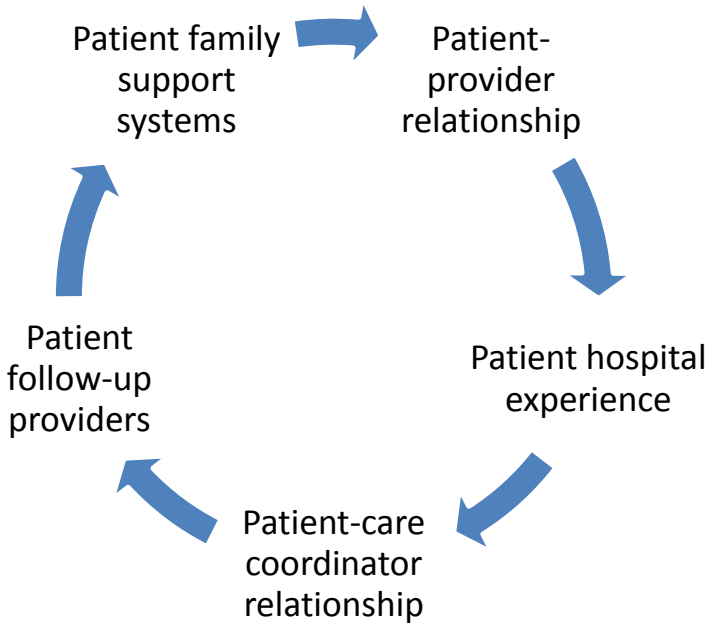

Figure 5. Diagram of the continuum of care.

Implications for Social Change

The improvements in hospital governance practices will not only improve the hospitals viability, but will also improve the lives of the individuals, and communities that the hospitals serve (Cliff, 2011; Tidwell, 2011; Urden & Ecoff, 2013). While the mandates from federal legislation were facilitating conduits for social change, the actual plans and actions hospital administrators take to improve the environment of care, will shape the future of healthcare delivery in the United States (Chatterjee et al., 2012; Friedberg et al., 2013). Tangible changes in care processes may enhance the patient experience in unprecedented ways. Improved patient outcomes resulting from education, communication, and technology in the continuum of care will change the lives of individuals and their families (CMS, 2013). Cultural changes required to enhance patient care may improve the lives of caregivers and the caregivers' families.

My published findings might provide practices that contribute to the way hospital practitioners care for patients and in the way patients care for themselves. Tangible changes include enhanced provider-provider communication, enhanced provider-patient communication, improved care processes, enhanced patient safety, and patient access to medical information through enhanced technologies. A hospital is part of the community and the benefits of great hospital care have far reaching implications as to the healthcare in the community as a whole.

Recommendations for Action

Hospital governance determines the success or failure of the organization by ensuring the hospital has a supporting framework from which to operate (Zuckerman,

2005). Hospital leaders set the path for the organization's unit managers to follow by selecting a framework with a proven record of success. The hospital's leadership establishes the culture, and in one hospital, a culture of courtesy, respect, teamwork, employee engagement, and innovation resulted in positive satisfaction scores. Recommendation 1: Hospital administrators should implement a culture containing proven business practices to create an environment for success (Robbins et al., 2012). The culture should be one where quality, safety, and continuous improvement are fundamental aspects of the culture (Badri et al., 2009; Fowler et al., 2011).

The case study hospital has a strong framework supported by the primary provider theory, Deming's PDSA, and disruptive innovation. Recommendation 2: Hospital administrators should ensure the leadership team defines the framework for care. The administration should have a clear written framework for the plan of care. Leaders may wish to integrate technology as part of the plan to change with the changing healthcare environment. Recommendation 3: Hospital administrators should plan and initiate actions to evoke necessary change through the use of readily available tools such as satisfaction surveys to benchmark and track success. Stelfox et al. (2013) determined measuring quality of care, based on patient feedback, is the first step in improving patient outcomes.

Employees and patients alike agreed the hospital team delivers exceptional patient care with skill and compassion (PI 1; Physician 2; Physician 3; Nurse Mgr. 4; Physician 5; Nurse Mgr. 6; Physician 7; Patient 1; PFM 1; PFM 2). While the administration has successfully implemented a culture of compassionate, skilled care, there is additional opportunity to enhance care through employee engagement (Physician 2; Nurse Mgr. 4;

Physician 7; LT 1). The degree of engagement varies between departments and by enhancing engagement so that all employees feel they have a voice quality outcomes and patient satisfaction will continue to improve (Cant & Erdis, 2012; Litwin, 2011; Morrow et al., 2012). Recommendation 4: Hospital administrators should set a precedence wherein all employees have a means to share thoughts on processes and systems to improve performance; enhanced engagement will result in employee satisfaction. Creating performance improvement teams of caregivers led by physicians will enhance collaboration and engagement between departments and will lead to enhanced care quality (Hwang et al., 2013). Robbins et al. (2012) indicated engaged employees improved the quality of care and resulting patient satisfaction.

