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Strategies to Improve Quality of Care and Increase Medicare Payments in Hospitals

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Walden University
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Abstract

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MBA, Our Lady of the Lake University, 2015

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Doctoral Study Submitted in Partial Fulfillment

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Doctor of Business Administration

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Abstract

The difficulty that nurse leaders experience in administrating quality of care while increasing Medicare payments threatens the hospital's patient well-being and financial stability. Health care administrators should be concerned about these issues to ensure their hospitals meet patient and community needs. Grounded in the performance improvement model, the purpose of this qualitative single case study was to explore strategies that hospital managers use to improve the quality of care and increase Medicare payments. The participants were six nurse leaders of a medium size hospital based in Houston, Texas. Data were collected using semistructured virtual interviews and a review of company documents. Through thematic analysis, five themes were identified: (a) leaders shaped the organizational culture, (b) leaders empowered staff through evidence-based workflows to mitigate potential issues, (c) leaders provide appropriate resources to improve patient care outcomes, (d) leaders' proactive engagement motivate employees to improve patient care, and (e) leaders use of innovative tools to measure and monitor the quality-of-care outcomes. A key recommendation is for nurse leaders to identify the gaps in the process and develop appropriate corrective actions to improve the quality of care and increase Medicare payments in hospitals. The implications for positive social change include the potential to improve the quality of health care, decrease mortality, and increase revenue for surrounding communities.

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Dedication

First and foremost, I dedicate this study to almighty God, Jesus Christ, who gave me strength, perseverance, and wisdom to complete my work. I want to thank my parents Francisco and Cirila, who are now both in heaven, watching over me, proudly applauding for my accomplishment, for giving me unconditional love and support. Most importantly, I dedicate this research to my family. I want to thank my wife Cecilia, the love of my life and the heart and soul of our family, who provided me with unconditional love, encouragement, and support to achieve my ultimate goal. This research will be impossible without you by my side. Finally, I dedicate this research to my precious and loving children, Abigail, Deanna, Sharlene, and Nicolas, who provided me with all the happy moments and encouragement, to be resilient on those challenging moments, to relentlessly pursue my dream. I do hope and pray that my accomplishment will serve as an inspiration to consider on your career paths. I love you all to eternity.

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Section 1: Foundation of the Study

Hospital leaders face the challenge of increasing the quality of care in accordance with value-based purchasing and Medicare reimbursement rates. The Centers for Medicare and Medicaid Services (CMS) standardized the rules in 2008 for every hospital to follow to create a baseline process to provide excellent care to all patients (CMS, 2019). The purpose of this qualitative single case study is to explore the strategies hospital managers use to improve quality of care and increase Medicare payments. I used the process improvement model by Fusch and Gillespie (2012) to analyze the leadership strategies used to improve quality of care and increase Medicare reimbursement.

Background of the Problem

Increasing costs and declining quality of care affect the health care industry. According to Sullivan and Hull (2019), annual health care spending is around $2.7 trillion, and the amount lost to fraud, waste, and abuse is $700 billion, which is 17% of the U.S. gross domestic product. The federal government is trying to devise ways to mitigate the worsening condition that will become a burden to hospitals and affect the profitability and value of the health care business. Health care leaders have a huge responsibility to improve the quality of care at a lower cost.

Several factors affect the costs of health care, including: (a) not executing evidence-based practice, (b) unnecessary testing, and (c) inappropriate billing. Reasons for these factors include an increase in patients' cost of care and lack of communication, collaboration, and support on the part of the leadership and physicians. When the health care industry suffers continuous financial losses due to low Medicare reimbursements,

stakeholders will eventually divest from the health care business and find other business opportunities to exploit. Therefore, hospital administrators must devise strategic plans to motivate employees to incorporate evidence-based practices in the workplace to improve quality of care and increase Medicare payments.

Problem Statement

CMS value-based programs include penalties for hospitals based on the quality-of-care outcomes (CMS, 2019). For fiscal year 2020, low-performing hospitals incurred a net decrease of 1.72% in their value-based programs (CMS, 2019). The general business problem was the loss of revenue to hospitals due to poor quality of care. The specific business problem was some hospital managers lack strategies to improve quality of care and increase Medicare payments.

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies that hospital managers used to improve quality of care and increase Medicare payments. The targeted population comprised of hospital managers from one hospital in the state of Texas, who developed and implemented successful strategies that improved quality of care and increased Medicare payments. The implications for positive social change include high-quality services that might lead to faster recovery and the potential to decrease mortality and improve people's lives during hospital visits.

Nature of the Study

The three research methods are qualitative, quantitative, and mixed methods (Yin, 2018). In a qualitative study, a researcher explores data using open-ended interviews

(Morgan, 2018). To gather rich data, I chose the qualitative methodology to explore the phenomenon of hospital managers' strategies for improving quality of care through: (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal. Quantitative and mixed methods are not appropriate choices, as I did not test a hypothesis about variables' characteristics or relationships using closed-ended questions. According to Morgan (2018), in the quantitative method, researchers use closed-ended questions and examine the variables' characteristics or relationships using statistical analysis. In the mixed-methods approach, researchers use a combination of qualitative and quantitative methods (Guetterman & Fetters, 2018). As I explored the phenomenon of business leaders' strategies using: (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal to develop in-depth data from the participants, the qualitative method was pertinent for this study.

Based on the goal of my qualitative study, which is to improve a hospital's quality of care and increase Medicare reimbursements, I considered three designs: (a) narrative, (b) ethnography, and (c) case study. According to Surangi (2022), narrative researchers explore participants' lives through their personal stories. Narrative was not my optimal choice, as I did not study the personal lives of participants. According to Conn et al. (2019), ethnography is about the actions, behaviors, and language shaped by organizational cultures. Ethnography was also not my optimal choice, as I did not explore an organization's culture. According to Yin (2018), in a case study design, the researcher is involved in bounding the case to determine the scope of the data collection, which links

the case, research questions, and the propositions of the study, thereby honing the focus of the study. Yin also noted that, in a case study, after a researcher defines the case in a small group, the researcher can easily distinguish which aspect will be part of the research. I chose a single case study to be my preferred qualitative design, as I seek to explore the phenomenon under study at only one hospital to gain in-depth information on the actual experiences of the participants on whether their assertions were correct.

Research Question

What strategies do hospital managers use to improve quality of care and increase Medicare payments?

Interview Questions

1. What are your organization's strategies to improve the quality of care?
2. How do these strategies relate to the mission and vision of your organization?
3. How do you measure the effectiveness of your quality-of-care improvement strategies?
4. What has worked best in your quality-of-care improvement strategy?
5. What have you found to be least effective in your quality-of-care improvement strategy?
6. How did you communicate any issues to your employees concerning your quality-of-care improvement strategy?
7. Please explain your employees' capability to review and apply tasks to improve the quality of patient care implementing your strategies.

8. What were the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments?
9. How did you address the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments?
10. What additional information would you like to share about the strategies your organization used to improve quality of care?

Conceptual Framework

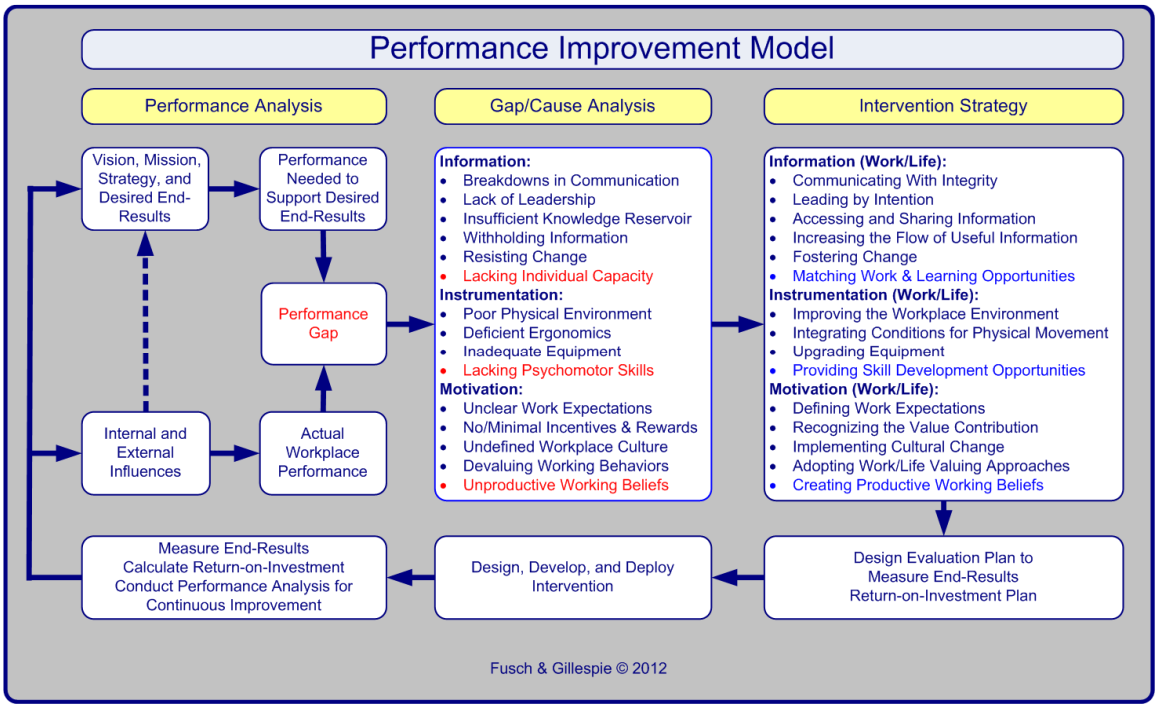
The conceptual framework for the research is the performance improvement model by Fusch and Gillespie (2012). Fusch and Gillespie developed their human competence model by expanding on Gilbert's (1978, 2007) behavioral engineering model. Fusch and Gillespie suggested that to improve performance behavior, employees must demonstrate the three elements of the performance improvement model, which are performance analysis, gap–cause analysis, and intervention strategy. According to Fusch and Gillespie, performance analysis involves analyzing the mission and vision of an organization, linking organizational performance to support the strategic plan, determining the method to measure the achieved performance, analyzing the internal and external environment, linking the organizational performance with the environment, and determining the causes of gaps between the desired performance and actual performance. Fusch and Gillespie further explained that aspects of information, instrumentation, and motivation determine performance gaps, causes, and remedies is essential to meet the desired results. There are two sides to the performance improvement model: the hard side, which deals with the management aspect, and the soft side, which deals with

employees' behavior (Fusch & Gillespie, 2012). The instrumentation element on the hard side describes how management deals with the use of data and communicates with employees to improve performance. In contrast, the soft side is dependent on employees' capability to review and apply tasks more effectively (Fusch & Gillespie, 2012).

The instrumentation element on the hard side addresses the efficacy of the working environment to improve employees' performance; however, to complete the tasks, employees must have the psychomotor abilities necessary, which is part of the soft side of employees' behavior (Fusch & Gillespie, 2012). For the motivation element of the hard side of management, employees typically need clear work expectations, better compensation, a defined work culture, and work behaviors valued by hospital managers to improve performance. However, to address the soft side, employees must have total control of their performance to accomplish the tasks (Fusch & Gillespie, 2012). According to Fusch and Gillespie (2012), the remedial intervention strategy requires a derivative change initiative based on the gap–cause analysis. Figure 1 is a graphical depiction of the performance improvement model as it applies to improving quality of care in a hospital. Therefore, using the performance improvement model by Fusch and Gillespie is likely to facilitate my research on exploring hospital managers' strategies on improving quality of care and increasing Medicare payments.

Figure 1

Performance Improvement Model



Note. Fusch and Gillespie (2012) developed their comprehensive performance improvement model as a tool to measure employee performance, identify employee performance gaps, develop interventions, and evaluate and measure results. From *A Practical Approach to Performance Interventions and Analysis: 50 Models for Building a High-Performance Culture* (p. 5), by G. E. Fusch and R. C. Gillespie, 2012, Pearson Education. Copyright 2012 by Pearson Education.

Operational Definitions

The following terms appear within the context of this study:

Low-performing hospitals: Low-performing hospitals are hospitals that did not meet CMS requirements on achieving the quality threshold based on the value-based purchasing program, which results in penalties from the CMS (CMS, 2019).

Value-based program: A value-based program is a tool administered by CMS as a gauge for reimbursing hospitals based on quality of performance (Chee et al., 2016).

Assumptions, Limitations, and Delimitations

Assumptions, limitations, and delimitations contribute to the validity of research. The assumptions, limitations, and delimitations of a research depict the aspects that are out of a researcher's control and the aspects that are within a researcher's control. Failing to distinguish between these aspects could result in poor outcomes. The intent of this research is to reveal strategies to improve quality of care and increase Medicare payments within a hospital, and failing to address the limitations, boundaries, and outside scope of my research could result in an invalid outcome to my study.

Assumptions

Assumptions are the fundamental but unverified aspects of a research problem, without which the research would be irrelevant (Leedy & Ormrod, 2010). Wolgemuth et al. (2017) explained that researchers use assumptions as a guide for which research is valid and what evidence counts. An assumption in this study is that participants will proactively participate in the open-ended interviews and that the data from the interviews could result in credible outcomes. Another assumption is the participants will provide accurate responses with minimal bias based on the one-on-one interview. Moreover, the data may help reveal the strategies that hospital leaders used to improve the quality of care.

Limitations

Price and Murnan (2004) explained that a limitation of a study is the systematic bias that researchers could not control, thereby affecting the outcome. Participants' bias

that leads to evading and refusing to answer some open-ended questions could be another limitation. Also, I cannot generalize the study findings to all health care organizations.

Delimitations

A delimitation is the scope or boundary of a study introduced by researchers (Price & Murnan, 2004). A delimitation of the study is the single-point location in Houston, Texas. The data that I gathered excluded data from long-term care facilities, rehabilitation hospitals, and nursing homes. The population was delimited to unit managers from the target hospital, who understood the clinical operations within the facility, which is vital to the decision-making process of a hospital.

Significance of the Study

High quality of care is essential to ameliorating a hospital's financial performance based on a value-based program. Connor et al. (2016) found that hospital nurses used evidence-based practice to improve patient care outcomes. Therefore, the results of this research might promote healing and faster recovery, reduce patients' morbidity and mortality, and improve families' lives during hospital visits.

Contribution to Business Practice

Quality of care is one of the major problems in the hospital under study that affect the profitability and value of the business. Hospital managers who read the findings from the study might be able to use the strategies described by hospital managers to improve the quality of care and the financial outcomes of their health care organizations. The collaboration between clinical staff and physicians, and the implementation of evidence-based practice, might improve quality outcomes. After quality of care improves, patient

satisfaction might improve. According to Connor et al. (2016), hospital nurses who use evidence-based practice might improve the quality outcomes of patient care. After the hospital managers improve the processes toward increasing quality of care, hospital profits might improve due to an increase in reimbursements from Medicare and other private insurance providers. Therefore, when quality outcomes improve, the profitability and value of the hospital might increase.

Implications for Social Change

Readers of my study findings might become aware of hospital strategies that were successful in improving the quality of care and increasing Medicare payments. With proactive approaches by leaders to improve the quality of care, hospital leaders, physicians, and employees might contribute to positive social change by improving mortality and promoting healthy lives within communities. Concomitantly, patients and their families could benefit by knowing that they are seeking health care in a safe and caring environment. Local communities may benefit from social change through an increase in employment in health care facilities.

A Review of the Professional and Academic Literature

The purpose of this study was to explore strategies that hospital managers have used to improve quality of care and increase Medicare payments. The conceptual framework guiding my research is the performance improvement model (Fusch & Gillespie, 2012). This section provides a comprehensive and critical analysis of the literature review concerning the performance improvement process. Fusch and Gillespie (2012) indicated that integrating performance measurement with real-time strategic and

operational management is essential for an organization to grow, prosper, and accumulate wealth. The performance improvement model includes the need for motivation to improve organizational performance.

The literature review includes the analysis of peer-reviewed articles, dissertations, and books related to this study. I used resources available through Walden University in my review, including Sage journals, EBSCO, ABI/INFORM, Science Direct, PubMed, *Journal of American Medical Association*, *American Nursing Journal*, and ProQuest. I also used Google and Google Scholar for online queries. The systematic approach to the literature review began with using keywords related to the research question, including *performance improvement model, quality of care, value-based purchasing, patient satisfaction, Magnet designation, physician leadership, mortality, hospital-acquired infections, staffing, change leadership, barriers to change, employee motivation, balanced scorecard, multidisciplinary team, length of stay,* and *electronic health record*. A total of 249 references appear within the literature review, with 160 (64.25%) published between 2018 and 2022.

This section includes studies related to hospital leaders' strategies to improve the quality of care and increase Medicare payments. The majority of my literature review (64.25%) includes peer-reviewed journal articles published between 2018 and 2022. Other sources include the originator of the performance improvement model and other seminal sources related to the development of the conceptual model.

The literature review contains four main sections. The objective in the first section is to gain an understanding of the hospital's quality of care and Medicare

payments, as well as causes, plans, types, and barriers. Also included in the review are a critical analysis of the performance improvement model followed by supporting and contrasting theories. The second section includes a brief background into various causalities of decreasing quality of care and Medicare payments. The third section includes analysis of research on ways to improve quality of care and increase Medicare payments. The fourth section is on change management.

Context of the Study

The goal of this qualitative study was to reveal strategies hospital leaders used to improve a hospital's quality of care and increase Medicare payments. As part of the Patient Protection and Affordable Care Act (ACA), the federal government entrusted the CMS to develop value-based purchasing to improve the quality of care and increase Medicare payments to deserving hospitals whose staff proactively and consistently practice quality standards of care in their pipelines (Kocakulah et al., 2021). Therefore, healthcare leaders must include key factors such as business demographics and workflow, culture, and resources in hospital strategies (Nnate et al., 2021). A well-planned workflow could improve the quality of care.