Implementing a framework for *caregiver-patient interactions* helps hospital administrators ensure provider-patient interactions are consistent throughout the hospital service teams. Recommendation 5: Hospital administrators should ensure employees receive periodic training on expected patient interactions. The AIDET training helped standardize patient interactions (Nurse Mgr. 6; On-boarding). Recommendation 6: Multidisciplinary family rounds should also be standardized hospital wide to enhance communication and care (Lown & Manning, 2010).

Ensuring the *hospital environment* meets both the needs of the patients and their families helps secure patient satisfaction (Warren, 2013). Recommendation 7: Hospital leaders should provide a comfortable, safe, clean, welcoming environment helps ensure patients will positively recommend the hospital (AHRQ, 2012). The hospital leadership

should provide convenient accessible parking, food services, comfortable waiting rooms, and access to technology.

The hospital administration must provide *hospital services* to meet the continuum of care for the patients. Regular communication both between caregivers and patients and among caregivers is essential to quality care (Hwang et al., 2013). Multidisciplinary rounds, daily bed board meetings, daily nursing huddles, and the EMR are tools hospital administrators may wish to implement to improve internal communications. Ensuring physicians, nurses, pharmacists, and all members of the care team communicate on some level is an essential part of patient care (Hwang et al., 2013). In the case study hospital, not all units utilize multidisciplinary rounds, or multidisciplinary daily team huddles to enhance performance (Lown & Manning, 2010). Recommendation 8: There is an opportunity to standardize processes between groups to enhance care. Additional opportunity lies in posting a data base of information on the processes, plans, and initiatives caregivers across the organization implement to enhance patient satisfaction. There is opportunity to create process flow diagrams for all workflows to ensure all caregivers understand all of the processes.

Innovation emerged as a necessary evolution in healthcare. The case study hospital's teams have incorporated multiple forms of *hospital technology* including enhanced television technology, advanced nurse call system technology, and the EMR. While the advancements in technology have advanced care, opportunity emerged to enhance the EMR in terms of process flows, care plans, and standardized inputs (Physician 2; Nurse Mgr. 4; Physician 5; Nurse Mgr. 6; Physician 7; LT1; Pharmacist 2).

Recommendation 9: Hospital administrators should ensure the hospital has an electronic medical record system that is robust and meets the needs of the caregivers. While implementing EMR, hospital administrators should ensure multidisciplinary teams have adequate input on process flows (Litwin, 2011). Once the system is in place, the caregivers should reconvene to optimized system performance. Litwin (2011) indicated that hospitals with highly engaged employees had better success in the implementation of the EMR. Nurse call systems should be used to the fullest extent possible to track patient needs and improve levels of care.

Training emerged as a necessity to keep current processes in the forefront and ensure new as well as existing employees carry out the framework of care expected throughout the organization (Nurse Mgr. 4; Physician 2; Physician 5; Nurse Mgr. 6). Recommendation 10: Hospital administrators should ensure the employees receive consistent training throughout the organization and continuous training as processes evolve (Aydin, 2013). As technology evolves, staff should be trained and receive appropriate documentation to refer to at a later date.

The findings from this study should be reviewed both internally and externally from the case study hospital. Through publication, health care researchers and hospital administrators may garner information to help improve hospital administration practices nationwide. Sharing the information through professional conferences will also help hospital administrators outside of the case study hospital learn proven methods for enhancing patient care processes.

Recommendations for Further Research

The single case study design was a limit of this study and future researchers may wish to conduct similar research at hospitals who have achieved high HCAHPS scores. By comparing plans and initiatives implemented by other hospital administrators, researchers may identify actions that may be transferable to other patient populations or other hospitals (Apekey et al., 2011; Baker, 2011). Hospital culture and environmental design may alter the effectiveness of patient satisfaction initiatives in different healthcare settings (Sinkowitz-Cochran et al., 2011). Researchers may be able to identify generalizable practices after comparing cultural nuances between hospitals.

Patient population demographics were a limiting factor for this study. By implementing similar care processes in hospitals with different patient demographics future researchers may determine if the demographics effect the success of care processes and resulting patient satisfaction scores (Ghuloum, Bener, & Burgut, 2010; Williams, Meltzer, Arora, Chung, & Curlin, 2011). The case study hospital was a specialty hospital that cares for critically ill patients. Other hospitals may not have the skill sets found at the case study hospital and as such are differentiated from the case study hospital. Demographics of both caregivers and patients may have affected the HCAHPS scores.

The difference in patient-centered care behaviors of the health care providers may change the patients' perception of the caregiver's patient-centeredness (Aragon & Gesell, 2003; Guarisco & Bavin, 2008). Each organization has a unique culture with different employee dynamics that may affect caregiver behaviors. As such, there is opportunity to investigate constructs of patient satisfaction in hospitals with different cultures.

Reflections

In reflecting on the DBA doctoral study process, and in particular during the research process, I garnered new information about the complexity of patient care. By discussing with physicians, nurses, pharmacists, lab techs, and other caregivers the processes required for safe quality patient care, I have gained a new appreciation for the complexity of the healthcare system. While working with the hospital teams as an observer, I gained a new perspective on the importance of multidisciplinary communication to create a positive patient experience. By visiting with many types of caregivers, a deeper understanding of how the healthcare teams and support teams must interact to achieve positive patient outcomes emerged.

In my role as the researcher, was able to observe without judging. By observing and being present to the patients and employees, I was able to garner information and see aspects of the patient experience as the employees and patients perceived. It was interesting to watch the quality, skilled, compassionate care, and the responses of patients who truly appreciated the care. While originally I had some concern as to whether participants would be forthright since I am an insider, I learned that the promise of confidentiality led participants to speak freely and openly about the participants experience within the case study hospital.

Summary and Study Conclusions

Summary

In order for hospital administrators to achieve and maintain high HCAHPS scores the administrators must create a framework from which plans and initiatives may evolve

to address the constructs of the patient experience. Hospital administrators must track the HCAHPS scores and implement measures to address care-giver patient interactions, hospital services, hospital environments, hospital technology, and hospital governance. The data garnered from the case study hospital highlighted the necessity to focus on provider-patient interactions to create a positive patient experience. Consistent with the primary provider theory, the results of this study indicate that it takes more than clinical skill to provide the care patients need for healing in the hospital environment. Skill and compassionate care emerged as the primary focus of caregivers, and as the main concern of patients and the patients' family members. The preponderance of the evidence indicated that patients value compassionate, skilled care as indicated by the list of best practices initiated by the case study hospital (See Appendix I). Front-line caregivers providing compassionate care to patients emerged as having the greatest effect on patients' perception of care.

Second to compassionate, skilled care, emerged the need for innovative technology and tools to provide care. While tools and technology enhance care, training, and employee input on the standardized use of the tools and technology emerged as a desired necessity. Multidisciplinary communication surfaced as necessary for quality care and resulting patient perception of care. Engagement on all levels surfaced as desirable by employees to enhance care quality. The HCAHPS scores provided evidence that a hospital team excels in the areas in which they focus. Measuring HCAHPS scores, planning, and implementing performance improvement initiatives to support the lower scoring areas, likely will result in higher scores.

Conclusion

Initiating plans to improve the patient experience is essential to the financial viability of acute care hospitals. Communicating plans between administrators and caregivers, and providing tools and resources to implement programs is critical for success. While plans likely will include the implementation of technology, ensuring front line caregivers take part in the planning and use of the technology is essential as technology implementation may be challenging for the best hospital teams. As hospital patient care processes evolve during periods of technological evolution, caregivers must ensure that change does not compromise patient safety. A culture of skill, care, and compassion is essential to achieve high patient satisfaction scores.

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Appendix A: Semistructured Interview Protocol

Selecting Respondents	Respondents: Initial contact by phone call or email, information emailed to potential participants, participants wishing to participate responded to phone calls.(19 contacts, 8 responded positively, 2 provided PI input after interviews completed)
Setting Interview Time and Place	Interviews took place in respondent's private office
Explaining the Study and Consent	Recapped the study purpose, verbally consented each participant, provided each participant consent form.
Recording the Interview	Recorded each interview. Thanked respondent in person and with a written card after interview.
Transcribing the interview	Transcribed interview and emailed transcription and interpretation to hospital study chair, and to respondents
Member Checking	Contacted each respondent and confirmed accuracy of transcription
Additional Questions	Asked a couple of follow-up questions based on preponderance of responses
Coding the Responses	Coded all responses
Questions	Notes
What plans or initiatives do your administrators use to encourage nurses to treat patients with courtesy and respect?	
How does your hospital administration ensure the nurses listen carefully to patients and explain things to them in ways they understand?	
How does your nursing leadership ensure after the patient pushes the call button, the patient receives assistance as soon as they wanted it?	