Workflow is essential to achieve a common goal. Improving quality of care requires a planned workflow that involves a multidisciplinary approach (Kashikar & Arya, 2020). The focus of this study was to reveal strategies used to adhere to the value-based purchasing domains bestowed by the CMS that improve Medicare payments. Representatives of CMS defined value-based purchasing as a strategy to increase the quality of care at the lowest possible cost (Tanenbaum, 2016). Increasing costs and

declining quality of care hamper the health care industry. Prior to the coronavirus disease 2019 (COVID-19) pandemic, 96,326 patients were admitted to hospitals daily in the United States (American Hospital Association, 2018). These numbers rose exponentially during 2020 (American Hospital Association, 2021); therefore, the federal government must develop a plan to mitigate the rising cost of health care. According to Sullivan and Hull (2019), annual health care spending is an estimated $2.7 trillion, with $700 billion lost to fraud, waste, and abuse, which is 17% of the U.S. gross domestic product, and forecasted to increase to 17.7% in 2028 (Keehan et al., 2020). The health care setting that is evolving from pay-for-service to pay-per-performance equates to an increasing need for hospital leaders to adjust their practice to improve the Medicare reimbursement outcomes (Kocakulah et al., 2021). Mitigating fraud, waste, and abuse, and holding hospital accountable for improving the quality of care at a lower cost could help decrease the rising cost of healthcare. Failure to mitigate controlling the cost of care could result in decreased quality of care.

Hospital's administration struggle to increase the quality of care at a lower cost. Hospitals' quality of care decreases when organizations struggle to execute effectively and when there is non-conformance to the lowest possible cost of care (Lee et al., 2020). Poor quality of care and decreasing Medicare payments are partly due to the considerable number of variables involved such as patient acuity and mortality (Lee et al., 2020). Hospital leaders must enact strategies to tackle the changing health care landscape outcomes (Ferris et al., 2018). Leadership's failure to enact could lead to poor quality of care. Healthcare organization must focus on tackling poor quality of care.

Poor quality of care is a major concern to the healthcare organization. Factors contributing to poor quality of care include, but are not limited to, the failure of leaders to establish an environment that fosters knowledge and capabilities between entities (Zhang et al., 2015). Likewise, poor quality of care sets a financial risk for stakeholders (Eaton & Kilby, 2015). The risk of a poor quality of care equates to reduced company value (Garzella & Fiorentino, 2014). The poor quality of care and decrease in Medicare payments dictate the financial outcomes. Maintaining a hospital's high standards of care requires the completion of all the components of the value-based purchasing domains, which can lead to excellent financial outcomes (Lee et al., 2020). Therefore, value-based could aid in improving the hospitals' quality of care.

The value-based purchasing domains are guides to achieve valued care. Value-based purchasing domains affect all hospital operations and consequently the achievement of hospital goals (Lee et al., 2020). According to Boyd (2017), hospitals face value-based purchasing challenges relating to compliance and payment reforms, reduced payments, and quality improvement. Managing value-based purchasing also influences other facets of a hospital, such as the systems, structures, and culture among employees (Lee et al., 2020). Health care leaders lead the initiatives of hospital workflows and structures (Nnate et al., 2021). Therefore, hospital must have standardized workflows that will aid in improving the quality of care outcomes.

Continuous implementation of workflows is essential to improve quality of care outcomes. Hospital leaders continuously work on workflows that contribute to the improvement of quality of care (Naus et al., 2018). However, inconsistencies exist across

health care systems regarding the details of the quality-of-care process and measurements (Lee et al., 2020). Some leaders of hospital organizations still practice pay-for-service while others have enhanced their capabilities with the adoption of current technologies to measure performance, each with varying degrees of success (Lee et al., 2020). Hospital leaders support quality improvement management (Ferris et al., 2018). However, leaders cannot assess hospital performance to maintain patient care (Ferris et al., 2018). Barriers to consistency exist throughout health care organizations in assessing the quality-of-care performance (Van Wert et al., 2020). Therefore, leaders must consistently track organizational performance using the latest technology to improve organizational decision on improving performance outcomes.

Performance Improvement Model

The performance improvement model is a continuous strategic process used to improve performance outcomes. Fusch and Gillespie (2012) developed their human competence model by expanding Gilbert's (1978, 2007) behavioral engineering model. Fusch and Gillespie posited six steps in the performance improvement process: (a) conduct a performance analysis, (b) conduct a gap/cause analysis, (c) conduct an intervention strategy, (d) design an evaluation plan, (e) design and implement intervention, and (f) evaluate and measure results. The steps are essential to implement better implement the performance improvement model. Performance behavior must be enhanced to improve performance.

Performance behavior is essential on implementing the performance improvement model. Fusch and Gillespie (2012) noted that, to improve performance behavior,

employees must demonstrate the three elements of the performance improvement model, which are performance analysis, gap/cause analysis, and intervention strategy. Fusch and Gillespie noted that performance analysis involves analyzing the mission and vision of an organization, linking organizational performance to support the strategic plan, determining the method to measure the achieved performance, analyzing the internal and external environment, linking organizational performance with the environment, and determining the causes of the gaps between desired performance and actual performance. Likewise, Champathes (2006) developed the COACH model to improve employee performance. *COACH* stands for clarifying needs, objective settings, action plan designing, and checking activities. Clarifying needs involves identifying whether employees are coachable; objective setting involves setting an agreement between the coach and the employee to achieve the goal, which involves a realistic timeline; action-plan designing involves a process to reach the desired outcomes based on specific goals; and checking activities involves validating the outcomes in comparison with the goal (Champathes, 2006). Identifying a coachable employee could improve the organizational performance outcomes. One of the main goals of improving performance is correcting the employee mistakes.

Correcting mistakes is essential to produce a positive outcome. Champathes (2006) explained that coaching is important for correcting mistakes that employees make to generate positive outcomes. Zhang et al. (2006) conducted similar research in accordance with the expectancy theory by Vroom (1964), in which the motivational process should link with a work motivation model to improve employees' job

performance for better outcomes. Zhang et al. revealed that the boundaries of their expectancy theory are: (a) long-term orientation, (b) relational harmony and people orientation, (c) high power distance, (d) a holistic and collective cognitive mindset, and (d) paternalistic leadership. Correcting employees' mistakes could lead to positive motivational outcomes. Therefore, improving employees' performances could lead to positive outcomes. Positive outcomes could lead to achieving the organizational mission.

The adhering to the organizational mission and vision is essential to achieve positive outcomes. Kogan et al. (2017) pointed out that the leaders of successful organizations define their organizations' mission, vision, and policies to ensure a successful organizational outcome. According to Thompson (2017), transformational change depends on successful process change. Health care leaders determines the outcome by verifying the methods used after achieving a goal. Health care leaders can use the mission, vision, and policies of their organizations to provide direction and priorities. The commitment to quality of leadership is one of the most important components of organizational change (Fokkema, 2016). Likewise, the hierarchy of an organization can impact change (O'Connor & Jackson, 2017). Therefore, organizational leadership is essential to implement the policies and procedures that are essential to drive towards positive outcomes. There are business factors to consider that affects business performance.

Analyzing internal and external factors is essential to business performance, as the analysis can affect the financial well-being of a business. Internal issues can include equipment and technology, breakdowns in communication, resistance to change, and

labor management issues. External issues can include economic conditions, competition, and customer–vendor relations (Fokkema, 2016). Change managers can acquire the right employees to influence the change process (Hwang et al., 2015). Fokkema (2016) explained that leaders of health care organizations should attain the level of desired quality through the appropriate change process. Therefore, change management is essential to achieve the desired outcomes. The gap/cause analysis plays a huge role on tracking change.

The gap/cause analysis is an essential measure to determine if the task is attained. The gap/cause analysis refers to the process of determining the breakdown or fallouts in the process of handling a specific task (Fusch & Gillespie, 2012). Through gap/cause analysis, leaders look for the causes of failure in the process and the interventions likely to fix these issues. Gilbert (2007) noted that the gap/cause analysis has three aspects: (a) information, (b) instrumentation, and (c) motivation. The information aspect includes a breakdown in communication, lack of leadership, insufficient knowledge reservoir, withholding information, and resisting change. The instrumentation aspect involves a poor physical environment, deficient ergonomics, inadequate equipment, and a lack of psychomotor skills. The motivation aspect includes unclear work expectations, no or minimal incentives and rewards, undefined workplace culture, devaluing working behaviors, and unproductive working beliefs (Gilbert, 2007). When implemented properly, the gap/cause analysis could motivate employees. Proper intervention strategy is essential to motivate employees.

The intervention strategy involves ways to fix the gaps in the process of handling a specific task. Fusch and Gillespie (2012) explained that the best implementation of strategy is the one with the most effective outcome at the most efficient cost is based on work–life approach, which is a core value that promotes healthy working environment in accordance with the organization's vision. The information (work–life) aspect involves communicating with integrity, leading by intention, accessing and sharing information, increasing the flow of useful information, fostering change, matching work environment, and learning opportunities. The instrumentation (work–life) aspect involves improving the workplace environment, integrating conditions for physical movement, upgrading equipment, and providing skill development opportunities. The motivation (work–life) aspect involves defining work expectations, recognizing the value contribution, implementing cultural change, adopting work–life valuing approaches, creating productive working beliefs, prioritizing, and managing time (Fusch & Gillespie, 2012). Thompson (2017) noted that incentives are an internal tool used in health care organizations to create changes and improve service outcomes. Therefore, proper work-life balance could improve organizational outcomes. Proper planning is necessary to improve the economic performance of the organization.

Return on investment is necessary to improve economic performance. The design evaluation plan to measure the return-on-investment (ROI) measure the actual organizational results involves in the plan and ROI (Fusch & Gillespie, 2012). This is the critical stage of the performance steps, as this plan measures the financial outcomes of the intervention. El-Halwagi (2017) noted that project sustainability relies on economic

stability and hitting the benchmark based on specific targets, and hence decision makers can use it to make informed decisions on a project. To achieve positive financial performance, the organization must be achieving the set goals. However, if the set goal is not achieved, action plans must be initiated to prevent failure.

Proper planning is essential in order to achieve the desired goal. In the design, develop, and initiate the plan aspects, leaders decide on the best action plan to mitigate or reduce the gap in the process to attain the desired results. Brown et al. (2016) explained that one of the main goals of the implementation of the change process is the assurance of the improvement of a health care organization's service quality delivery. Likewise, the design intervention aspect is the phase wherein leaders deploy and measure the necessary performance interventions, such as purchasing products or services to improve outcomes. Kuipers et al. (2014) posited that the focus of executing the revision of process in health care organizations is aligning the process directly to attain organizational objectives by allocating resources and implementing multiple activities and processes across all levels of an organization. Proper change planning could lead to improving organizational outcomes.

Proper planning is essential implement change. For the measure-results component, the model user calculates ROI performance analysis by making the plans operational based on gap and analysis, evaluation plan and design, and ROI validation (Fusch & Gillespie, 2012). ROI is the measure of performance and an efficiency evaluation of an investment (Hassanzadeh & Bigdeli, 2019). A hospital is a service-oriented business; hence, the provision of health care depends on the continuous loyalty

and commitment of customers to improve financial outcomes (Afridi et al., 2020). The social ROI involves using aggregate social and environmental factors to measure the noncalculated part of the traditional ROI (Hassanzadeh & Bigdeli, 2019). Using conventional ROI can only reflect the financial status of the overall business and not social factors that contribute to successful business practice (Hassanzadeh & Bigdeli, 2019). Manca (2015) explained that monitoring and evaluating the change process ensures the execution of processes proceeds as planned. Monitoring and assessment are useful tools for determining whether the change process works successfully in comparison to other methods (Manca, 2015). Therefore, proper assessment, monitoring, and execution of plans are necessary to implement a successful change.

Related Conceptual Frameworks

The path-goal theory, theory of diffusion of innovation, expectancy theory, and transformational leadership theory were also considered. These theories can guide health care teams to improve the quality of care and increase Medicare payments. Components of each of these theories are included in the performance improvement model theory but the alternate theories considered individually are insufficient to guide this study.

The path-goal theory is essential to implement change process. The basis of the principle of path-goal theory is four leadership styles that are the guides on the positive outcomes of the study: (a) directive, (b) supportive, (c) participative, and (d) achievement oriented (Famakin & Abisuga, 2016). The path-goal theory is designed for leaders to help employees engage with their selective behavior process to promote satisfaction and success in the workplace (Laureani & Antony, 2019). Therefore, holding employees

accountable for their actions could lead hospital organizations to success through positive impacts on quality of care and on financial performance.

The theory of diffusion of innovation is a tool that hospital leaders use as the framework of evidence-based practice (Alqahtani et al., 2020). According to Alqahtani et al. (2020), the theory of diffusion of innovation incorporates the relationship and knowledge of a person on innovation, and the choice of whether to use it. Alqahtani confirmed the theory of diffusion of innovation influences the knowledge and attitude, which are the driving forces of evidence-based practice, which measures the quality of care. Therefore, applying the path-goal theory and theory of diffusion of innovation could improve quality and cost of care through accountability and innovation. According to Vroom (1964), advocates of the expectancy theory believe their performance will satisfy their needs. The expectancy theory relates to rewards based on employees' performance toward achieving goals (Vroom, 1964). Therefore, rewards and incentives will drive employees to perform at their peak level to achieve the goals. Conversely, employees' performance depends on their level of motivation, which might compromise organizational outcomes. With respect to employee motivation, the transformational leadership theory promotes cultural change to improve the quality of care and increase Medicare payments (Sanford, 2016). The transformational leadership style is essential to improve the hospital's quality of care.

The transformational leaders drive employee motivation. The transformational leadership theory motivates employees through the proactive engagement of their leaders to improve performance (Sanford, 2016). Likewise, Pearson (2020) explained that

transformational leadership tends to increase the quality standards by giving employees the autonomy to solve problems in innovative ways to achieve those goals through proper communication and coaching. Labrague et al. (2020) noted that transformational leadership promotes employees' contentment, thereby reducing employee turnover. Wu et al. (2020) further explained that transformational leadership helps to prevent stress on nurses and to maintain a positive working environment. Spaulding et al. (2020) posited that transformational leadership, lower staffing ratios, open communication, completion of goals, and team collaboration can be attributed to high hospital value-based purchasing. In theory, transformational leadership is positively correlated with a variety of organizational outcomes (Labrague et al., 2020). Therefore, transformational leadership theory helps increase performance outcomes.

Improving the Quality of Care

History of Hospitals' Quality-of-Care Initiatives

The explicit and systemic use of death rates as a quality indicator by Florence Nightingale in the mid-1800s marked the emergence of quality assurance in health care (Marjoua & Bozic, 2012). In 1915, Ernest Codman suggested applying an outcome-oriented medical audit, which led to the establishment of the Hospital Standardization Program of the American College of Surgeons in 1918 (Chassin & O'Kane, 2010). Avedis Donabedian conceived the structure–process–outcome theory (Kobayashi et al., 2011). According to Donabedian, quality is a product of two factors: the science and technology of providing care and the application of the first factor in practice (as cited in Berwick & Fox, 2016). Donabedian (1966) proposed that the components of quality in

health care are efficacy, effectiveness, optimality, legitimacy, equity, and acceptability. In the 1950s and 1960s, the Joint Commission Organization (JCO) adopted Donabedian's theory and created the quality assessment and improvement framework based on the physical and staffing characteristics of caring for patients, the method of delivery, and the results of care (Patterson, 1995). Over the years, JCO's mission grew to include most health care settings.

State licensing programs prevailed in the 1800s (Sheingold & Hahn, 2014). In 1906, the Food and Drug Administration undertook the national regulation of medication. In 1935, the Social Security Act set the standards for maternal care and childbirth. In 1965, Medicare was institutionalized and mandated principles central to hospital operations, staff credentialing, around-the-clock nursing care, and utilization review (Marjoua & Bozic, 2012). In the 1980s, the health care quality improvement initiative allowed professional standards review organizations to apply patient care algorithms to claims history and data sets to screen cases and to describe how well care conformed to established guidelines (Patterson, 1995).

On March 23, 2010, President Barack Obama signed the Affordable Care Act into law (CMS, 2021). One week later, he signed the Health Care and Education Reconciliation Act of 2010, which made numerous changes to the ACA. The ACA is likely to lead to new patient care models, a new continuum of care, new Agency for Healthcare Research and Quality (AHRQ) programs, metrics-based reporting, and a data-driven national quality strategy.

History of Value-Based Purchasing

The creation of value-based purchasing took place in 2013 to reward hospital staff for rendering excellent quality care. CMS created value-based purchasing through the ACA (CMS, 2021). The value-based purchasing concept started from value-based health care, which originated with Michael Porter, a professor at Harvard University, and Elizabeth Teisberg, who together wrote the book *Redefining Healthcare Creating Value Based Competition* on ways to increase patient value driven by performance and costs (Porter & Teisberg, 2006). The benefits of value-based health care are (a) patients spend less for better outcomes, (b) increased patient satisfaction, (c) improved care coordination, (d) reduced health care costs and improved care, and (e) stronger cost control and reduced risk to payers.

Value-based purchasing veered away from traditional fee-for-service care rendered in hospitals and by physicians (Jha, 2017). Unlike fee-for-service care, in which hospitals receive compensation based on the quantity of procedures performed, value-based purchasing compensates hospitals based on performance outcomes (Chee et al., 2016). This initiative puts pressure on hospital leaders (Sinaiko et al., 2019). Value-based purchasing involves minimizing medical errors, adopting evidence-based process to improve outcomes, improving patient experience, increasing consumer transparency, and recognizing hospitals that render high quality care at a lower cost (CMS, 2021). According to CMS (2021), value-based purchasing has four domains: (a) clinical outcomes, (b) person and community engagement, (c) safety, and (d) efficiency and cost reduction. CMS (2021) weights each domain at 25% on reimbursing the hospitals.

Medicare reimburses hospitals through an inpatient prospective payment system based on a specific category under a diagnosis-related group (CMS, 2021). Reimbursement is a mechanism for hospital leaders to drive high-quality care while increasing patient access and lowering the cost of care (CMS, 2021). Value-based purchasing financially rewards hospitals, physicians, and other health care providers who meet performance targets (Chee et al., 2016). However, the disadvantage of value-based purchasing is (a) employees can feel demotivated if the goals set are too hard to achieve, (b) too much of the process relies on the quality of judgment made by a manager, and (c) it reduces pay equity and can make a company liable to costly equal-pay challenges if not operated fairly (Jha, 2017). The premise of the value-based purchasing concept is that health care payers such as the government and consumers hold care providers such as hospital leaders and doctors accountable for improving the quality of care at a lower cost (Cattel & Eijkenaar, 2020). Therefore, value-based purchasing is a tool that serves to encourage patient participation in care and promotes preventive care (CMS, 2021).