How do your physician leaders encourage their physician colleagues to treat patients with courtesy and respect?	
How do your physician leaders encourage their physician colleagues to listen carefully to patients?	
How do your physician leaders ensure doctors communicate with patients in a way patients can understand?	
How do your caregivers improve the patients' perception of hospital cleanliness?	
What activities does your hospital staff perform to improve the patients' sense of quiet in an around the rooms at night?	
How have your caregivers enhanced the HCAHPS score pertaining to patients' bathroom needs?	
How do your caregivers improve the patients' perception of pain control?	
How do your caregivers share information in regard to medication administration including side effects, and the need for medication to improve patient perception of the same?	
What follow-up services, including patient contact after release, do your discharge planning team perform?	
In regard to patients recommending the hospital, what steps increase the likelihood the patient rates the hospital positively?	
In regard to patients recommending the hospital, what steps increase the likelihood the patients recommend the hospital to friends and family?	
How does your management ensure caregivers share decision making with the patient's family on items including follow-up care and personal health management?	

What other initiatives in regard to patient satisfaction would you like to share with me today?	
Follow-up questions to physicians	
Do physicians feel connected to hospital processes? For example, do physicians feel they have adequate input on PI initiatives whether being involved with existing initiatives or new initiatives? Do physicians feel in control of what is going on in the hospital? Could you provide an example?	
Do physicians feel the My Chart, the EMR and other electronic systems have created a safer environment and will the technology improve patient outcomes.	

Appendix B: Data Gathering and Observation Plan

Data Considered	Notes
Hospital Patient Satisfaction Policy	
Hospital Core Values Document	
Hospital Vision Mission and Values Statement	
Joint Commission Website Search of References to Study Hospital	
Emails to Staff in Regard to Patient Satisfaction	
Hospital Patient Satisfaction Strategic Plan (Check if there is more than one, i.e. by department)	
HCAHPS scores for study hospital	
Observation of physicians/physician rounding	
Observation of nurses/nurse rounding	
Observation of lab techs	
Observation of housekeepers	
Observation of food services representatives	
Observation of multidisciplinary rounds	
Observation of care coordinators	
Observation of pharmacists	

Appendix C: Informed Consent Interviewed Participants

Greetings Participant!

You are invited to take part in a research study exploring strategies to enhance HCAHPS patient satisfaction scores. As a study participant, you are asked to answer interview questions at a time and place of your convenience. The interview will take about an hour. To be eligible to participate, you must be (a) over 18 years of age, (b) a current hospital employee, and (c) be familiar with the hospital patient satisfaction initiatives. This document is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

Background Information:
The purpose of this qualitative study is to understand how and why the hospital has attained high patient satisfaction scores and to understand the hospital administration's strategy for attaining these scores. The study is from the viewpoint of the employees at the study hospital.

Procedures:
If you agree to be in this study, you will be asked to:

- Spend about an hour answering questions in relation to the study.
- May be asked to meet a second time for 30 minutes for follow up questions or to validate the study results.

Here are some sample questions:
How does management ensure caregivers share decision making with the patient's family on items including follow-up care and personal health management?
In regard to patients recommending the hospital, what measures increase the likelihood the patient rates the hospital positively?
How do caregivers improve the patients' perception of hospital cleanliness?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you wish to participate in the study. No one will treat you differently if you decide not to be in the study. If you choose to join the study now, you can still change your mind during or after the study. You may stop at any time.

Risks and Benefits of Participating in the Study:
Participating in this type of research involves some risk of the minor discomforts that can be encountered in daily life, such as stress related to the hospital environment.
Participating in this study will not pose a risk to your safety or well-being. The study may add new knowledge to the field of hospital quality plans and processes and patient satisfaction.

Payment:
There is no payment for participation in this study.

Privacy:
All information related to this study is confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include participant's name or anything else that could identify the participant in the study reports. The data resides on my password protected personal computer and on a password protected flash drive stored for safe keeping. Data does not reside on any public computers. Data will reside in storage for at least five years.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you may contact the researcher via email at Valerie.shoup@waldenu.edu. If you want to talk confidentially about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University official who can discuss this with you. Her phone number is 1-800-925-3368, extension 1210. Walden University's approval number for this study is IRB will enter authorization number here, and it expires on IRB will enter the expiration date.

Exclusion Criteria:
- I am not over 18.
- I am not familiar with hospital patient satisfaction initiatives.

Statement of Consent:

I have read the above information, and I think I understand the study well enough to make a decision about my involvement. By answering interview questions, I understand that I am agreeing to the terms described herein.

Please retain a copy of this informed consent. If you are willing to participate in this research study, please let me know when a good time is to meet with you for the interview.

Appendix D: Informed Consent Observed Participants

Greetings Participant!

You are invited to take part in a research study exploring strategies to enhance HCAHPS patient satisfaction scores. As a study participant, you are asked to allow the researcher to observe you as you interact with patients during your routine rounds. To be eligible to participate, you must be (a) over 18 years of age, (b) a current hospital employee, and (c) be familiar with the hospital patient satisfaction initiatives. This document is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

Background Information:
The purpose of this qualitative study is to understand how and why the hospital has attained high patient satisfaction scores and to understand the hospital administration's strategy for attaining these scores. The study is from the viewpoint of the employees at the study hospital.

Procedures:
If you agree to be an observed participant in this study, you will be asked to:

- Allow the researcher to round with you in your routine patient rounds.
- May be asked to meet a second time for 30 minutes for follow up questions or to validate the study results.

Here are some sample questions covering what I will be looking for during rounds:
How does management ensure caregivers share decision making with the patient's family on items including follow-up care and personal health management?
In regard to patients recommending the hospital, what measures increase the likelihood the patient rates the hospital positively?
How do caregivers improve the patients' perception of hospital cleanliness?

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you wish to participate in the study. No one will treat you differently if you decide not to be in the study. If you choose to join the study now, you can still change your mind during or after the study. You may stop at any time. Declining or discontinuing will not negatively impact your relationship with the researcher.

Risks and Benefits of Participating in the Study:
Participating in this type of research involves some risk of the minor discomforts that can be encountered in daily life, such as stress related to the hospital environment. Participating in this study will not pose a risk to your safety or well-being. The study may

add new knowledge to the field of hospital quality plans and processes and patient satisfaction.

Payment:
There is no payment for participation in this study.

Privacy:
All information related to this study is confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include participant's name or anything else that could identify the participant in the study reports. The data resides on my password protected personal computer and on a password protected flash drive stored for safe keeping. Data does not reside on any public computers. Data will reside in storage for at least 5 years.

Contacts and Questions:
You may ask any questions you have now. If you have questions later, you may contact the researcher via email at Valerie.shoup@waldenu.edu. If you want to talk confidentially about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University official who can discuss this with you. Her phone number is 1-800-925-3368, extension 1210. Walden University's approval number for this study is IRB will enter authorization number here, and it expires on IRB will enter the expiration date.

Exclusion Criteria:
- I am not over 18.
- I am not familiar with hospital patient satisfaction initiatives.

Statement of Consent:

I have read the above information, and I think I understand the study well enough to make a decision about my involvement. By answering interview questions, I understand that I am agreeing to the terms described herein.

Please retain a copy of this informed consent. If you are willing to participate in this research study, please let me know when a good time is to meet with you to discuss participation in the study.

Appendix E: Document Analysis

Data	Interactions	Services	Environment
Mission Statement (2014)	Education	Innovative, Quality Service	Safety
Care Commitments (2014)	Respect, Confidentiality, Discrete, Privacy, Patient- focus, Professionalism	Solve problems, Anticipate needs, Innovation	Peaceful, Quiet, Clean, Safe, Dress professionally,
PACT Cards (2014)	Teamwork, Respect, Compassion, Professionalism	Problem solver	
Video: What if we were treating you.	Treating patients as if they were you, Kindness, Concern, Compassion, Empathy,	Anticipate needs Quality Care	
Continuous Quality Improvement Training (2013): There are 137 quality improvement projects that have taken place since 2010.	Reduce wait times, Improve communication	Teamwork	Tools include: Brainstorming, Fishbone diagram, Patient surveys and Observations, HCAHPS Press-Ganey
About Us: XYZ Medicine: Patient Satisfaction (2014)	Attentiveness	Clean spaces, Food quality	Tools include surveys, Press Ganey, HCAHPS
XYZ Wins Two National Patient Satisfaction Awards (2011)	Courteousness, Confidence, Expertise and Skill, Concern.		Team-care approach
Emails to Staff in Regard to Patient Satisfaction: Most Improved Patient/Family Satisfaction Award (2013)	Positive experiences, Keeping promises, Welcome,	Quality care, Expertise *P, Innovation[p]	Paying attention to scores, Teamwork** Press Ganey***, HCAHPS***

	Informed[p], Courteous**, Respect, Concern[p], Communicaton[p], Compassion[p]		
Patient Satisfaction Training (2010)			Teamwork, Focus on Press Ganey and HCAHPS scores, Post results, Focus on Teamwork
XYZ's stroke unit's "team approach" saves patient's life (2014)	Competency, Communication with family, Skilled, Compassion and care, Innovation		
Literacy	Survey patients on literacy		
Onboarding packet	Mandatory training, Guiding Principles, AIDET, Communication with new hire	Address concerns	Setting up the work area
HCAHPS Review	High scores for physician and nurse communication	High scores for follow-up services	