Value-Based Purchasing

Value-based purchasing is essential to mitigate healthcare inefficiencies. CMS created value-based purchasing to improve the quality of care at the most efficient cost (Lee et al., 2019). According to Cattel and Eijkenaar (2020), value-based purchasing requires the pursuit of a triple aim, namely (a) limiting per-capita cost of care, (b) improving patient experience, and (c) improving population health to achieve the best health outcomes. The focus of the value-based payment program is on bundled payments for specific diagnoses and treatments of the disease process and pay-for-performance

models that reward hospitals based on achieving explicitly measured values (Cattel & Eijkenaar, 2020). Therefore, aside from high quality of care, cost-conscious behavior, team approach, and well-orchestrated care and prevention are necessary to achieve optimal returns from value-based purchasing programs (Peikes et al., 2018; Quentin et al., 2018; Scott et al., 2018). Therefore, value-based purchasing could drive hospitals to improve healthcare costs. CMS is providing incentives to high performing hospitals.

CMS is providing incentives to high-performing hospitals through pay-for-performance measures once attained. Glickman et al. (2007) addressed the attention that the pay-for-performance programs in health care are receiving due to the incentives that CMS is giving to participating hospitals. Glickman et al. explained that the total incentives that CMS provided are $17.55 million for the first 2 years based on five clinical conditions. Glickman et al. elaborated that, to achieve a bonus, participating hospitals must be in the top decile based on five clinical conditions. Similarly, Tran (2020) noted that the number of value-based purchasing programs that provide incentives or penalties to health care organizations is continuously rising, although questions remain regarding the accounting of social risk on performance measurement. The pay-for-performance is working only to the top docile hospitals; hence, hospitals must excel better to improve their performance to be part of the top docile group.

Disparities in care create a financial issue to the hospitals that participated in the pay-for-performance program. Tran (2020) explained that dual eligibility is one of the measures of the social risk, which masks disparities in care. Tran also explained that Congress passed the 21st Century Act that directs the CMS to evaluate hospital

performance against peer hospitals that carry Medicare and Medicaid to address the social risk issue. Tran contended that there are unintended consequences on some CMS programs toward disadvantaged communities; however, social determinants could have a long-lasting benefit in such communities. Furthermore, Mendelson et al. (2017) indicated that pay-for-performance programs pay incentives or penalize health care providers based on their measures of quality performance. Mendelson et al. explained that, even with the popularity of pay-per-performance, it is not showing promising results, as evidence from such programs in the United States showed little effect on patient outcomes. Therefore, some of the pay-for-performance programs do not fit other hospitals, hence, created a discrepancy which penalized the affected hospitals. Evidence-based programs must initiate by the hospitals to improve the quality of care.

Evidence-based practice is essential to drive structured patient care. Ferreira and Marques (2019) noted that hospitals are a complex structure with staff capable of delivering timely, equitable, and patient-centered care guided by evidence-based processes. Carthon et al. (2021) explained that the higher the quality of care rendered, the better the effectiveness and patient outcomes, including patient satisfaction. Ferreira and Marques contended that performance is not always about quality but rather a function of the consumption of resources and the efficiency of services. Ferreira and Marques conducted a quantitative study and used nonparametric techniques to assess health care services in relation to operational efficiency. Ferreira and Marques pointed out that the results of their study revealed an association between good clinical safety practices and a

low technical efficiency level. Therefore, timely patient-centered care could drive better quality of care outcome. Value-based purchasing could enhance the quality of care.

Efficiency is essential in promoting the value-based purchasing program. Ferreira and Marques (2019) explained that promoting efficiency can decrease patient safety in the hospital setting. However, Johnston et al. (2020) explained that Medicare evaluates the physician program based on cost and outcomes through its value-based purchasing program. Johnston et al. explained that Medicare has little known facts on geriatricians' measure of performance on the older adult population. Johnston et al. further elaborated that geriatricians' patient population are older adults with multiple comorbidities, including functional impairments, frailty, depression, and dementia, which is associated with prescribing fewer medications as per previous research. Therefore, Medicare must focus more on geriatrics to determine the actual impact it has on cost outcomes. Data enhancement is necessary to track geriatric care.

Focusing on geriatric care is essential to improve VBP outcomes. Johnston et al. (2020) explained that not all physicians have publicly available data; hence, the study did not include some geriatric specialties. Moreover, Johnston et al. elaborated that the range of their study did not cover some of the value-based purchasing program; therefore, future study is necessary, as value-based purchasing is continuously expanding. Milstein and Schreyoegg (2016) argued that pay-for-performance programs enhance financial incentives in hospitals to improve the quality of care. However, Milstein and Schreyoegg explained that, even if the number of members increased, they still cannot explain the success of pay-for-performance. Therefore, enhancing the geriatric data could provide

CMS the actual status of the program in the geriatric field. The VBP is not effective in all program aspects.

The VBP has flaws. Jha (2017) explained that value-based purchasing is ineffective for rewarding or penalizing hospitals that are contingent on a pay-for-performance system based on a complex set of measures on process measures, mortality on targeted conditions, patient experience, and efficiency. Such hospitals normally receive a reward or penalty of 2% based on the required aspects of the pay-for-performance system (CMS, 2019). Jha pointed out that, prior to rolling out the value-based purchasing program, the mortality rate was down to 0.13% per quarter and patient experience rate was up by 1.5% per year in U.S. hospitals. When a value-based purchasing program was in effect, the mortality rate decreased by 0.03% and patient experience increased by only 0.60%, revealing no effect when compared with non-value-based purchasing hospitals and thus no impact on patient outcomes. Jha recommended either retooling or stopping value-based purchasing. Therefore, the VBP data revealed there are little to no effect when it comes to mortality and patient experience. VBP enhancement is necessary to drive patient outcomes.

Retooling the VBP enhance hospital incentives. Jha (2017) explained that, in order to retool value-based purchasing, Medicare must start paying higher incentives for mortality. Jha recommended offering incentive rates of 5–10% to encourage hospital leaders to improve the quality of care. However, Spaulding et al. (2020) explained that non-Magnet-designated hospitals would not be able to withstand the penalties brought about by value-based purchasing due to the decline in employees' performance, process

of care, and patient experience. Moreover, Nambiar et al. (2017) elaborated that investing in hospitals without continuous workflow improvement is useless. Therefore, retooling the VBP is useless unless the hospital workflows are enhanced to improve the quality of care.

Increasing Quality and Medicare Payments

Health Care Business Operations

The typical process in hospital operations is that hospital leaders seek financial assistance to continue to support the health care business. However, borrowing rates are costly due to the high loan rate that they accrue, which hampers growth (Weaver et al., 2016). Weaver et al. (2016) noted that Medicare is the largest hospital payor. According to American Hospital Association (2021), in 2019, 63% of hospitals received Medicare payments. However, hospitals lose money under the Medicare payment system (Rosko et al., 2020), and hospital leaders must implement changes to improve reimbursement (Weaver et al., 2016). Therefore, hospital leaders must implement changes in the hospital to improve Medicare reimbursements. Increase in Medicare reimbursement could lead to profitable outcomes.

Efficiency could lead to increase financial outcomes. Rosko et al. (2020) noted that leaders can achieve profitable outcomes in an organization through the efficient use of their resources. White and Wu (2014) posited that Medicare payments affect financial outcomes. Medicare payment reductions are identifiable through the type of hospital: for-profit and not-for-profit. Jeurissen et al. (2020) elucidated that leaders in for-profit hospitals will reduce operating costs to improve profit and satisfy shareholders; in

contrast, leaders in not-for-profit hospitals reinvest the profit for hospital growth. Rosko et al. (2020) explained that, based on their study, leaders in not-for-profit hospitals tend to increase efficiency to increase profit. Therefore, not-for-profit hospitals tends to grow better as all the profits go back to the organization to purchase new equipment and expand the facility to gain more business. For-profit hospital's expansion is dependent on the investors' support.

Increasing the profit in for-profit hospitals is a challenge. According to the Medicare Payment Advisory Commission (2017), for-profit hospitals will suffer a decrease in profit, unlike their counterparts. For-profit hospitals do not outperform other health care institutions, as for-profit hospitals charge higher fees due to higher overhead and more capital expenditures (Jeurissen et al., 2020). Hospital leaders must make changes to avoid decreasing the quality of care (Boyd, 2017). A reformed payment system is essential for providing high-value care to patients (Erickson et al., 2020). Therefore, better financial support equates to higher quality of care (Dobrzykowski et al., 2016). Therefore, for-profit hospitals must reform their service at the most cost-efficient way without sacrificing the quality of care. Inefficiencies could lead to deeper financial pressures.

Hospitals are under financial pressure from Medicare. Ly and Cutler (2018) posited that hospitals are under financial pressure with Medicare and Medicaid but manage to thrive. One of the reasons is the upcoding of a diagnosis-related group to a more severe diagnosis to inflate payments (Ly & Cutler, 2018). Likewise, Kuiper et al. (2019) pointed out that the care demands of patients are related to healthcare cost.

Moreover, Otsuki and Watari (2021) and Panagioti et al. (2019) explicated that diagnostic errors can lead to negative financial ramifications. Therefore, hospitals must be efficient to maintain healthy financial outcomes (Ly & Cutler, 2018). Hospital efficiency is necessary to avoid negative economic outcomes. Positive financial outcomes keep hospitals in business.

Profitability drives growth in the hospitals. Hospitals' profitability is increasing (Ly & Cutler, 2018). Joynt et al. (2014) elucidated that the profit is the result of subpar care that led to readmission. Moreover, Joynt et al. verified that hospital leaders decreased the number of employees to improve financial outcomes, which led to a further decline in quality of care. Panagioti et al. (2019) recommended that, to maintain financial stability, hospital leaders must focus on quality of care and timely discharge. Therefore, to improve the quality of care, the number of employees must be kept on par to provide timely patient discharge. Decrease in quality of care could lead to hospital readmission.

Mitigating hospitals' 30-day readmission rate could improve the cost of care. The Hospital Readmission and Reduction Program was enacted under the ACA and penalizes hospitals for 30-day readmissions (Banerjee et al., 2021). Yang et al. (2018) corroborated that the staff's responsiveness to patient care led to mitigation of the 30-day readmission. Likewise, using a patient advocate to conduct post-discharge follow-up with patients prevents a 30-day readmission (Mileski et al., 2017). Moreover, the continuous monitoring of outpatient parenteral antimicrobial therapy tools by pharmacists on infectious disease patients can decrease admission rates (Rivera et al., 2021). Snipes (2016) explained that minimizing patient readmission reduces hospital costs. Therefore,

mitigation of 30-day readmission is essential to improve financial outcomes. It is very important to track the readmission rate through health information system.

Tracking the quality standards is essential to better manage care. Health information technology (HIT) is essential to monitor quality standards in hospitals to promote efficiency and decrease costs. Hand et al. (2022) noted that a relationship exists between costs, access, and quality of care. Therefore, information technology is essential to connect costs, access, and quality of care (Mindel & Mathiassen, 2015). Alvesson and Sveningsson (2015) contended that new technology leads to better interaction with hospital employees. Therefore, technology plays a huge role on tracking the health standards to improve costs. Technology is now used widely in clinical informatics.

Technology is now a crucial tool in healthcare. Tian et al. (2019) posited that technology continues to shape society. Technology is a tool that is critical for health care executives and administrators to influence patient outcomes. Health care leaders are applying technology in the form of electronic health records (Mindel & Mathiassen, 2015). Tian et al. noted that electronic health records technology involves using analytics, informatics, safety, cloud computing, and telemedicine. With proper execution, health data technology will drive efficiency in the health care industry.

Health information technology is now adopted in the healthcare industry. The health care industry is moving away from traditional ways, and healthcare leaders are adapting HIT internationally (Yen et al., 2017). Reynolds and Jones (2016) posited that HIT promotes high quality at a lower cost. Yen et al. (2017) explained that HIT can help achieve progress. Therefore, hospital management is crucial in the implementation of

HIT (Tian et al., 2019). HIT is crucial to the healthcare organization to enhance organizational growth. Electronic healthcare record is one of the HIT aspects that is crucial to drive the value of care.

Electronic healthcare record is essential to track patient care. Tian et al. (2019) posited that electronic health records help health care providers provide the finest care to patients. Likewise, Tian et al. noted that electronic health records provide improved patient outcomes through effective clinical decisions made by physicians who have access to the system. Tian et al. explained that the previous practice was for health care staff to supply physicians with patient information. Kelsey et al. (2017) noted that physicians now have increased access to health care data. Therefore, medical care is improving and making an impact through the application of HIT (Yen et al., 2017). EHR provides effective clinical decision making, especially by the physician, to improve the quality of care. Improving the quality of care could lead to increase Medicare payments.

Ways to Improve Hospitals' Quality of Care and Increase Medicare Payments

Improving the quality is necessary to improve Medicare payments. To improve the quality of care and increase Medicare payments, hospitals' clinical perspectives must improve (Materla et al., 2019). A workflow management system is the cyclical flow of activity managed by an organization that involves the transformation of resources, provides services, or processes information (Zheng et al., 2020). Workflow management involves the data, rules, and tasks needed to achieve goals (Zheng et al., 2020). Workflow management stems from hospital leadership, and hospital leadership must enhance their workflows to cascade down to employees to achieve better patient care (Zheng et al.,

2020). Therefore, hospital leaders must be enhanced to the employee level to be able to provide the standards of care across the facility. Effective use of workflow could improve the patient care delivery.

Workflow management could lead to better patient outcomes. Effective workflow management promotes patient safety and minimizes risk in hospitals (Brady et al., 2017). To improve the workflow, hospital leadership must initiate process improvement plans by enhancing the flow of useful information to the employees (Zheng et al., 2020). However, clinical changes can easily disrupt the workflow (Zheng et al., 2020). Information must be relevant, valid, timely, and reliable to be understood by the intended recipient (Fusch & Gillespie, 2012). Therefore, workflow can enhance the flow of communication, which can lead to better employees understanding of care standards.

Information

The flow of information is essential to communication among caregivers. The flow of useful information is essential to provide overall care to patients (Shahid & Thomas, 2018). The flow of information that needs communicating to patients must be relevant, valid, useful, timely, and reliable. Communicating relevant information from physicians and nurses to patients can help to ensure clarity (Brady et al., 2017). Likewise, valid information is critical to avoid any confusion among patients when caregivers provide information to the patients (Erickson et al., 2020). Information must be useful to patients, especially when patients need to provide consent for a treatment or procedure (Erickson et al., 2020). Reliable information is necessary for patients to understand the situation regarding their health and the cost of care (Erickson et al., 2020). Reliable

information can produce patient trust that can lead to increased patient satisfaction (Shahid & Thomas, 2018). Therefore, the flow of information is vital to enhance patients' understanding of care. Effective communication could lead to improve rapport and trust among caregivers and patients.

The flow of communication enhances the relationship among patients and employees. One of the important channels for improving the flow of information is through communication (Shahid & Thomas, 2018). Success in the flow of information depends on the leaders (Wu et al., 2020). Effective communication between leaders and caregivers is essential to improve rapport and trust (Yang et al., 2018). Effective communication in health care is important to improve quality of care, decrease costs, and increase daily operating efficiencies (Yang et al., 2018). Likewise, communication is important for improving patient satisfaction, as it promotes convenience in accessing, managing, and tracking medical records from a secure online location (Kocakulah et al., 2021). Therefore, flow communication could improve quality of care and increase patient satisfaction. The effective flow of communication could improve financial outcomes through patient satisfaction.

Effective flow of communication is essential to increase Medicare payments. An effective flow of communication can lead to employee satisfaction and can increase the confidence of nurses (Shahid & Thomas, 2018). Medicare rewards hospitals that achieve an increase in patient satisfaction rates (CMS, 2021). To ensure that patients absorb information fully, caregivers must educate their patients (Kocakulah et al., 2021). The dialogue process is necessary to ensure the messages delivered to patients are clear and

accurate (Kocakulah et al., 2021). After the education is complete, medical errors may be prevented (Shahid & Thomas, 2018). Therefore, continuous flow of communication among caregivers and patients could lead to patient safety and high quality of care. The flow of communication could promote patient safety.

Effective communications promote patient safety and increase Medicare payments. Effective communication helps to protect patients from serious harm due to medical errors arising from misdiagnosis, wrong-site surgeries, or erroneous medication administration (Shahid & Thomas, 2018). Kang et al. (2020) noted that medical errors are the third leading cause of death in the United States. By preventing medical errors, hospital leaders can reduce malpractice costs and improve Medicare reimbursements (Katz, 2019). According to Katz (2019), in 2008 hospitals spent $55 billion on defensive medicine. Hospitals can receive a bonus of up to 2% if they meet value-based purchasing metrics (Jha, 20217). By employing a process to handle patient communication with courtesy and respect, patient satisfaction will likely improve (Kocakulah et al., 2021). Therefore, effective communication among caregivers can save on healthcare costs and enhance patient safety without sacrificing the quality of care.

Patient satisfaction increase Medicare payments in the hospital. Patient satisfaction is an important quality measure for hospitals, based on the quality of care rendered by their employees (Carthon et al., 2021). A Magnet designation signifies that a facility is a distinguished hospital that meets the criteria for providing a high quality of care to patients in accordance with the Magnet status guidelines (Levenberg et al., 2019). Hospitals must improve employees' customer service relations with patients to achieve

maximum reimbursements from Medicare, as well as achieve Magnet status to achieve recognition as an excellent facility at which to seek care (Diana et al., 2019). Therefore, Magnet status could improve Medicare reimbursement through high patient satisfaction scores. The low patient satisfaction scores could lead to low quality of care

Enhancing patient safety to improve the quality of care. Materla et al. (2019) noted that health care providers are having a difficult time dealing with the needs of customers, which results in poor quality of care, low patient satisfaction, and higher costs of care. Materla et al. posited that health care providers will be able to understand patients' needs by developing strategies to improve the quality of care. Lasater et al. (2019) contended that the health system will improve the quality of care through patients' experience and the process of care. Lasater et al. explained that efforts to mitigate patient safety can develop from clinical guidelines, electronic health care records, financial incentives, and disciplinary measures. Patient safety can be enhanced by holding the employees accountable through care standards guidelines could lead to better patient care.

Enhancing the working environment through innovation improve the quality of care. Lasater et al. (2019) further explained that one innovation is Magnet hospital recognition, which recognizes hospitals through their working environment and improved patient outcomes. Lasater et al. indicated that their research about the Magnet designation can be useful to leaders, executives, and policymakers to improve quality outcomes in the health care system. McCaughey et al. (2020) posited that the Magnet hospital is a designation by the American Nurses Credentialing Center for hospitals whose personnel

provide an excellent working environment and excellent care to patients. McCaughey et al. explained that the patient experience data on good working environments are important, as the data are linked to CMS and the Hospital Consumer Assessment of Healthcare Providers and Systems. Therefore, better working environment could lead to better patient experience outcomes, resulting in higher Medicare payments.

The pandemic altered the flow of communication among caregivers and patients. However, during the COVID-19 pandemic, the climate was altered, and the modes of communications changed. According to Viftrup et al. (2021), 39% of patients were unsatisfied with their experience, as they were not satisfied with the explanations they received. Moreover, the cancellation of outpatient surgeries put hospitals on a losing end financially due to low patient volume (Viftrup et al., 2021). Hospital workflows were tremendously altered due to COVID-19 (Garbey et al., 2020). Therefore, hospital leaders must change their tactics to be able to communicate with patients frequently to alleviate their stress by modifying communication channels (He et al., 2021). To be able to improve the communication among caregivers, a multidisciplinary team approach, comprised of healthcare employees with different expertise, is necessary.

The collaboration of different healthcare professionals as a multidisciplinary team enhances the patient care. Janssen et al. (2018) noted that multidisciplinary teams (MDTs) are important to the delivery of health care services to cancer patients. Janssen et al. explained that the use of health information systems in cancer care built the MDT's capacity toward engagement on improvement and implementation projects. According to Janssen et al., the optimal use of ICT in hospitals will improve the patient-centered

outcomes of MDTs. Likewise, Pillay et al. (2016) explained that the impact of MDTs involves changes in diagnosis and staging, initial management plans, higher rates of treatments, shorter time to treatment after diagnosis, better survival rates, and improved adherence to clinical guidelines per single patient care visit; however, these changes require significant amounts of time and money. According to Pillay et al., MDT meetings impact assessment and management practices, but there was no evidence of improvement in clinical outcomes. Pillay et al. recommended that hospital leadership weigh the costs associated with using MDTs prior to adapting the program. Therefore, the addition of MDT to the patient care increase the time and money involved, however, is very effective on the clinical outcomes.

The MDT plays a huge role in improving the patients' quality of care. Wickersham et al. (2020) explained that the adoption of interdisciplinary rounding to patient care units has improved patient safety and engagement. Wickersham et al. explained that interdisciplinary rounding has also improved communication and patient care. Likewise, the multidisciplinary approach enhances collaboration among health care teams to improve patient care (Urisman et al., 2018). The results of Wickersham et al.'s study revealed that there is perceived improvement in interdisciplinary communication, care communication, and teamwork; however, there were no changes in the length of stay. Wickersham et al. indicated that the value of interdisciplinary patient rounding is essential in the education of attending doctors in patient units. Therefore, MDT is effective in the care outcomes, however, there is no effect on the length of stay of the patients.

The task is complete provided the validation is accomplished. Validating the outcomes is essential to be able to verify if the process is effective in improving quality of care. Validating intended outcomes is essential to be able to track the progress of a goal (Fusch & Gillespie, 2012). The absence of a tracking mechanism can lead to failure of a goal. One of the measures to track the progress of a goal is through a balanced scorecard (BSC) (Aryani & Setiawan, 2020). Therefore, to improve the quality of care outcomes, the metrics must be tracked in order to support the leadership decision on making the necessary changes to the process. The balance scorecard (BSC) is one on the tracking tools that can help monitors organizational plans.

The BSC is a tool that hospital leaders use to monitor and plan their strategies to improve the overall outcomes of the hospital. Aryani and Setiawan (2020) addressed the importance of the BSC in performance management. Aryani and Setiawan explained that the BSC is a tool for senior managers to integrate nonfinancial information that is a strategic consideration. Moreover, according to Aryani and Setiawan, the BSC is valuable to health care practitioners in improving organizational performance and attaining strategy. However, Porporato et al. (2017) emphasized that use of the BSC does not align with a cause-and-effect relationship, as the popularity and usefulness of the BSC as a strategic tool lacks empirical evidence on its effectiveness. Therefore, BSC has limited functions geared towards non-financial aspects of the business plan, however, it is a useful tool on tracking organizational performance. The BSC tracking tool is used worldwide.

BSC is widely used in different business industries by senior leaders to track their strategies. According to Porporato et al. (2017), the lack of attention on the merger of composite indices to a higher level of measure is the reason for the ineffective use of the BSC. Likewise, Hegazy et al. (2020) posited that the BSC is a strategic planning and management tool widely used in business and industry, as well as government and nonprofit organizations worldwide, that has performance measurement and the evaluation of effective strategy as its focus. Hegazy et al. further explained that the BSC is an effective tool for measuring organizational outcomes and for evaluating successful strategic outcomes but is not an effective tool for a diagnostic information system. Therefore, BSC is effective on tracking performance outcomes but not diagnostic information system.

Employee Motivation

Employee motivation is crucial to drive the quality of care to the highest level. Hospital leaders must hire transformational leaders, as such leaders are essential to promoting motivation among employees. Hwang et al. (2015) noted that leaders who implement the organizational change must consider the impact of their choices on organizational change. Klar (2018) explained that the goals and objectives of organizational change must be clearly defined among different sets of procedures and plans. Moreover, the chain of command must be clearly emphasized to implement the change (O'Connor & Jackson, 2017). Therefore, motivation is essential to promote successful organizational change. Leaders must clearly define the change process to be effective.

Transformational type of a leader is essential on driving the organizational change. The organizational change process must include economic, human, and other resources to be effective (Chams, & García-Blandón, 2019). Ganta and Manukonda (2017) explained that leaders will have an easier time making the organizational change after they verify the departments impacted. Transformational leaders are essential to drive quality to the top level, as their nature as leaders is to mentor employees through building rapport and trust and hence promoting positive outcomes (Asif et al., 2019). Transformational leaders could affect organizational change as long they verify which department is impacted. Innovative approach on change management is essential to affect change.

Innovative approach, with the use of technology, by transformational leader is essential to implement a successful organizational change. Mikkelsen and Olsen (2019) addressed how change leadership can change the landscape of the health care industry through an innovative approach with the aid of technology, which can enhance job performance and employee satisfaction. Mikkelsen and Olsen noted that change leadership can change organizational culture, improve the landscape on job satisfaction, and minimize learning demands from employees. Likewise, Sfantou et al. (2017) noted that transformational leadership is directly involved with the implementation of successful outcomes on safety, quality, stability, and reduced turnover. According to Sfantou et al., leadership styles correlate with quality of care; hence, transformational leaders are responsible for the successful and effective implementation of organizational outcomes. Therefore, transformational leaders are essential to drive the organizational

change with the aid of technology to produce positive outcomes. Safety and quality are priorities of healthcare organizations.

Healthcare leaders prioritize safety and quality as the pillars of their organization. Moreover, Boamah et al. (2018) contended that safety and quality of care are the priorities of health care organization globally, and leadership across health care organizations play a huge role in improving patient safety. Boamah et al. explained that health care organizations in North America and Europe are prone to adverse events in which injuries or complications caused by health care management result in a prolonged hospital stay, disability, or death and hence in increased health care costs. Kowalski et al. (2020) indicated that transformational leaders promote autonomy and respect, as well as provide resources, organizational commitment, innovation, and improvements, to enhance patient safety and quality of care. According to Boamah et al., transformational leadership has a strong influence on job satisfaction and on decreasing adverse events. To drive organizational safety and quality to the highest level, transformational leaders must drive the initiative through innovative and respectful approach. Respectful approach with employees is essential enhances rapport.

Good working relationship between leaders and employees is essential to improve working environment. Brimhall (2019) noted that, in order to foster inclusion in the workplace, leaders must encourage engagement and openness toward employees to help them acclimate to the working environment and to promote an exchange of ideas, build trust, and drive innovation and job satisfaction, thereby resulting in better outcomes of care. Brimhall showed that inclusion drives innovation and engagement, resulting in

innovation, which drives high quality of care. Kowalski et al. (2020) explained that leaders' behaviors affect the attitudes of employees, which directly affect performance. Luu et al. (2019) explained that job crafting enabled organizational leaders to revise the process, thereby, changing the employees' experience of producing the organizational outcomes. Employee inclusion drives innovation and engagement, resulting in positive organizational outcomes. The charismatic type of leaders could bring positive organizational outcomes.

Charismatic leaders could drive innovation and creativity in the organization. Brimhall (2019) posited that charismatic leaders have a direct impact on job crafting by contributing to the improvement of the quality of care in hospitals. Luu et al. (2019) elucidated that job crafting provides social, cognitive, and motivational resources, which results in building positive emotion for the employees. Brimhall revealed that charismatic leadership is an indicator of public service motivation (PSM), and leaders continue to leverage PSM in general to affect change. Brimhall confirmed that charismatic leaders influence team creativity through job crafting, thereby promoting team trust, innovation, and sharing of information. Havold and Havold (2019) elaborated that the process involves having better and more efficient leadership in place to provide strategic thinking. Havold and Havold explained the importance of using legitimate, expert, and reward powers in this type of situation. Therefore, charismatic leaders affect organizational change by promoting creativity and innovation in the workplace through employee motivational approach that may drive positive outcomes. Other types leadership powers could affect organizational change.

Leadership powers can be either legitimate, expert, or reward. Havold and Havold (2019) posited that legitimate, expert, and reward powers have influenced the motivation aspect; likewise, legitimate, referent, and reward power influenced trust, and, conversely, coercive power influenced trust negatively. Havold and Havold (2019) argued that leaders use power appropriately to promote innovation and trust, which results in positive outcomes in the quality of care. Brimhall (2019) suggested that leaders' engagement, innovation, and inclusion rather than job satisfaction drive quality of care. To promote culture and desired goals to achieve outcomes, an effective onboarding process of employees is necessary (Kurnat-Thoma et al., 2017). Therefore, when use appropriately, leadership powers foster innovation and inclusion, that could affect organizational outcomes. Proper employee onboarding could foster positive organizational outcomes.

Effective onboarding of employees is necessary to promote organizational culture. Onboarding employees is crucial for the employees to be able to adapt to the current skills needed to improve the quality of care and mitigate employee turnovers (Kurnat-Thoma et al., 2017). Human resources and the service line department leaders must have a specific program designed to orient employees to improve their competencies to mitigate lapses in patient care, which could instigate safety issues (Kurnat-Thoma et al., 2017). Oppel et al. (2019) addressed the importance of strategic human resource management in shaping the attitudes of employees in both public and private entities regarding the motivational aspects of an organization to improve the outcomes. Therefore, human resources management play a huge role on hiring and training the

employees to adapt to the organizational culture in place that could drive positive outcomes.

Human resources personnel contribute to increase the quality of care. Strategic human resource management is responsible for increased quality of care, organizational commitment, and employee retention. Oppel et al. (2019) explained that human resources personnel must be aware of the types of attitudes between physicians and nurses and which aspects motivate them between career development, training, and incentives. Kamalasanan et al. (2020) pointed out that employee training and development are an important part of the quality improvement process, as it enhances employees' skills to become efficient according to their job role. Moreover, Decock et al. (2022) elaborated that having a well-developed employee's skills competency is an indicator of quality-of-care outcomes. These measures will help drive employee retention. Therefore, human resources play a huge role in molding the employees to be able to contribute to the positive organizational outcomes. Compensation plays a huge role on employees' actions.

Employee retention is dependent on compensation. Compensation can be a driver of employee motivation (Qomariah et al., 2022). Likewise, compensation is an effective measure to improve employee retention (Khalid & Nawab, 2018). Kelbiso et al. (2017) noted that the quality of nursing care is dependent on the quality of life. Compensation can drive health care organizations to achieve successful outcomes through employee performance (Khalid & Nawab, 2018). Yang et al. (2018) explained that employees' poor response to patients' needs during a hospital stay can result in higher readmission rates. Employee participation with compensation decisions relating to their job role makes

employees feel valued by the organization, which results in higher rates of employee retention and performance (Khalid & Nawab, 2018). Right compensation drives the motivational approach of employees to render care that could lead to higher quality of patient care. Also, employee motivation could drive patient safety in the hospital.

Instrumentation

Appropriate resources are necessary to promote safe environment. Appropriate use and acquisition of equipment and resources such as staff, supplies, and medications are important to minimize hospital-acquired infections (HAIs), readmission, morbidity, and mortality. Garcia et al. (2019) explained that patient safety is dependent on physical and human resources. According to Sloane et al. (2018), nurses are an important part of health care, as they continuously transform the health care environment due to their presence in the patient care area around the clock. Likewise, nurses are the main source of patient information for physicians (Sloane et al., 2018). Sloane et al. (2018) noted that, with better nursing resources, hospitals will have better outcomes. Safe environment can be attributed to the amount of resources; therefore, hospital must provide enough resources to mitigate morbidity and mortality, resulting in high quality of care. High technology resources are essential to promote positive outcomes.

High technology equipment is important to improve the quality of care. Wei et al. (2018) explained that using high-technology equipment can make the workflow more efficient and hence leads to better care. Wei et al. further explained that inefficiencies in hospitals cause mortality. Likewise, Maki and Zervos (2021) explained that the lack of equipment and resources to disinfect equipment and the lack of handwashing can lead to

an increase in HAIs. Therefore, using high-technology equipment is necessary to improve early intervention and treatment of patients. High technology equipment is essential to prevent patient harm.

Healthcare associated infections is one of the VBP aspects that Medicare measures to provide appropriate payments to the hospitals. HAIs are one metric from hospital-acquired conditions that are measured by CMS to determine hospitals' quality of care (CMS, 2019). CMS (2019) accessed HAIs data from the National Healthcare Safety Network to determine proper hospital reimbursements. According to CMS (2019), the following data on HAIs were gathered from the National Healthcare Safety Network: (a) central-line-associated bloodstream infections (CLABSIs), (b) catheter-associated urinary tract infections (CAUTIs), (c) surgical site infections, (d) methicillin-resistant Staphylococcus aureus bacteremia, and (e) clostridium difficile infections (CDIs). These aspects are essential for hospital to track in order to determine the status of Medicare payments. HAIs contributes to morbidity and mortality in the hospital.

Improper handling patient safety devices leads to HAIs. Pettemerides et al. (2018) addressed the rate of device-associated HAIs published from 2007 to 2017 by comparing the data from developing countries with data from developed countries. Pettemerides et al. noted that the threats to patient safety are devices associated with HAI that can be attributed to extended hospital stays and that result in morbidity and mortality to patients if not prevented and treated. Pettemerides et al. further explained that the aspects of infection included in their study are CLABSIs, ventilator-associated pneumonia, and CAUTIs. HAI is a serious threat not only in hospitals but in the community; hence,

proactive prevention is essential to prevent the spread of HAIs (Aljamali & Al Najim, 2020). Aljamali and Al Najim (2020) pointed out that proper surveillance is necessary to mitigate the spread of HAIs. HAIs could lead to morbidity and mortality if not prevented and treated, hence, proper usage of safety devices are essential to drive patient safety. HAIs can originate from microorganisms.

Prolong stay in the hospital may lead to exposures to different microorganisms could lead to contracting HAIs. Rafter et al. (2019) reported that 30 acute public hospitals were involved in a HAI study using the Irish National Adverse Event Study and the Point Prevalence Survey data and comparing them to European HAI data as a benchmark. Aljamali and Al Najim (2020) noted that contracting HAIs prolongs patient stays in the hospital due to exposure to different microorganisms passed on from caregivers to patients or to a person infected with the pathogens from environmental factors. Rafter et al. elaborated that the top microorganism on the list is E. coli, followed by Staph Aureus and Clostridium Dificile. HAIs extend patients' stays in hospitals to over 10 days, which equates to 32.5% of a burden in numbers, resulting in the 2009 estimate of 121 million euros added to hospitals' bottom line (Rafter et al., 2019). Therefore, hospital must have proper process to combat the spread of infections. Hospital leaders must determine the microorganisms involved to treat the symptoms.

The spread of infections is responsible for hospitals' morbidity and mortality cases. A CDI is an anaerobic microorganism that originated from patients' feces and can be spread through contaminated hands or medical devices (Goldenberg et al., 2017). Louh et al. (2017) explained that CDI is a leading cause of morbidity and mortality in

hospitals, affecting 13 out of 1,000 patients, and could cost between $9,000 and $15,000 per patient case, or an estimated annual cost between $1.5 billion and $3.2 billion. Therefore, proper intervention is necessary to mitigate the spread of CDI. Having a proper surveillance system of HAIs can prevent the condition from happening (Aljamali & Al Najim, 2020; Rafter et al., 2019). Hospital leaders must mitigate the spread of infections to prevent decreasing quality of care and economic losses. CLABSIs is one of the HAIs that caused major harm to the patients.

CLABSIs cases are rising due to ineffective workflows. Ferrari and Taylor (2020) reported that one in every 25 patients will experience at least one hospital-acquired condition due to CLABSIs. According to Ferrari and Taylor, the Ferrari method for practice standardization reduced CLABSI rates by 48% over a 1-year cycle. However, Ferrari and Taylor noted that the standardization of care is difficult to implement across organizations, as some units experienced challenges adopting the evidence-based practice due to disbelief. Ferrari and Taylor recommended management adopt the Ferrari method into their system to practice assessing, evaluating the evidence, and developing practice standards across the organization. Aljamali and Al Najim (2020) explained that the involvement of management is crucial in mitigating the spread of HAIs. Not managing an intervention will result in the process being ineffective (Gutema et al., 2018). Therefore, hospitals must change their practice to incorporate evidence-based practice to mitigate the spread of CLABSIs and other microorganisms. Also, antibiotic administration to spread of microorganisms.