Appendix F: Constructs of Observed Behaviors

Questions	Notes ----------
AIDET training ensures nurses to treat patients with courtesy and respect. How did the caregiver show patient courtesy and respect?	Each of the caregivers followed the AIDET constructs.
The nurses understand they must to listen carefully to patients and explain things to them in ways they understand. How did the caregiver explain things to the patient? Did the caregiver listen to the patient?	Physicians, nurses, care coordinators and others were attentive and listened to the patient. The caregivers asked the patients for feedback
How long does it take for the nurses to respond to the call button, the patient receives assistance as soon as they wanted it?	Nurse manager shared reports where duration is tracked.
How did the physician interact with the patient that indicated they were treating them with courtesy and respect?	Physicians greeted patients, asked the patient questions, listened, and responded politely and attentively.
Did the physician listen carefully to patients?	The physicians looked at the patients and appeared attentive.
How do your physician leaders ensure doctors communicate with patients in a way patients can understand?	Interviewed three patients, and three patient's family members and asked the question if the physicians communicated in a way they could understand. The patients replied affirmatively
Did the caregiver do anything to improve the patients' perception of hospital cleanliness?	During the observation phase, had detailed discussions with EVS and EVS managers. Field notes confirm steps to improve perception.
Did the evening staff do anything to improve the patients' sense of quiet in an around the rooms at night?	Observed evening protocols, dimming lights, clustering rounds.
Did the caregivers do anything pertaining to patients' bathroom needs?	Caregivers asked patients about bathroom needs during care rounds. Responded to call lights.

Did the caregivers improve the patients' perception of pain control?	Caregivers asked patients about pain, used pain rating scale tools, discussed pain expectations.
Did the caregivers share information in regard to medication administration including side effects, and the need for medication to improve patient perception of the same?	Caregivers shared information both verbally and in writing. ICU pharmacists rounded on patients.
Observe discharge planning team discussing follow-up services perform?	Care coordinators discussed services with patients.
Did the caregiver do anything considered notable during their interactions?	Caregivers smiled, were pleasant in manner, sat or stood close to patient, made eye contact.
Did the caregiver share decision making with the patient's family on items including follow-up care and personal health management?	Care coordinators, social workers, and navigators had discussions on care with patients.

Appendix G: Categorization of Responses to Semistructured Interview Questions

Inductive Categories	Participant Responses
Interactions	*Behaviors: Provider-patient relationships*
	The hospital has a longstanding culture of courtesy and respect.
	Faculty and physicians are compassionate and very helpful.
	Physician leaders have built a culture of compassion, accountability and trust with their patients.
	It is important to understand the cultural nuances of patients; certain cultures do not shake hands.
	Actively listen to patients, let them tell their story.
	Keeping patients well informed is a priority.
	Speak to the patients in the language they understand.
	Use simple language.
	We include the family in decisions, and we keep the family informed to the extent hippa allows.
	We cluster care at night so patients can sleep.
	We acknowledge the patient, we introduce team members, we explain timelines of care, we answer questions, and we thank the patient every time we interact.
	We knock on the door before entering the room; we call the patient by name.
	We ensure we are discrete and confidential in our conversations.
	We ensure we are adequately staffed to meet the patients' needs.
	Our clinics ensure the individuals answering phone reflect a happiness and positivity.
	Methods:
	We use the Press-Ganey scores and the HCAHPS scores to measure our performance.
	All employees receive AIDET training.
	Residents and physicians round separately and together and compare notes.
	A professionalism committee reviews reported incidences in regard to provider-patient interactions.
	We recognize teams for high patient satisfaction scores.
	Peers recognize peers for positive behaviors in performance, accountability, teamwork, and compassion.
	Physicians and senior staff members lead by example.
	Performance improvement committees share issues in regard to patient-physician interactions.
	Care coordinators round on patients and give patients the opportunity to voice issues.
	Nurse managers round on patients and give patients the opportunity to voice issues.
	Multidisciplinary rounds ensure good communication between caregivers.
	We schedule family rounds so the patients' family knows when the physician will be rounding.
	We use the electronic medical record to enhance communication.
	Interpreters help caregivers communicate in the patients' natural language.
	Multidisciplinary team meetings, daily bed-board meetings, and nursing shift huddles are venues to address patient-provider issues.
	We use the teach-back method of communication to ensure patients understand their care.
	We have white boards in each room with the plan of care for the day.
	We use the white boards to communicate names of caregivers, expected treatment times and discharge dates, and phone numbers for caregivers.
	We provide the patients a daily report card on their progress.
	Bedside reporting at shift change enhances care coordination and patient satisfaction.
	We help match personnel who have customer service skills to customer service positions.
	Employees who do not feel comfortable interacting with patients receive back of house positions.
	Each patient receives a literacy assessment so we ensure we communicate with them in a way that the patient understands.
	Nurses ask patients if they are auditory learners, or learn by demonstration; how do they learn?
	Patients receive information on website addresses where they can report about their stay including vitals.com and healthgrades.com.
	We encourage patients to rate their care.
	We send each patient a thank you note after discharge.
Services	We take care of the whole patient.
	Each patient has multiple care providers working together to meet the needs of the patient.
	Care coordinators act as liaisons between physicians, nurses, and other care providers.
	Patients wear either yellow or blue socks depending on the patient's risk of fall.
	Pharmacists review all prescription orders.
	Pharmacists round with physicians in the ICU and on some of the units as requested by the physician.