Improper antibiotic administration leads to harm. Gutema et al. (2018) addressed the ineffective administration of antibiotics in hospital wards in Ethiopia due to their rampant consumption without a physician's order, resulting in worsening patient conditions. According to Gutema et al. (2018), the top five frequently occurring infections are the following, with corresponding percentages: (a) pneumonia (26.6%), (b) surgical site infections (21.5%), (c) neutropenic fever (6.9%), (d) sepsis (6.4%), and (e) urinary tract infections (4.7%). Based on the antibiotic's use, cephalosporin was the antibiotic administered most frequently, among 82.7% of the patient population. The four most frequently used cephalosporin-based antibiotics in three wards are the following: (a) Ceftriaxone, (b) Metronidazole, (c) Vancomycin, and (d) Ciprofloxacin. Likewise, Rafter et al. (2019) explained that HAI can promote readmission if an infection consistently comes back, as the antibiotics are not effective for the type of microorganisms within the patient's system. Therefore, HAI can result in an increase in hospital costs due to the treatments and medications needed to treat the infection.

To improve the quality and decrease the cost of care in hospitals, there are several ways to mitigate HAIs. Rafter et al. (2019) suggested that proper surveillance of HAIs is necessary for hospitals to intervene on types of HAI and organisms that affect patients. Aljamali and Al Najim (2020) explained that recognizing the factors of HAIs will enable caregivers to initiate interventions to mitigate the spread of the infections. Chatfield et al. (2017) wrote that handwashing is the most basic form of preventing the spread of infections in hospitals and that noncompliance may lead to the spread of HAIs.

Therefore, hand hygiene must be implemented across all healthcare facilities. Hospital leaders must devise a proper process to prevent gaps in hand hygiene process.

Hand hygiene is essential to prevent the spread of infections in the hospital. According to Chatfield et al. (2017), to be able to sustain momentum in handwashing, leadership must devise a strategy for employees to follow without fault. Chatfield et al. further explained that (a) hand hygiene training must be hardwired in employees, as compliance rates of handwashing is decreasing; (b) management support is lacking in the implementation of hand hygiene initiatives; and (c) subjective criteria influence hand hygiene, as patients might perceive themselves as dirty when employees wash their hands in front of the patients. Louh et al. (2017) elucidated that proper hand hygiene, combined with wearing gloves during patient care, is effective in mitigating the spread of CDI. Durant et al. (2020) noted that, to minimize the hand hygiene issue and prevent the spread of HAIs, an electronic surveillance system is necessary to track employee compliance and to initiate performance improvement measures with every employee who violates the rules. Although, hand hygiene cannot totally eliminate HAIs, it is still the first line of defense against the spread of infections. Proper hand hygiene cannot ensure the elimination of HAIs, but another process that helps to prevent HAIs is chlorhexidine (CHG) bathing.

CHG bathing is essential to prevent HAIs. According to Musuuza et al. (2019), chlorhexidine or CHG bathing is a process to prevent the spread of hospital-acquired bloodstream infections, primarily central lines, by lowering the microbial threshold on a patient's skin to prevent organisms entering the bloodstream from the site. Also,

Musuuza et al. noted that CHG bathing is crucial for eradicating the spread of central-line infections, which is the cause of mortality and morbidity from HABSIs. CHG bathing can save a hospital $1.56 million per year based on a 93-bed intensive care unit (Musuuza et al., 2019). However, Louh et al. (2017) contended that CHG bathing is not effective for CDIs; hence, disinfection with chlorine-based products on surfaces that had contact with patients is necessary to prevent the spread of CDI. Another way to prevent HAIs, specifically CAUTIs, is to use an external urinary catheter (Warren et al., 2020). Therefore, CHG bathing must be consistently done to prevent the spread of HAIs and improve economic outcomes in the hospital. CAUTIs are the other HAIs that promote harm to the patients.

CAUTIs induced harm to the patients. Warren et al. (2020) suggested using an external urinary catheter in place of a Foley catheter, which is an invasive device inserted in the urethra to promote urinary output, to prevent CAUTIs. Warren et al. conducted a study in the intensive care unit of a large academic medical center that involved decreasing the use of an invasive urinary catheter, which is a precursor to CAUTIs. Laborde et al. (2021) posited that using nurse-driven protocols on the Foley catheter decreased Foley catheter trauma from 1.81 to 0.97 incidence per month. According to Laborde et al., exacerbation of Foley catheter trauma could lead to mortality. To support process intervention on preventing mortality, proper antibiotic management is essential (Gutema et al., 2018). Therefore, hospital leaders must implement nurse-driven protocols to prevent CAUTIs cases to improve the quality of care. Ineffective treatment of antibiotics could lead to death.

Inability to track antibiotic treatments could lead to patient mortality. The antibiotics administered must match the bacteria that they are intended to contain; otherwise, bacterial resistance to antibiotics will occur, which could lead to the ineffective treatment of infections (Gutema et al., 2018). Gutema et al. (2018) noted that the antibiotics stewardship process must be strictly monitored at both local and national levels to understand fully the relationship between the types of antibiotics and their resistance to infection. With this outcome, health care practitioners can obtain the information necessary regarding the extent and composition of the antibiotics use and the rationale of prescribing it, thereby setting the boundaries for proper intervention. Likewise, Dugassa and Shukuri (2017) recommended sensitivity testing to pinpoint the antibiotics that are effective in treating certain microorganisms. Healthcare leaders must initiate proper antibiotic administration to prevent patient morbidity and mortality (Gutema et al., 2018). Therefore, antibiotic treatments must be tracked to determine the efficacy using antibiotic stewardship to prevent harm and possible death to the patients. Healthcare mortality is an issue that could be prevented.

Health-care-related mortality is one of the most sensitive issues in health care. Mortality rates must decrease to improve outcomes; hence, hospital leaders must find a way to identify, monitor, and mitigate health-care-related mortality. Ido et al. (2018) posited that patients who received the lowest quality of care had higher odds of dying in 1 year as compared to patients who received a high quality of care. Poon et al. (2004) noted that 98,000 deaths per year are attributed to medical errors. Poon et al. addressed the issue through computerized physician order entry (CPOE) to prevent serious medical

errors in hospitals. Alanazi (2020) concurred that CPOE significantly decreases mortality. Therefore, hospital leaders must create a process to mitigate medical errors to prevent mortality to occur. Hospital leaders must develop tools to prevent medical errors.

CPOE is one of the high technology tools to prevent medical errors. Even with the effectiveness of CPOE, only 10–15% of health care leaders have adopted the system (Poon et al., 2004). Poon et al. (2004) addressed three barriers that cause the low adoption of the CPOE system: (a) physician and organization resistance occurs when CPOE alters their workflows, which could result in physician rebellion; (b) high cost and lack of capital, which prevent hospital leaders from purchasing CPOE software; and (c) product or vendor immaturity, which prevents vendors from offering products that do not match a hospital's existing platform. Alanazi (2020) explained that the success of CPOE requires a focus on the issue rather than on an individual and adherence through proper guidelines and best practices of a hospital. Therefore, the CPOE platform must have the proper assessment and monitoring standard to be able to improve clinical outcomes.

To mitigate mortality in the hospital, prompt and proper monitoring, assessment, and treatment are necessary to improve clinical outcomes. Agarwal et al. (2016) elaborated that the best management practice is the driver of performance and productivity, which is the impact of health care delivery in operations, performance monitoring, targets, and people management. Agarwal et al. elucidated that it is crucial to benchmark the practices to determine the measure of management's practice to develop a dependable health care system and hence to promote the delivery of effective and efficient care. Likewise, the use of the awakening and breathing coordination, delirium

monitoring, and early exercise (ABCDE) bundle can mitigate the mortality of critical care patients (Collinsworth et al., 2020). Collinsworth et al. (2020) noted that using an ABCDE bundle can decrease the odds of inpatient mortality by more than 60% and decrease the cost of care by $15,077 per life saved. Pérez-Rodríguez et al. (2019) recommended using a checklist when treating patients against Staphylococcus aureus bacteremia (SAB), to avoid missing indicators. Therefore, ABCDE bundle is essential to mitigate mortality and improve the hospitals' financial outcomes. SAB is another microorganism contributes to mortality in the hospital.

Hospital-acquired SAB infections leads morbidity and mortality. Pérez-Rodríguez et al. (2019) explained that SAB is one of the main causes of bacterial infections in the community and in the hospital, as it infects 4–40 per 100,000 persons per year. Pérez-Rodríguez et al. identified the factors responsible for the increase in the mortality of SAB, which are methicillin resistance, advanced age, comorbidities, ICU admission, and delay in appropriate treatment. High levels of compliance with the standardized ABCDE bundle intervention decrease the 14- and 30-day mortality rates associated with SAB (Pérez-Rodríguez et al., 2019). Harris et al. (2018) recommended admitting critical care patients to the critical area within 4 hours. Therefore, strict compliance on using ABCDE bundle is essential to mitigate the rise SAB infections. Mortality occurred in critical acre areas.

Timely admission in critical areas is essential to prevent mortality. Harris et al. (2018) further elaborated that the goal of their study was to estimate the effect of prompt admission to critical care areas on mortality among deteriorating ward patients.

According to Harris et al., prompt admission to a critical care area decreased the 90-day mortality rate. However, Harris et al. pointed out that the benefit of prompt critical care admission is not equal across all patient referrals; hence, prioritization of critical care patients is essential to prevent mortality. Ido et al. (2018) pointed out that specific elements of clinical stroke care showed better patient outcomes. Therefore, prompt and proper admission to the critical care could prevent mortality to patients who are in critical condition. Stroke is one of the conditions that could lead to mortality.

Stroke is a condition that could lead to mortality if not prevented and treated in a timely manner. Ido et al. (2018) explained that the Georgia Coverdell Acute Stroke Registry was established in partnership with the Centers for Disease Control and Prevention to measure, monitor, and improve the quality of care for stroke patients across the state of Georgia. Ido et al. further explained that the hospitals that participated with the registry showed significant improvement in the delivery of care. Ido et al. conducted the quantitative study using SAS Version 9.3 to assess the 1-year mortality of acute ischemic stroke patients treated in the hospitals that participated in the registry. Likewise, Collinsworth et al. (2020) posited that the use of the ABCDE bundle contributed to 1-year mortality reduction in critical care patients. Ido et al. encouraged the hospital leaders to implement the quality improvement process to improve long-term outcomes. Therefore, hospital leaders must implement the use of ABCDE bundle to mitigate the risk of mortality. However, mortality is on the rise during Covid-19 pandemic.

Mortality becomes prominent during the peak of the Covid-19 pandemic. COVID-19 pandemic led to a huge issue in the mortality and financial aspects of

hospitals (Khullar et al., 2020). Sayan et al. (2021) posited that the COVID-19 mortality rate for critical illness is 49% and 50–90% when under a mechanical ventilator. Wang et al. (2020) explained that the worldwide deaths caused by COVID-19 exceeded Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). Wang et al. elaborated that COVID-19 mortality was caused by insufficient resources in hospitals. Khullar et al. explained that COVID-19 posed a huge financial burden to hospitals, especially those hospitals that deal with outpatient diagnostic and surgical procedures. Wang et al. suggested employing early interventions on COVID-19 patients to improve outcomes. COVID-19 prolongs a patient's length of stay in the hospitals (Wang et al., 2020). Covid-19 pandemic brought serious rise in mortality rate, hence, timely intervention is necessary to prevent the mortality rate and economic costs to rise. Also, longer hospital length of stay could pose higher cost to the hospital.

Hospital length of stay pose a greater threat to the overhead cost of the hospital. Hospitals' length of stay is one of the most important quality measures (Kocakulah et al., 2021). Patients' overstay can affect the financial outcomes of the hospital (Crisafulli et al., 2018). Medicare will only pay a certain portion of the cost based on the diagnosis-related group (CMS, 2021). Likewise, an increased length of stay equates to higher chances of comorbidities (Tal, 2021). Therefore, hospitals' quality of care might decrease due to longer lengths of stay as patients might catch HAIs that could lead to morbidity or mortality (Wang et al., 2020). Therefore, timely discharge of the patients could lead to better financial outcomes and decreases the possibility of contracting HAIs. Also, prolong stay in the hospital could decrease patient satisfaction.

Increase hospital length of stay could decrease patient satisfaction. Patel et al. (2019) noted hospital capacity becomes limited due to delays in discharging patients, which increases the length of stay and results in a decrease in patient satisfaction. According to CMS (2019), unplanned readmissions puts hospitals at risk for financial losses due to penalties. Williams et al. (2017) noted patients' length of stay of 4 days or greater will be a risk factor for 90-day unplanned readmission and could decrease the quality of care due to the changing payment model of the payers; hence, length of stay is a risk for readmission. Patel et al. further explained that, due to prolonged inpatient discharge, waiting times in the emergency department increase, which causes overflow. Patel et al. used the continuous improvement model to optimize the impact of multidisciplinary rounds to discharge planning and efficiency of care. Williams et al. posited that health care payers are incentivizing the length of stay and unplanned readmission to improve the quality of care. Therefore, timely patient discharge is necessary to avoid bottleneck in the hospital throughput and mitigate patient dissatisfaction. The Covid-19 patients affect the hospital length of stay.

The hospital length of stay increases during the Covid-19 pandemic. The length of stay deteriorated due to COVID-19 (Wang et al., 2020). Wang et al. (2020) noted that the median length of stay on COVID-19 patients age 45 and over was 19 days. Khullar et al. (2020) explained that COVID-19 brought financial burden to hospitals, and one in five rural hospitals might close due to the financial impact brought on by the pandemic. Wang et al. suggested that timely interventions and control measures are necessary to decrease

the length of stay. Hospital leaders can track the control measures through patients' electronic health records. Big data is essential to enhance organizational decision making.

Big data can affect the organizations' financial outcomes. Liu et al. (2020) emphasized that the introduction of big data affected technological change in the field of medicine and public health. Likewise, Yee et al. (2012) addressed the importance of electronic medical records to the quality and cost of care, as well as overall documentation efficiency. Yee et al. further explained that the American Recovery Act included an initiative to stimulate the economy that covered health care provisions, with $20 billion allocated specifically to electronic medical records, with a projected savings on managing the use of chronic disease patients of $81 billion annually. Therefore, hospital leaders must acquire the emerging technology to improve financial outcomes.

Factors Affecting the Quality of Care and Medicare Payments

Barriers to change impede the change process. Alexander et al. (2022) pointed out that resisting change is a human response to a change process. According to Amarantou et al. (2017), resistance to change was indirectly influenced by employee–management relationships, personality traits, employee involvement in decision making, and job security. Bishop et al. (2022) asserted that opposition is something strategically resolved. Alexander et al. (2022) explained that resistance to change stems from unresolved issues that leaders fail to address. Technology is a barrier to employees as well (Amarantou et al., 2018). Therefore, technology must be used wisely to eliminate complications and employee resistance. Technology plays a huge role in the healthcare industry.

Technology is essential to the new era in healthcare. Amarantou et al. (2018) addressed the influence of technology and market shifts on changes in the health care landscape. Vaishnavi et al. (2019) explained that the rapid changes in technology, strategic competence, and emerging issues with employees and patients are barriers. Shahbaz et al. (2019) further explained that organizational leaders used big data to examine large amounts of complex data for efficient decision-making. Shahbaz et al. pointed out that, as technology progressed, data increased and became more complicated. Therefore, hospital leaders must create a plan mitigate complications to be able to incorporate seamlessly to the healthcare operations. Cyber-attacks added to the technology complications in the hospitals.

Cyber-attacks posed a greater threat towards patient care. The rise of cyber-attacks has affected health care operations worldwide (Alami et al., 2019). Health care has rich data; therefore, cyber criminals are attracted to it (Barad, 2019). According to Williams et al. (2020), cyber-attacks cost the health care industry $6 trillion, which is projected to increase fivefold after the COVID-19 pandemic. Williams et al. elaborated that 90% of health care providers have encountered cyber-attacks. Pullin (2018) noted that cyber security is the best defense against cyber-attacks. Hospital leaders must encourage teamwork and holds employees accountable to combat cyber-attack threats through the acquisition of encrypted and secured software, regular employee training, and continuous monitoring (Williams et al., 2020). Likewise, organizations must adhere to data protection policies to mitigate the risks of technological innovation to keep organizations valuable in the long run (Meinert et al., 2018). Technology can impede

communication with patients regarding their condition, which can affect patient care (Williams et al., 2020). Hospital leaders must create a concrete process to mitigate the onset of cyber-attacks. Communication can affect patient care.

Communication is essential to patient satisfaction outcomes. Communication is also a barrier if the intended recipient fails to understand the care provider (Brady et al., 2017). Miscommunication can stem from the structure of the conversation that is biased to the caregivers' side and not to the patients or if patients are affected by medication that can cause delirium and hence confusion or misunderstanding (Zamoscik et al., 2017). Moreover, environmental factors such as noise and other distractions can contribute to inhibiting poor communication (Brady et al., 2017). Therefore, enhancing communication could improve patient care. Poor communication could decrease patient satisfaction.

Poor communication can send a bad signal to the patients. Poor communication through improper body language by caregivers can send a bad signal to patients that the caregivers do not care (Brady et al., 2017). An example is if a caregiver holds the doorknob while talking to the patient, which can send a message that the caregiver is in a rush to get out of the room to avoid conversations with the patient. Poor communication can produce a low patient satisfaction score (Brady et al., 2017). With these gestures, poor leadership style can be the result of poor communication with patients (Boamah, 2018). Therefore, leaders and employees must be hold each other accountable in improving patient communication to improve patient satisfaction. Some leaders are destructive leaders.

Destructive leadership affects employees' morale and patient care. Lavoie-Tremblay et al. (2016) exclaimed that abusive and destructive leadership has the tendency to promote self-interest at the expense of others; similarly, abusive leadership has detrimental effects to the attitudes and psychological well-being of employees due to low job satisfaction, high work–family conflict, and emotional depression. Destructive leaders have a negative effect on nursing performance, which can lead to turnover (Labrague et al., 2020). Boamah (2018) noted that transformational leadership promotes a better environment through mitigating adverse events, thereby improving patient safety and quality of care. Lavoie-Tremblay et al. recommended training nurse managers using the transformational leadership style to improve quality of care and reduce the turnover rate of nurses, thereby alleviating the nursing shortage. Hospital leaders must eliminate destructive leaders and replace with transformational leaders to improve employees' morale and improve patient care. Proper staffing plays a huge role in improving patient care.

Proper nurse staffing is essential to provide safe patient care. Proper nurse staffing is an important part of hospital operations to prevent harm to the patients (Griffiths et al., 2020). To improve the quality of care, the staff-to-patient ratio must support staff being able to provide the highest and safest care to patients (Wang et al., 2021). As the staff-to-patient ratio gets larger, patient care might become compromised and hence impact quality and safety (Wang et al., 2021). However, teamwork and collaboration among employees can bring positive outcomes to hospitals (Kang et al., 2020). A proper staffing ratio is necessary to prevent overwork among nurses (Wang et al., 2021). Therefore,

proper staffing and teamwork are essential to elevate the quality of care. Nurse staffing rationing is a problem.

Nurse rationing could lead to poor quality outcomes. Zhu et al. (2019) addressed the aspect of rationing of nursing care failed to initiate properly due to limited time, staffing level, or skill mix, in which nurses feel overworked, hence affecting nursing care. Zhu et al. conducted a quantitative study using survey results from 7,802 nurses and 5,430 patients to test the mediation effect of rationing of nursing care and the relationship with nursing staffing and patient outcomes. According to Zhu et al., a lack of nursing staff leads to rationing of nursing care, which leads to poorer patient outcomes; therefore, developing a strategy on nurse staffing is essential to improve patient outcomes. Likewise, Qureshi et al. (2019) contended that achieving a high quality of care at a lower cost is a global concern, as hospital managers face competing priorities on improving care, increasing patient safety, and maintaining a safe work environment. Therefore, hospital managers must develop a strategic plan to eliminate rationing of nurses to improve patient care outcomes.

Limited labor costs pose a staffing challenge to the hospital. Qureshi et al. (2019) explained that challenges arise from limiting direct labor costs, which leads to understaffing, overtime, and an excessive workload, and thus to fatigue, stress, burnout, absenteeism, or work-related musculoskeletal disorder. Moreover, Kim et al. (2019) pointed out that nurse staffing is an important aspect of decreasing the incidence of falls; hence, nurse leaders should ensure that proper staffing is in place to achieve a high quality of care and high patient outcomes. Kim et al. explained that the incidence of falls

varies depending on the setting, ranging from 1.0 to 11.5 falls per 1,000 inpatient days. According to Kim et al., inadequate staffing is responsible for patient falls. Understaffing pose a greater risk to patient safety; hence, labor costs must be aligned to the current market trends to improve staffing.

Staffing issue could affect patient satisfaction, safety, and quality of care. Inadequate staffing can lead to burnout among employees (Dyrbye et al., 2019). Hospital leaders must develop a plan to improve staffing systems in hospitals. Hourly rounding is a crucial measure for increasing patient satisfaction. For example, rounding on patients in the nursing care units on an hourly basis helps to eliminate frequent call-light use (Emerson et al., 2014). By streamlining the workflow process, hospital leaders can alleviate stress among the nurses so they can focus on improving the care of patients (Zheng et al., 2020). Poor responses by nurses can lead to subpar quality of care and can compromise patient safety (Dyrbye et al., 2019; Garcia et al., 2019). Short-staffing issue could affect the quality of care patient satisfaction, however, by having a proper workflow aids the nurses to make their workload easier which alleviate the employee burnout.

Willingness to Change

Employees' willingness to change is essential to successfully implement organizational change. Milella et al. (2021) noted that organizational changes are dependent on individuals' input toward accepting the changes. Kirrane et al. (2017) explained that individuals' willingness to change only improves when the change workflows are effective and the employees' perception is geared toward learning

development. However, Allen (2016) noted that readiness to accept change can be a barrier to change as well. Achieving change outcomes depends on employees' willingness to accept change proposed by the leadership (Milella et al., 2021). Therefore, the success of employees' accepting change is dependent on the level of learning they had with their leaders. Likewise, employees' readiness to change is a challenge to implement.

Employees' readiness to change is important to be able for leaders to determine the timing of organizational change. Employees' readiness to change involves both cognitive and emotional aspects (Milella et al., 2021). The staff's willingness to accept changes is dependent on (a) operational workflow, (b) the identity of a worker, (c) the element of change, and (d) the behavior of the person implementing the change (Holten & Brenner, 2015). Hornstein (2015) studied that factors related to changes germane to employees' willingness to change are communications, the level of staff engagement to the change, and the extent of engagement in the change. Hornstein confirmed that the implementation of employee-centered change is effective in the service industries. Therefore, the success of the employees' readiness to change is dependent on the level communication and understanding they had with their leaders.

Implementing Health Care Change

Healthcare organization face a lot of challenges on implementing organizational change. Milella et al. (2021) pointed out that health care organizations undergo health care changes continuously to improve outcomes. Political influence from different interest groups of stakeholders with different roles who dictate how to provide care drive

health care changes (Rogers et al., 2020). Hence, hospital leaders face pressure to improve the quality of services (Allen, 2016). Some of the challenges are a shortage of human and financial resources to provide a higher quality of care (Allen, 2016). To satisfy stakeholders' expectations, the availability of resources must align with the change initiatives (Bengat et al., 2015). Likewise, Bengat et al. (2015) examined the connection between change-related communication, exchanges between executives and supporters, and the impact of such expectations on change results. Therefore, hospital leaders must be ready to answer all the questions the stakeholders have regarding change implementation.

Understanding change implementation is necessary to create a positive outcome. Bengat et al. (2015) noted that commitment to change can result from positive expectations. Bengat et al. posited that nurses' choice to change relies on communication between the nurses and the leaders. Bengat et al. found that the expectations of nurses about commitment to change are important. Larson (2015) claimed that other industries face the same challenge as the health care industry when it comes to change implementation. Changes occur continuously in health care organizations, in both operational and political standpoints (Houngbo et al., 2017). Therefore, change implementation must be addressed to all employees in a clear manner to alleviate resistance. ACA creates a lot of changes in the Medicare reimbursement.

ACA overhauled the entire healthcare landscape. The government's implementation of the ACA has drastically changed the landscape of the health care system in the United States in terms of clinical practice, organization, and finances

(Birk, 2016). Other government agencies aligned their regulations to a value-based purchasing model from the fee-for-service model (Erickson et al., 2020). Buntin and Graves (2020) pointed out that, to sustain the long-term impact of spending brought about by the ACA, changes to the payment system are necessary. The U.S. health care system upgraded the diagnosis coding system to ICD10 from ICD9 in 2015 (Hellman et al., 2018). Therefore, to sustain an effective and efficient outcome, stakeholders must adapt according to the prevalent changes (Al-Ali et al., 2017). According to Kogan et al. (2017), to ensure sustainability, stakeholders must employ new methods to promote organizational culture change. However, a lack of understanding about the change can result in uncertainty, which can enable people not to respond to change (Kogan et al., 2017). Therefore, change initiatives must be addressed to all stakeholders to gain full support. Clear understanding of the workflow is a challenge to the organization.

Clear understanding of process change is important to be supported. According to Kirrane et al. (2017), understanding the reason for change is essential for an organization to gain support from the staff and stakeholders and to influence the change process. According to Diab et al. (2018), to achieve a successful change process, organizational leaders must consider outcomes. Therefore, management must clarify the new processes, new technologies adopted, and stakeholders' expectations as a result of the change process (Allen, 2016). Therefore, support for a successful change is dependent on the clear presentation of the process change. Workflow is essential to the hospital.

Change process fortify the hospital workflow. Saarnio et al. (2016) pointed out that the application of the change process enhances quality-of-care services and

strengthens the effectiveness of hospital workflows. Diab et al. (2018) noted that the route to change must be followed to produce successful outcomes. Likewise, organizational leaders must determine and discuss the general timelines of change process implementation with the stakeholders (Bengat et al., 2015). Moreover, Yen et al. (2017) explained that organizational leaders must justify the cost of implementing the change process. Therefore, clear and concise presentation of the change process in regards to the overall cost could lead to successful outcomes.

Negative approach on pushing change implementation could have a negative effect on the approval of change process. Having a pessimistic approach on the change process can derail an organization's goal (Milella et al., 2021). Therefore, the change process means a lot for staff in terms of their expectations or shortcomings after the change process implementation (Yen et al., 2017). When the change process involves employees' job roles, clear communication from the management is important for the employees to understand the new roles (Seamons & Canary, 2017). Diab et al. (2018) explained that once management modifies the new role, it expects the employees to be flexible and have a positive outlook to support the organizational change. Therefore, clear expectations of the change initiatives are necessary to have a successful roll out of the change.

Institute for Health Care Improvement's Triple and Quadruple Aim Frameworks

Triple aim helps improve the healthcare outcomes. The triple aim is the simultaneous improvement outcomes on patient experience, health outcomes, and cost of care (Stokes et al., 2021). The U.S. health care system faces difficulties in comparison to

other health care systems around the world; hence, Institute for Healthcare Improvement (IHI) developed the triple aim (Skochelak et al., 2016). The triple aim framework enables health care organizations to modify existing practice for optimal efficiency of organizational activities (Institute for Healthcare Improvement, 2017). Skochelak et al. (2016) posited that the triple aim holds health care organizations accountable for implementing and improving the three elements during the change process. The triple aim's primary focus is improving patients' experience process (Stokes et al., 2021). Therefore, hospital must follow the guidance of triple aim in order to achieve successful clinical and financial outcomes.

Enhancing the workflow create positive outcome to the organization. Change happens when the new way of completing tasks, quality of care, and performance efficiency provided to patients considerably improve (Havens et al., 2018). Through relational coordination, nurses can improve outcomes by enhancing workflow information, employees' well-being, and resilient responses to performance failures (Havens et al., 2018). Therefore, nurses are happy about what the health care organization has to offer when it comes to facility and quality. Improving the health of the population served by a health care organization is another focus of the triple aim.

Triple aim improves the general health of the community. The triple aim helps health care organizations improve the general health of the population being served by providing available services (Skochelak et al., 2016). The focus of population management is disease prevention rather than high-risk patient management (Stokes et al., 2021). Improvement in the health of the population is linked to improved quality

services (Whittington et al., 2015). A measure of success is ensuring the population does not have to spend more for health care services (Billings & Halstead, 2015). However, Stokes et al. (2021) posited that population health management increases the cost of care due to secondary care. Stokes et al. (2021) further explained that the severity of a disease that needs a specialist consultation determines secondary care costs. Therefore, Medicare should lower the secondary cost of care in order to be affordable.

Triple aim helps the hospital increase their financial outcomes. The focus of triple aim is decreasing per-capita costs by first ensuring a healthier population to save costs (Stokes et al., 2021). Martin et al. (2020) noted that the per-capita costs of health care rose to 4.6% to reach $3.8 trillion for 2019 in the United States. Martin et al. discovered that health care accounted for 17.7% of the gross domestic product in 2019. Himmelstein et al. (2020) explained that the reason for increasing costs was the inefficiencies of the U.S. private insurance system. Skochelak et al. (2016) warned that the price of care is likely to increase to catch up with the value of health care, which is a challenge to health care organizations. Therefore, a change process is necessary to update the health care system, operation, and performance. Achieving goal is important to the organization.

Identifying the target population is essential to achieve the goal. To provide the necessary change process, identifying the target population is the main goal (Skochelak et al., 2016). Identifying the demographics being served will help determine the quality and price of health care (Brainard & Hunter, 2016). Once the targeted demographics are identified, the next step is to define the objectives and strategies of the organization. After the organization achieve the goals, the change achievement method is attained (Brainard

& Hunter, 2016). Developing separate projects produces separate outcomes (Allen, 2016). For example, developing a separate project involves creating and applying methods to improve the quality of care while lowering the costs (Skochelak et al., 2016).

Developing separate projects by leaders seek to explore new technologies to enhance efficacy and efficiency of patient care services (Skochelak et al., 2016). Likewise, health care organizations' leaders should guarantee a good patient–provider relationship to achieve the triple aim goals (Erickson et al., 2020). Health care organizational leaders should develop and communicate by customizing care services (Storkholm et al., 2019).

Patients' involvement on every phase of their care improves patient experience outcomes. Erickson et al. (2020) explained that patients must be a part of every stage of the change process. Making patients aware and knowledgeable about the change process though series of questions is important for a successful outcome (Institute for Healthcare Improvement, 2017). Likewise, providing autonomy to patients and families to control their health and handle issues will result in good patient experience outcomes (Erickson et al., 2020). Therefore, an assurance of patient–provider communication promotes high-quality care.

Quadruple aim replaces triple aim to enhance patent-provider experience. Healthcare organizations deemed triple aim initiatives unsuccessful after 19 years of existence, as the cost of care continued to rise; as a result, quadruple aim came into fruition with improving the work–life balance of health care providers as an additional element (Erickson et al., 2020). The quadruple aim helps to improve the patient–provider

experience (Haverfield et al., 2019). Nurses suffer from burnout, which affects the quality of care (Havens et al., 2018). Stress among nurses, brought on by emotional exhaustion and the requirement for professional efficacy, places a burden on their health and results in frequent absences and turnover, which decreases the quality of patient care and jeopardizes patient safety (Privitera, 2018). Therefore, with the entry of quadruple aim, the employee experience is now part of the measure in which hospital leaders need to take care of. The work-life balance approach is essential to quadruple aim.

The work-life balance approach enhances the employee-provider experience. Improving the work–life balance of hospital nurses will increase employee satisfaction and improve provider engagement (Havens et al., 2018). Causes of employee satisfaction can include quality communication and relationships among providers for excellent care coordination (Havens et al., 2018). High-quality positive relationships among health care employees promote work engagement through shared knowledge, shared goals, and mutual respect (Havens et al., 2018). Communicating with purpose has a direct link to quality, safety, and performance efficiency in patient care. Better connections between health care providers improve patients' symptoms, increase use of clinical guidelines, and minimize medical errors (Haverfield et al., 2019). Through relational coordination, hospital leadership can improve the well-being of nurses to provide care to the patients by enhancing the working environment.

Other Factors to Increase the Quality of Care and Increase Medicare Payments

Physician leadership is essential in the hospital operation. Sanford (2016) pointed out the importance of physician leadership in the hospital, noting that not all physicians

are leaders as employees may assume. Sanford explained that, to become better physician leaders, the following characteristics are necessary: (a) must have a vision and be able to motivate peers and employees, (b) must be assertive, (c) must be accountable, (d) must be well-engaged, and (e) must be nonpolitical in focus; moreover, the physician leaders must act in accordance with their ethical values instead of pleasing others. Sanford encouraged hospital leaders to use physicians as leaders of the health care facility to facilitate improvement on the quality of care by coordinating and communicating with fellow physicians on ways to improve the care of patients. Tasi et al. (2019) indicated that physician leaders in the hospital will drive better quality outcomes provided that hospital management personnel provide training and development to those physicians without any leadership experience to advance their career. Therefore, hospital leaders must train prospective physician leaders in order to advance their skills and contribute to improving patient care outcomes. Physician leaders are essential to the organization to drive success.

Physician leadership can bring positive outcomes to the healthcare organization. Geerts et al. (2020) explained that the aim of leadership development intervention is to encourage the innovative design, delivery, and evaluation of leadership development related to organizational outcomes. Geerts et al. noted that physician leadership intervention can positively influence patient outcomes and quality improvement in the health care system. However, Guevara et al. (2019) contended that physicians can demonstrate clinical skills and competence, but not in organizational leadership. Therefore, must undergo rigorous training to enhance their skills on becoming organizational leaders. Physician leaders must possess the transformational leader traits.

Leadership style is essential emerging physician leaders. Guevara et al. (2019) examined leadership style and health care provider job satisfaction. Based on the research, Guevara et al. explained that transformational leadership had the most impact on leadership and health care provider job satisfaction. Furthermore, DeRusso et al. (2020) noted physician leadership is essential to strengthen the leadership competencies of physicians to affect change. According to DeRusso et al., the initial assessment and one-on-one coaching are the most important aspects of the physician leadership program. Therefore, hospital leaders must train the prospective physician leaders to become a transformational type of a leader to improve the patient care outcomes. Communication skills is important for emerging physician leaders.

Physician leadership and communication skills are important to improve patient care outcomes. DeRusso et al. (2020) determined that physicians' communication skills and interspecialty care of patients improved outside the physician leadership program. Moreover, DeRusso et al. further explained that those physicians who do not have an executive coach were not sure how to use the skills. DeRusso et al. explained that the implementation of the physician leadership program in collaboration with organizational leaders could build a pipeline of physician leaders that can align to organizational strategies. Likewise, driving high-value patient-centered care using a health information system can enhance effective communication to improve patient care (Erickson et al., 2020). Therefore, physician leadership skills can be enhanced using sophisticated technology to improve communication in order to improve the patient care outcomes. Physician relationship with caregivers is important.

Physician rapport and partnership are important elements for improving quality of care and financial outcomes. Kralewski et al. (2015) addressed the relationships of physician practice to quality of care and costs through their practices. According to Kralewski et al., physician practices indirectly affect costs, through screening and monitoring measures, which directly affect net revenue of the hospitals. In contrast, Sowers et al. (2013) explained that physicians align themselves to hospitals due to governmental regulations that affect financial, quality, and regulatory demands. Hospital–physician integration, if done right, will positively affect quality of care at a lower cost.