	Each patient receives a private room. The patients' family members may stay overnight in the patients' rooms.
	Each floor has a lobby area where patient families can relax.
	We provide room service where the patients select from a menu to the extent the patient's physician allows.
	We provide prompt meal service.
	We have nutritionists who ensure the patients receive the proper nutrition.
	When we round on patients we ask them about potty, pain, position, and possessions to ensure we meet the needs of the patients so they do not have to call.
	Each patient receives a care plan and we communicate any delays or change in service.
	We have pain management specialists on staff that can assist the physician with pain protocols if needed.
	We provide patients with realistic expectations of pain pre-operatively.
	We educate the patient on their pain control plan and on their medication plan.
	We ensure the patient understands we use systematic and scientific evidence to control pain.
	We provide patients written information on surgery, on pain control, and on medication.
	Nurses highlight critical information the patients need to know.
	We maintain written materials about common medications and common surgeries to provide to our patients.
	Social workers provide discharge services including home care, equipment, hospice care, and any other outpatient care the patient needs.
	Navigators or care coordinators schedule follow-up appointments before the patient leaves the hospital.
	Discharge prescription services delivers medication to patients' room and discusses the medication with the patient.
	Patients receive binders with information, and with phone numbers needed for questions or follow-up care.
	We encourage family members to take an active role in patient recovery.
	A third party company provides follow-up phone calls to patients to assess satisfaction with care and to determine if the patient needs any additional or unplanned care.
	We are a referral hospital and take patient cases no one else will take.
	We save lives.
Environment	We provide valet services.
	First impressions are important, we ensure the lobbies, elevators, and stairs are clean.
	Rigid cleaning protocols ensure a clean environment at all times.
	Housekeepers are visible. The housekeepers leave cards about service performed if patient is not in the room at time of service.
	Housekeepers leave welcome cards in the room after each discharge clean.
	We foam in and foam out of the patient rooms.
	Guest service personnel located in the lobby direct patients to where they need to go.
	Guest services escorts patients as needed to ensure the patient makes it to their destination.
	We provide a hospitable environment, prompt, and attentive service.
	We provide a hotel-like environment, with a good cafeteria, vending machines, and comfortable surroundings.
	We have a chapel and provide chaplain services.
	We dim the lights at night.
	Some patients receive do not disturb signs on their doors at night if night time care is not warranted.
	Yacker trackers remind nurses and staff members of the need to maintain a quiet environment.
Technology	The nurse call system allows patients to contact nursing staff for care.
	Nurse managers can track response time for each nurse call request.
	Bed alarms alert staff if patients who are fall risk get out of bed.
	The skylight system allows patients to request services over the television.
	The skylight system allows patients to rate care.
	The skylight system is a means for physicians to remote into a patient's room and discusses care.
	HUCs alert caregivers of the need to attend to a patient via the caregiver's phone.
	Nurses locate patient information including physician orders through the electronic medical record.
	The lab techs attain physician orders through the EMR.
	The pharmacists attain physician orders through the EMR.
	The My Chart system allows patients to contact physicians for follow-up care including appointment scheduling and prescription refill. The patients can email the physician through My Chart.
	The skylight television contains programming to teach the patients about their health condition.
Governance	The Magnet journey has improved patient and staff safety.
	Through the Magnet journey, inter-disciplinary coordination and collaboration improved.
	The magnet journey has resulted in improved continuity of care. Lean six sigma dropped wait times.
	The magnet journey allows bottom up governance.
	Performance improvement committees create process improvement.

	Performance improvement committees are a resource for nurse managers to garner support to improve care processes.
	Bed board meetings daily create a culture of collaboration, information sharing, and support.
	Liaisons between patients, physicians and families make the patient feel like they are totally taken care of.
	EVS staff participates in team meetings and makes suggestions and provides feedback for cleaning methods.