Magnet Designation

The Magnet designation is essential to the hospital operations. The Magnet designation is one measure of nurses' excellent care to patients. McCaughey et al. (2020) obtained their data from 518 acute care facilities across the United States, wherein 50% were from Magnet facilities and the other 50% were from non-Magnet facilities. Sloane et al. (2018) posited that hospitals enrolled in a Magnet accreditation program promote a good working environment for employees. According to McCaughey et al., the patients treated at a Magnet hospital are more satisfied and would likely recommend the hospital. Levenberg et al. (2019) explained that the health care system created the Evidence-based Practice Center (EPC) to provide high-quality, safe, and high-value care. Levenberg et al. explained that aim of developing the EPC was to address nursing policy and practice supporting the quadruple aim and Magnet designation goals. Therefore, hospitals that have Magnet designation could have good chance of having a safer environment and

render high quality of care. Evidence-based practice supports Magnet designated hospitals.

Evidence-based practice is essential to improve quality of care. Levenberg et al. (2019) noted that the Institute of Medicine Roundtable recommended that, by 2020, evidence-based practice be 90% complete with regard to clinical decisions. Levenberg et al. conducted a study based on descriptive analysis of a hospital's EPC and 40-item electronic questionnaires for nurses who requested the EPC review. According to Levenberg et al., a dedicated EPC can empower nurses and can support the quadruple aim and Magnet designation across the health care system. Furthermore, Coelho (2020) addressed the importance of nursing certifications to improve quality outcomes in hospitals. Therefore, EPC is essential to the continuous support of the Magnet hospital to drive high quality of care. Accountable care organization (ACO) also contributes to high quality of care.

ACO guides the hospitals on improving patient care at a lower cost. Bergerum et al. (2019) posited that the program theory on the quality improvement process was behind patient involvement through an approach that determines what works, how, for whom, to what extent, and under what conditions. Bergerum et al. conducted a qualitative study on patients' active involvement in the quality improvement process, which also involves health care professionals and leaders. Diana et al. (2019) suggested using an accountable care organization composed of physicians, health care leaders, and hospital employees that provides coordinated care to patients at a lower cost. Diana et al. conducted a quantitative study that showed the effectiveness of using an accountable care

organization using the theory that better technology promotes better organizational outcomes to improve patient satisfaction. Therefore, hospital leaders must adapt the ACO guidelines to be able to improve the quality of care and increase Medicare payments.

Transition

In Section 1, I developed the business problem under the problem statement. Likewise, I elaborated the purpose statement and determined the type of case study used, the location where I conducted the study, and how my study may bring positive social change. Moreover, I developed the nature of the study and verified the specific research method and design that I used to strengthen my research. Furthermore, I explained the conceptual framework that I used to ground my research. I developed my research problem based on my problem statement and research questions to gather rich data. Also, I explained how my research might contribute to business practice and social change through the significance of the study. In Section 2, I further explain how I identified the specific role of the researcher and participants, as well as the population and samples that I used to gather rich data while adhering to ethical standards. Also, I elaborate on my data collection instruments, data organization techniques, and data analysis process for gathering and analyzing the data. Additionally, I determine the elements needed to establish the reliability and validity of my research. In Section 3, I present my findings, including any applications to business practice, implications for social change, and suggestions for future research using the qualitative method.

Section 2: The Project

The intent of this qualitative single case study was to explore hospital managers' strategies to improve the quality of care and increase Medicare payments. This section includes a restatement of the purpose statement and discussions on the role of the researcher, participants, method and design, population, and sampling. This section subsequently includes information on ethical research, data collection instruments, data collection technique, data organization technique, and data analysis. The concluding subsections include reliability and validity of the study followed by a transition and summary.

Purpose Statement

The purpose of this qualitative single case study was to explore the strategies that hospital managers used to improve the quality of care and increase Medicare payments. The targeted population comprised of hospital managers from one hospital in the state of Texas, who have developed and implemented successful strategies that improved quality of care and increased Medicare payments. The implications for positive social change include high-quality services that might lead to faster recovery and the potential to decrease mortalities and improve people's lives during hospital visits.

Role of the Researcher

In qualitative research, the researcher is the primary instrument for data collection (Clark & Vealé, 2018). Credibility is one of the most important aspects that a researcher must possess to create a valid study. Birt et al. (2016) noted that trustworthiness is the

foundation of high-quality qualitative research. For this study, I am the primary data collection instrument.

My role as a researcher was to recruit participants, collect data, code and analyze the data, and interpret the data. Likewise, I stayed focused to understand, assess, and verify the value of the participant's inputs. I recruited nurse managers to participate in an interview with open-ended question to explore the strategies on improving the quality of care.

The *Belmont Report* guides the ethical principles of a researcher by protecting, safeguarding, respecting, and avoid deceiving human subjects, and treating all participants equally (U.S. Department of Health and Human Services, 1979). To adhere to the *Belmont Report* protocol, researchers should abide by ethical standards to protect research participants (Zhou & Nunes, 2013). I abided by the *Belmont Report* protocol by adhering to the ethical standards and guidelines set forth on the protection of the participants.

My healthcare experience includes 11 years as a respiratory therapist and 11 years in management. These duties involved all aspects of ancillary support to nursing that involves the respiratory system. I avoided bias due to my history within the hospital's quality of care practices by maintaining my objective. I enrolled participants from another healthcare organization to prevent conflict of interest. Alimo (2015) posited that enrolling participants outside the organization validate the research goal. Yin (2018) posited that the researchers must have a neutral stance with limited bias on the subject

matter to promote accuracy on the data interpretation aspect. I used an interview protocol to promote accuracy while preventing bias on my study.

As I am an experienced leader in the hospital, the participants might perceive personal bias and sway the outcome according to my personal interest. To mitigate bias and avoid viewing data through a personal lens, I listened attentively, with a tactful demeanor, to make the participants feel at ease and develop rapport with the participants. Likewise, I structured the interview questions to eliminate doubt among the participants by asking fair and nonoffensive questions, with honesty and respect, to prevent the participants refusing to respond to questions. I practiced member checking to give the participants the option to review the accuracy of the interpreted data and to warrant a valid outcome. Member checking is a validation technique in exploring the credibility of data outcomes (Birt et al., 2016).

During the interview process, I adhered to the interview protocol to uniformly gather in-depth data from all the participants regarding their lived experiences (See Appendix A). Yin (2014) posited that the interview protocol is essential to address the actual research questions. Flick (2002) noted that the semistructured interview protocol is a guide that allows creativity and flexibility to researchers for gathering rich data from the participants. I used the interview protocol to keep the interview in order, while maintaining participants' confidentiality. After the interview, I used the data triangulation process to mitigate bias and accurately interpret the data for accuracy through (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal. Bans-Akutey and Tiimub (2021)

pointed out that triangulation prevents bias; likewise, Fusch et al. (2018) explained that triangulation adds depth to collected data. After I achieved data saturation, I ceased collecting new data. Fusch and Ness (2015) noted that triangulation has a direct link to data saturation; hence, failing to reach data saturation will have a negative impact on the quality and validity of the research.

Participants

The participants were six nurse managers who manage a nursing unit in the hospital in the state of Texas, who have directly implemented successful strategies on improving the quality of care and increase Medicare payments. Rahi (2017) posited the most important consideration in selecting participants in a study is that they must have the knowledge and experience of the subject matter allowing the researcher to gain insight into the phenomenon and answer the researcher's questions. Martinez-Mesa et al. (2016) noted that a study may have bias without the right representative sample. Therefore, selection of the qualified participants is crucial to minimize bias in a study.

To gain access to prospective participants, I contacted the executive director of nursing to request a roster of hospital managers who meet the participant criteria. Once the executive director of nursing provided the names of the participants that met the study criteria, I contacted each potential participant by telephone and through a follow-up email attaching the informed consent (Appendix B) to request their voluntary participation. During the conversation phase with the potential participants, I assured them that I would protect their privacy in order to develop trust. Birt et al. (2016) noted that extensive ethical attention to protect the participants prevents maleficence and promotes

beneficence. I presented myself in a calm, professional, and friendly manner to develop rapport. Moreover, to avoid any ethical issues, I provided a detailed explanation about the purpose of my research.

To establish a good working relationship with the potential participants, I asked them to select the date and time when we conduct their Zoom or other videoconferencing interview to make them comfortable in their territory and make them feel that I am a responsible individual by explaining the details of the informed consent and how the interview protocol works. Barlo et al. (2021) pointed out that responsible researchers provide a safe and trustworthy environment to participants. Likewise, I adhered to the ethical standards set forth by the rules and regulations established in the participants' organization. There was no IRB on my target organization. Moreover, I initiated a friendly and professional conversation to develop trust and rapport, and I remained transparent and honest throughout the conversation to maintain mutual trust.

Research Method and Design

Successful completion of my study relied on the research method and design. My research method was qualitative, and my research design was a case study. Using the qualitative method and case study design, I explored the phenomenon of my overarching research question on the hospital managers' strategies to improve the hospital's quality of care and increase Medicare payments.

Research Method

In a qualitative study, a researcher explores the research data using open-ended questions (Morgan, 2018). Also, in a qualitative study, a researcher can develop an

enhanced way of thinking through inquiry, by means of data collection, that helps reveal assumptions and generates interesting claims (Huffman & Tracy, 2018). I chose the qualitative methodology as the appropriate choice for exploring the phenomenon of hospital managers' strategies on improving quality of care through asking open-ended questions to gather rich data.

In a quantitative study, researchers use statistical analysis on numerical existing data, surveys, or experiments using statistical analysis (Morgan, 2018). Quantitative researchers generalize data through measurement and analysis of statistical significance (Slevitch, 2011). For this study, data was non-numeric and came from interview transcripts and other documents. The emphasis was on understanding a phenomenon, rather than predicting or explaining.

A mixed-method study is necessary when researchers use a combination of qualitative and quantitative methods (Guetterman & Fetters, 2018). The focus of my research was exploring the phenomenon of the business by asking open-ended questions to elicit response from the participants. I did not use the quantitative method; therefore, a mixed-method study was not pertinent.

Research Design

I considered a case study, a narrative, and an ethnography for my research design. I chose the case study as my preferred qualitative design because I sought to explore the scope of my data collection within a small group to gain in-depth information on the actual experiences of the participants. Yin (2018) explained that, in a case study design, researchers bound the case to determine the scope of the data collection. Likewise, in a

case study, the participants are the immediate topic of the research (Yin, 2018). Moreover, Yin explained that a single case study entails an explanatory approach and hence is suitable for portraying a real-life scenario. Bans-Akutey and Tiimub (2021) confirmed that case study gathered data from multiple sources, hence, fortifying the validity of the research results. Rooshenas et al. (2019) explained that triangulation means that the researcher is using multiple methods on gathering data during a research. Therefore, Yin (2018) confirmed that data triangulation derived from observation, interviews, and reviewing historical data enhances the validity of the case study findings through the convergence of information from different sources. Surangi (2022) elucidated that a narrative is about storytelling the lives of an individual. Narrative is not my optimal choice as I am not studying the lives of a person. Conn et al. (2019) noted that ethnography is about the actions, behaviors, and language shaped by a company's culture. Ethnography was not my optimal choice as I sought to explore employees' actions, behaviors, and culture.

Population and Sampling

Martinez-Mesa et al. (2016) explained that the population must fit with the intended goal of the research. I gathered rich data through a single hospital to obtain insights on improving the quality of care and increase Medicare payments. The population was nurse managers who managed a nursing unit in the hospital in the state of Texas, who directly implemented successful strategies on improving the quality of care and increase Medicare payments. Guest et al. (2020) posited that the optimal number of participants in the research relies on the analytic level of the researchers. Rahi (2017)

pointed out that population criteria are essential to warrant that the participants have dealt with the phenomenon and can answer the research questions. The population was capable of providing in-depth, nonbiased data regarding the quality of care in the hospital and dependent on bounding of my study in order to reach data saturation. Fusch et al. (2018) pointed out that the depth of the data is paramount to reaching data saturation. To assess data saturation, researchers ensure that no new information is generated and similar responses are coming from the participants (Fusch & Ness, 2015).

Palinkas et al. (2015) posited that a small sample size is applicable for qualitative research. Marshall and Rossman (2016) argued that small sample size can gain understanding of the phenomenon. I conducted interviews with the participants through Zoom or other videoconferencing formats in order to make them feel comfortable to provide in-depth information to me. Fusch and Ness (2015) posited that data saturation is attained when researcher can no longer gather new information from participants. Marshall and Rossman corroborated that data saturation is achieved through the composition of sample size and not the size of the sample. Moreover, Emmel (2015) pointed out that the range five to fifty sample participants can achieve data saturation on qualitative research. Likewise, data saturation occurs when no new themes are evident during the data analysis process (Guest et al., 2020). I also reviewed relevant hospital documents. I continued conducting semistructured interviews until there was no new information gathered to warrant data saturation. The nurse managers at this hospital had a history of continuously excelling in their work according to the hospital's quality parameters for the past 2 years. Fusch and Ness (2015) elucidated that quality and

quantity of information supersede the number of participants. I used the purposeful sampling method to gather rich data. I also considered convenience, quota, and snowball sampling as methods of choice. Martinez-Mesa et al. (2016) described purposeful sampling as the method used to explore in-depth information about a phenomenon from an expert in a particular field.

The purposeful sample is the sample that researchers acquire due to their knowledge and expertise of the participants involved in qualitative research (Campbell et al., 2020). Convenience sampling involves relying on participants who are readily available (Stratton, 2021); thus, convenience sampling was not my optimal choice as such individuals might not be the persons with the right credential that I intend to interview. Quota sampling involves selecting a population based on gender, age, and other criteria to achieve a quota (Martinez-Mesa et al., 2016); thus, quota sampling was not my optimal choice. Snowball sampling involves picking an initial group of participants and then consequently picking additional participants based on similar characteristics (Martinez-Mesa et al., 2016); thus, snowball sampling was not my optimal choice.

Ethical Research

The informed consent process details the explanation to all participants regarding the importance of the research, the benefits to the organization, the process of conducting the research, and the voluntary aspect of the research (Honig et al., 2014). Consent forms provides safeguarding the rights of the participants during the interview process (Ibbett & Brittain, 2020). I sent consent forms to all participants' email and requested responses via

email. I provided potential participants the opportunity to ask questions or raise any concerns through email of phone call prior to giving their permission.

Ibbett and Brittain (2020) posited that to be compliant with the informed-consent protocol, approval of the participants must the obtained. Likewise, Honig et al. (2014) added that the researchers must address the participants that they can withdraw their participation at any time without penalty. (Honig et al., 2014). I notified all participants and, placed on the informed consent form, of their ability to withdraw their participation at any time. Participation in this research study was strictly voluntary. There was no compensation for participation.

As a researcher, my duty was to practice transparency and honesty with the participants to gain trust. I initiated respectful gestures before the study; at the beginning of the study; during the data collection process; during data analysis, and while reporting, sharing, and storing the data. Before conducting the study, I obtained approval from the Walden University Institutional Review Board (IRB). Seiber (1998) explained that the IRB holds researchers responsible for assessing the participants' risks and protecting them from harm. I made sure that I understood the Belmont protocol to avoid increasing risk to the participants. The areas of ethical concerns in a research study involving human subjects are (a) justice, which involves fairness to the participants, (b) autonomy, which involves freewill to the participants to participate on the research, and (c) beneficence, which involves protecting the participants against harm (U.S. Department of Health and Human Services, 1979). Honig et al. (2014) confirmed under the *Belmont Report* that ethical protection provision to participants can be achieved by employing three primary

ethics principles. I observed *Belmont Report* principles to ensure the ethical protection of study participants. Bias is a significant risk that can distort study results or outcomes (Popovic & Huecker, 2021). Making a conscious effort can aid in eschew biasing the participants (Popovic & Huecker, 2021). Excluding individual beliefs and opinions based on experience could aid in mitigating bias (Yin, 2018). I withheld my personal beliefs and opinions acquired from working in a hospital business office and evaluate the interview questions with a neutral third party that does not have a stake in the research study to ensure no bias.

I made sure to abide by the Health Insurance Portability and Accountability Act (HIPAA). The act is a federal law that protects the confidentiality of patient information (Burns et al., 2020). At the beginning of the study, I informed the participants about the purpose of the research and ask the participants to sign a consent form to develop mutual understanding prior to the interview. I informed all the participants that they could withdraw from the interview process at any time without penalty if they do so. During the data collection process, I established rapport with and respect the culture of the participants to gain trust to gather in-depth data. I used pseudonyms by assigning alphanumeric identities such as P1, P2, etc., to the participants to help ensure confidentiality. Zhou and Nunes (2013) pointed out that using pseudonyms to distinguish participants, as well as the affiliated organization, during research helps to maintain confidentiality.

During the data analysis process, I practiced fairness by not taking sides or disclosing what the participants discuss to strengthen the validity of the study. I respected

the participants' privacy by protecting the identity of the participants, especially during the recording and coding processes. Birt et al. (2016) elucidated that authenticity on the part of the researcher promotes high-quality research. During the reporting, sharing, and storing phase of the research, I followed protocol and use pseudonyms to enhance the final write-up of my study while protecting the confidentiality of participants. Fusch et al. (2017) pointed out that academic integrity can improve the reputation of both researchers and authors. I kept all the raw data, including all other materials collected, in a safe deposit box for 5 years to protect from disclosure. I transferred the electronic data to a physical hard drive and stored them with physical data in the safe deposit box. Furthermore, I will destroy all the data in secured storage after 5 years. Seiber (1998) recommended storing raw data for 5 to 10 years.

Data Collection Instruments

The researcher is the primary data collection instrument in a qualitative study (Yin, 2014). The researcher serves as the medium on the flow of data derived from different sources. As I was the sole researcher of this qualitative study, I was the primary data collection instrument. As the researcher, I conducted the data collection in an orderly manner through: (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal. A semistructured interview is a process wherein an interviewer uses open-ended questions based on the focus of the research to elicit responses from the participants to gather detailed information (DiCicco-Bloom & Crabtree, 2006). I gathered the information by exploring the phenomenon through face-to-face semistructured interviews. I used open-ended

questions to gather in-depth information from the participants. I asked probing questions in addition to the scripted questions to gather rich data based on verbal and nonverbal responses through the interview protocol (see Appendix). Probing questions are essential for aligning an interview based on the research question (Fusch et al., 2018). Observation is the explicit articulation of research based on findings from nonverbal actions (Gephart, 2004). Birt et al. (2016) noted that member checking is a method through which researchers share their interpretation of the participants' interview responses to mitigate bias and hence ensure the credibility and consistency of the interpreted data. I used member checking to enhance the reliability and validity of the collected data. Reviewing company-related documents is another important data collection technique used support the findings from semistructured interviews. Yin (2018) noted that reviewing archival documents is another tool for data analysis. Yin further explained that archival documents exist in the form of public files, organizational records, or survey data, which researcher can use with other sources of data. However, Yin warned that the origin of data might taint the accuracy of the research outcomes.