Appendix H: Cross Reference Table for Data Sources

Table 1

Cross Reference for Table for Data Sources

Interview Respondents	**Observed Participants**	**Documents**
Performance Improvement (PI#1)	Physician (Dept. Dir. #1)	Mission Statement
Physician (Physician #2)	Physician (Physician Obs. #2)	Care Commitments
Physician (Physician #3)	Pharmacist (Pharmacist #1)	Video
Nurse Manager (Nurse Mgr. #4)	Pharmacist (Pharmacist #2)	On-Boarding
Physician (Physician #5)	ICU HUC (HUC#1)	QI: Improve Wait Times
Nurse Manager (Nurse Mgr. #6)	Social Worker (SW #1)	About Us
Physician (Physician #7)	Care Coordinator (CC#1)	Clinical Transformation
	Resident (Resident #1)	Most Improved Patient/Family Satisfaction Award
Casual Conversation	**Indirect Observation**	XYZ Wins PS Award
Nurse Director (Director #8)	Physician (Cardiologist #1)	XYZ Wins Two National PS Awards
Nurse Director (Director #9)	Physical Therapist (PT#1)	PS Training Document
Clinic Manager (Clinic #10)	Physical Therapist (PT#2)	Team Approach
Nurse Manager (Nurse Mgr. #11)	Nurse (Nurse #1)	Medicare.Gov
Director of EVS (EVS#1)	Physical Therapist (PT#3)	RO News
Manager of EVS (EVS#2)	Team work (Nurse Mgr. #6/EVS#1)	PACT Service Awards
Manager of Engineering (Eng. #1)	Bed-board meeting (BBM)	XYZ MSC PS
Lab Tech (LT#1)	Nurse Huddle (NH)	Clinical Transformation Website
Patient (Patient #1)	Multidisciplinary Team Meeting (MDTM)	On-line interview with CNO
Patient Family Member (PFM#1)	Patient (PID#1)	
Patient Family Member (PFM#2)	Patient (PID#2)	
Guest and Patient Services (GPS#1)	Patient (PID#3)	
Guest and Patient Services (GPS#2	Patient (PID#5)	
Housekeeping (EVS#1)	Patient (PID#6)	
Valet (Valet #1)	Patient (PID#7)	
Food Services (FS#1)	Patient (PID#8)	
Director of Pharmacy (DOP#1)	Patient (PID#9)	
	Patient (PID#10)	

Appendix I: Table of Best Practices

Inductive Categories	Best Practices
Technology	**Innovation**
	EMR
	Nurse Call Advanced Technology
	Bed Alarms
	Skylight Interactive Television/Control temperature/Lighting/Order Meals
	My Chart
	Interactive Cell Phone Technology
	Wi-Fi in Patient Rooms
	Videoconferencing to Show MRI's, X-rays, CT scans on Television, Patient education
Interactions	**Caregiver Rounding**
	Call the patient by name
	Use Simple Language
	Teach-back Method of Patient Communication
	Interpretation Services/Understanding Cultural Nuances
	Physicians Round with Interns
	Physician and Residents Round Separately and Compare Notes
	Multidisciplinary/Family Rounds
	Pharmacist Rounds with Physicians
	Nurse Manager Quality Rounding
	Health Literacy Assessment
	Train& Re-train on Customer Service
	Communication: White Boards, Daily Progress Reports, Written Medication Sheets
	Pre-op set appropriate expectations with patients in regard to pain etc.
	Encourage Families to Take an Active Role in Care
	Patients Establish Daily Goal to Fit Into Care Plan
	Discharge Services Includes Binders with Contact Numbers
Governance	**Employee Engagement**
	Multidisciplinary Caregiver Meetings
	Daily Multidisciplinary Bed-Board Meetings
	Daily Nursing Huddles at Each Shift
	Magnet Journey/Bottoms –up Change
	Performance Improvement Projects Including all Disciplines/Patient Safety Committee
	Automated Patient Satisfaction Scorecards
	Recognition for Performance
	Input from Front Line Workers
	Continuity of Care
	Care Coordinators free up physicians of load
Environment	**Patient Experience**
	Cluster rounds at night to maximize patient sleep time.
	Hotel-like
	Valet/Guest Services/Patient Liaisons
	Waiting Rooms/Vending/Cafeteria/Chapel
	Quiet/Dim Lights at Night
	Family Oriented, Waiting Rooms with Books, Wi-Fi, Games, Computers, Televisions, Vending
	Foam In – Foam Out
	Valet
	Guest Services
	Cleaning/First Impressions, Ensure Lobbies, Elevators, Stairways Clean
	Private Rooms
Services	**Patient Experience**
	Follow-up Services After Discharge
	Room Service
	Chaplain Services
	Prescription Concierge/Pharmacists Review Prescriptions
	Pain Specialists/Set Expectations for Pain Up Front
	Make Appointments Before the Patients Leave the Hospital