I used a reflective journal to add depth to the collected data by describing my feelings and interpretations during the research. A reflective journal contains a researcher's personal notes in the field based on experiences to reflect on personal bias that could affect the outcome of research (Sangasubana, 2011). I used the data collection instruments to gather in-depth data, which could result in attaining data saturation. Researchers reach data saturation if the same information repeatedly appears, and no new data emerge during the interview process (Fusch & Ness, 2015).

Data Collection Technique

After obtaining IRB approval from Walden University, I began the data collection process. I contacted the hospital's executive nursing director to obtain the lists of prospective participants who met the eligibility criteria. Once obtained, I contacted the participants, through phone and email, to confirm their willingness to participate on the data collection process. I sent the consent form, by email, to the prospective participants to assure their willingness to participate in the study. Once I received the signed consent forms from the participants, I began the data collection process by conducting interviews through Zoom and other videoconferencing formats with the participants at a date and time of their choice to make them feel comfortable.

I gathered data in an orderly manner through: (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal to achieve data saturation. I explored the strategies that hospital managers have used to improve quality of care using the qualitative method to collect data through semistructured interviews with follow-up member checking. I used the interview protocol (see Appendix) to conduct face-to-face semistructured interviews using open-ended questions to gain in-depth knowledge from the participants. Moreover, I asked probing questions during the interview process to gain rich data.

I offered the participants the option to partake in interviews through Zoom or other videoconferencing formats so I could record the participants, with permission, in both video and audio modes during the interview. Gathering in-depth data is essential to reach data saturation (Fusch et al., 2018). The advantage of having an excellent data

collection technique is that the researcher can gather rich data provided that all the data collection instruments are in place and depending on the way the researcher asks the questions to gather in-depth responses from the participants. Bans-Akutey and Tiimub (2021) noted that researchers must have the interviewing skills necessary to elicit useful data. The disadvantage of the data collection technique is when a participant refuses to answer questions and becomes uncooperative during the interview process, the researcher will need to find a replacement participant, which results in a loss of valuable time and money. I observed the participants' nonverbal behavior through their body language, in accordance with the interview protocol (see Appendix), during the semistructured interview process, as Gephart (2004) noted that an observation is the explicit articulation of research based on findings from nonverbal actions.

I also reviewed the organizational documents pertaining to the quality metrics, the Hospital Consumer Assessment of Healthcare Providers and Systems and CMS data, to fortify the validity of my research. The Hospital Consumer Assessment of Healthcare Providers and Systems is a standardized survey for patients to measure the quality of care in hospitals regarding their experience on a recent stay in the hospital (CMS, 2020). I recorded my experiences in a reflective journal to add depth to the collected data by describing my feelings and interpretations during the research. Sangasubana (2011) noted that a reflective journal is the personal reflection of a researcher's feelings toward the research, which adds depth to the data gathered. I used member-checking by giving the participants the opportunity to review and modify their responses at the conclusion of each interview. Yin (2018) posited that member-checking consists of follow-up

discussions which fortify the reliability and validity of the study. Therefore, I asked open-ended questions (Appendix A), member-checking, and data triangulation to warrant the reliability and validity of the study.

Data Organization Technique

Data organization is essential for streamlining the data analysis process (Yin, 2014) and for enhancing the overall picture of the in-depth knowledge gathered through company documents, and (c) a reflective journal, in order to effectively explore the phenomenon under study, which is the strategies to improve a hospital's quality of care. I gathered all the validated data from member checking and then organized the data in chronological order to determine the timeline of every encounter with the participants. I sorted out the collected data gathered from the data collection instruments by properly labeling all the data files, which will include digital files, to have a clear and organized file system.

Data triangulation refers to using multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (Bans-Akutey & Tiimub, 2021). Triangulation is viewed as a qualitative research strategy to assure validity through the convergence of information from different sources (Yin, 2018). Yin (2018) posited that member checking and triangulation fortify the validity and reliability of the case study.

The sorted data was used to identify concepts and ideas. I logged all the data in the NVivo to help develop common themes through repetitive words or short phrases based on the information collected. I also coded the validated data using NVivo and

mind-mapping software to verify the achievement of data saturation, which determines the end of the data collection process. Hoover and Koerber (2011) noted that NVivo software can import internal and external sources to identify snippets of information.

The consistency of the data gathered from different methods signifies credible outcomes (Bans-Akutey & Tiimub, 2021). Researchers have reached data saturation when the same information repeatedly appears, and no new data are available during the coding process (Fusch & Ness, 2015). Fusch et al. (2018) noted that triangulation led to in-depth data; hence, proper organization is necessary to prevent valuable information from getting lost during filing, which would prevent data saturation. Fusch and Ness (2015) reported that a direct relationship exists between rich data and data saturation.

I secured all the data, both hard copy and electronic, by transferring the data onto a hard drive and will store the hard drive in a safe deposit box for 5 years. A reasonable amount of time to store interpreted data is between 5 and 10 years (Seiber, 1998). I intend to destroy the data by burning physical files and deleting electronic files after storing them for 5 years. Storing, securing, and destroying the data is essential to mitigate corruption from other researchers (Saunders et al., 2016).

Data Analysis

Data analysis is critical for presenting high-quality research in a qualitative study (Green et al., 2007). Data analysis involves gathering data from people and documents and interpreting those data into valid outcomes (Merriam, 1998). Bans-Akutey and Tiimub (2021) pointed out that data triangulation is a process that involves using different data sources based on one design that adds depth to the collected data to achieve

data saturation. I used data triangulation in my single case study to compile the data gathered from different sources: (a) semistructured interviews with follow-up member checking, (b) related company documents, and (c) a reflective journal. To assure that my interpretation was correct, I used the member checking process by transcribing the responses from the interview questions and send to the study participants. The consistency of the data gathered from different methods signifies credible outcomes (Bans-Akutey & Tiimub, 2021).

The data analysis process is one of the most intricate components of qualitative research (Thorne, 2000). Researchers should conduct systematic data analysis and provide a logical and sequential narrative of the analysis process (Nowell et al., 2017). I used Yin's (2018) 5-step data analysis model consisting of (a) compiling, (b) disassembling, (c), reassembling, (d) interpreting, and I concluding to analyze the data I collect. During the data analysis, I assessed how the qualitative data fit within the conceptual frameworks for this study.

Compiling

The first step of Yin's data analysis model is to compile the collected data into to format to find meaningful answers to the research question (Yin, 2018). A critical aspect of the compiling step is for a researcher to become familiar with the collected data through repetitive review. I compiled the collected data from the interview process and the provided company documents using Microsoft Word. I reviewed the transcribed

interview files and documents collected. Once I completed compiling the data, I disassembled the data.

Disassembling

Researchers disassemble the compiled data to choose the necessary data for the study (Wulansari, 2019). Disassembling consists of separating and creating specific groupings such as themes, concepts, or ideas through the coding process (Castleberry & Nolen, 2018). Belotto (2018) stated that coding allows researchers the ability to interpret large segments of text data to assess the meaning and identify common themes. I reviewed the compiled data to identify common themes, phrases, or similarities in the data. I disassembled the data into fragments and labels based on similar wording and sentences that convey a similar meaning, which I then coded and reassemble.

Reassembling

Reassembling consists of grouping codes with each other to create themes, which may represent a patterned response or meaning within the collected data (Castleberry & Nolen, 2018). After disassembling the data into fragments, I reassembled the data by clustering similar codes to categorize the data into higher-order themes using thematic hierarchies. After I organized the gathered data into clusters of statements with similar meanings, I coded the repetitive words or short phrases based on the collected information. I created hierarchical themes through the lens of the performance improvement model.

I used NVivo computer-aided qualitative data analysis software (CAQDAS) to organize the data and assist in identifying patterns of codes. Hoover and Koerber (2011)

pointed out that researchers use NVivo software to identify snippets of ideas and to create codes to analyze data. I input the textual data into the computer tool NVivo to assure the development of emerging patterns to determine the frequency of codes. Auerbach and Silverstein (2003) posited that using computer-assisted tools makes coding easier. I placed the coded information into different arrays, tabulated the frequency based on events, and sorted the information in chronological order to analyze the coded data. Likewise, I also used mind mapping during theme identification. Mind mapping involves analyzing qualitative data through a graphical depiction and detection of potential bias (Tattersall et al., 2007). I linked the coded concepts and ideas from NVivo and mind mapping to understand the influence between the coded data.

Interpreting

After reassembling the data into patterns and themes, I continued to interpret the data. The interpretation aspect of qualitative research is about the knowledge learned from the research (Lincoln & Guba, 1985). Researchers interpret the codes and develop themes to address the research question (Castleberry & Nolen, 2018). Castleberry and Nolen (2018) cautioned researchers from simply restating codes or themes as interpretations and suggested identifying and aligning the interpretations with the overarching research question. I reviewed all the identified codes and themes and discuss the relationships between the themes by ensuring the interpretations align with the research question and the intent of the study, which were strategies to improve a hospital's quality of care and increase Medicare payments. I compared all relevant topics from the interviews and other relevant information from the hospital. The data analysis

results provided successful strategies that hospital leaders use to improve the quality of care and increase Medicare payments.

Concluding

After the interpreting step, researchers represent their findings and conclusions using the concluding step (Yin, 2018). Conclusions are the final summation of the findings in response to the overarching research question (Castleberry & Nolen, 2018). After interpreting the data, I summarized the interpretation of the findings with the lens of the conceptual framework and overarching research question, and determine what aspects or trends are prominent in the data according to the participants' inputs.

Reliability and Validity

Reliability and validity are the important components of a research study. Reliability instills consistency, while validity portrays accuracy toward the research. In quantitative studies, reliability is consistency in measurement and validity is measuring what is intended to be measured (Morgan, 2018). Bans-Akutey and Tiimub (2021) noted that trustworthiness, authenticity, and credibility equate to the quality and rigor in qualitative research.

Reliability

Reliability refers to the consistent approach of a researcher toward a study (Bans-Akutey & Tiimub, 2021). I sent an informed consent form to all participants to address my intention in the data-gathering process. I used consistency in my data-gathering process by using the interview protocol across all participants to gather in-depth information. Furthermore, I used a recorder to record all the participants during the

semistructured interviews to create consistency for data transcription. Consistently applying (a) the semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal to gather rich data could lead to data saturation. Failing to reach data saturation impacts the validity of research (Fusch & Ness, 2015). The dependability of qualitative research relies on the quality of the aggregated data collected through verification of data saturation and coding-recoding of data through data analysis. Lincoln and Guba (1985) emphasized that the essence of dependability is consistency.

Validity

The credibility of a study is dependent on the rigors of a researcher's approach toward the study. Validity is the stronghold of the research based on the standpoint of the researcher, participants, and audiences (Bans-Akutey & Tiimub, 2021). To ensure the validity of the study, I focused on credibility, confirmability, and transferability.

Credibility

Credibility will rely on an accurate account of the participants based on: (a) the semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal. I used member checking by returning my interpretation of the data to the participants to verify its accuracy. Member checking entails verifying the accuracy of the researcher's account of the participants' experiences (Birt et al., 2016). I intend to triangulate the data from different sources to fortify the validity of my study. Moreover, I strengthened the credibility aspect of my study by

discussing contradictory information contained in the context of my research to produce a realistic work.

Confirmability

Confirmability refers to the neutrality of the information gathered (Tobin & Begley, 2004). I enhanced confirmability by using methodological triangulation to gain in-depth data to achieve data saturation. I used data triangulation through: (a) semistructured interviews with follow-up member checking, (b) a review of related company documents, and (c) a reflective journal. Probing aligns an interview with the research question (Fusch et al., 2018). I used member checking to fortify my research by validating my interpretation of the data from the participants' accounts on the semistructured interviews. I further assured confirmability by making sure that the findings of my research came from the data collected and that I did not skew the data, hence mitigating research bias.

Transferability

Marshall and Rossman (2016) posited that transferability refers to the capability of other researchers to use the existing findings by applying to another research study. Leininger (1994) noted that transferability preserves the meaning of the study whether the findings are transferable or not. To transfer the research findings to other researchers, I provided a detailed description of the context by specifying the assumptions, samples, and demographics explored, as well as the boundaries of the study through applying the same methods through different locations, populations, and participants with different experiences. Yin (2018) noted that researchers can satisfy transferability by reaching data

saturation. Inability to reach data saturation affects the validity of research (Fusch & Ness, 2015). Researchers achieve data saturations when they can find no new data, and other researchers can replicate the research (Fusch & Ness, 2015). Therefore, attaining data saturation is an essential guide to the audience on deciding about the transferability of the study outcomes.

Transition and Summary

In Section 2, I restated the purpose statement to establish my single case study. Likewise, I elaborated the rationale of using the research method and design chosen to fortify my study. Moreover, I explained the specific role of the researcher and participants, and I identified the population and samples that I can gather data from, while emphasizing the importance of ethical considerations. Also, I established my data collection instruments, my data organization techniques, and data analysis process. Furthermore, I determined the important elements under the reliability and validity subsections to enhance my study. In Section 3, I present my findings, applications to business practice, implications for social change, and suggestions for future research using the qualitative method.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative single case study was to explore strategies that hospital managers use to improve quality of care and increase Medicare payments. The targeted population was hospital managers from one hospital in the state of Texas, who developed and implemented successful strategies that improved quality of care and increased Medicare payments. The mission and vision of this organization is to prevent harm and improve the overall health of the patients, hence, preventing morbidity and mortality to occur. The leaders must uphold the hospital culture in order for the hospital missions' to achieved.

According to all participants, education and training are essential to improving the quality of patient care. Nurses must be oriented and empowered to implement all established protocols and workflows, based on evidence-based practice, to provide safe patient care. Moreover, with the aid of highly reliable equipment, quality of care outcomes will be better as healthcare interventions will be much quicker. The flow of information is important to be able to relay to the healthcare provider to execute the plan of care to the patients to improve their conditions. Technology played a huge role on monitoring and measuring the quality of care outcomes. Likewise, technology played a huge role on creating action plans to any gaps on the processes.

Presentation of the Findings

The intent of this qualitative single case study was to answer the central research question: What strategies do hospital managers use to improve quality of care and

increase Medicare payments in hospital? To answer this question, I conducted virtual interviews through Webex, to comply with COVID-19 pandemic regulations, with six nurse leaders, in single acute care hospital X, located in Houston, Texas. I reviewed relevant current and archival data pertaining to quality of care from Hospital X. Hospital X is a midsized acute care hospital with 423 licensed beds and 1,271 employees. Hospital X is a certified Level 2 Trauma and Level 3 NICU in the United States. Furthermore, Hospital X has comprehensive cardiovascular services and customized treatment for stroke and other neurological services. Hospital X received excellent bariatric surgery and provides minimally invasive robotic and comprehensive surgical services. In 2021, Hospital X had 14,783 inpatient admissions, 2,898 outpatient surgeries, and 56,758 emergency room visits. Hospital X is considered a high-performing hospital, as they mostly exceeded the value-based requirements according to the CMS data collected. Hospital X is a part of a larger health care system in the United States.

During my participants recruitment, seven nurse leaders were invited to participate in the study. The criteria for selecting participants included nurse leaders who worked in the nursing units that involved in improving the quality of care and increase Medicare payments. Out the seven nurse leaders who received invitations to participate, six agreed to participate. All six participants worked in the acute care nursing units in the hospital as department nurse leaders. I achieved data saturation as no new theme emerged (see Fusch & Ness, 2015).

I conducted and recorded all interviews through virtual electronic communication platforms Webex. The six participants responded to nine open-ended interview questions

listed in an interview protocol (see Appendix). Interviews lasted about 40 minutes. Throughout the interviews, each participant shared lived experiences and perspectives based on their roles within the acute care settings regarding the strategies to improve the quality of care and increase Medicare payments. I used pseudo names for the participants, such as Participant 1 (P1), Participant 2 (P2), and so forth.

I thanked all the participants for their support to the study after each interview. I transcribed the recorded interviews and e-mailed the transcripts to the participants to verify for accuracy. Thereafter, I conducted member-checking interviews using a virtual electronic communication platform Webex. As part of member-checking process, I provided the participant with the interpretation based on their interview responses to the open-ended questions. Likewise, the member-checking process provided an opportunity to explore additional information, which can aid to achieve data saturation.

I used data triangulation on my case study research. I used one-on-one interview with member-checking and archival data acquired from the organization. I integrated the data I collected throughout the virtual interviews by reviewing hospital proprietary documents, hospital's website, and CMS reports. I followed Yin's (2018) five-step process after the data collection process. Yin's process involved: (a) compiling, (b) disassembling, (c) reassembling, (d) interpreting, and (e) concluding the analyzed data. I transferred all interview data into Microsoft Word where I manually coding and analyzing the data to identify key themes. I coded the data, interpret, and developed theme with the aid of NVivo12 qualitative analysis software.

Five themes emerged from the data: (a) leaders shaped the organizational culture, (b) leaders empowered staff through evidence-based workflows to mitigate potential issues, (c) leaders provide appropriate resources to improve patient care outcomes, (d) leaders' proactive engagement motivate employees to improve patient care, and (e) leaders used innovative tools to measure and monitor quality of care outcomes, as demonstrated from Table 1. Each of the five themes validated common themes from the literature review and the documents reviewed for this study. The documents I reviewed were derived from hospital X's website, archive, and CMS reports on hospital performance in relation to quality of care.

Table 1

Coding of Participants' Responses Related to Themes

Themes	Participants[a]	Responses[b]
1. Leaders shaped the organizational culture	6	9
2. Leaders empowered staff through evidence-based workflows to mitigate potential issues	6	9
3. Leaders provide appropriate resources to improve patient care outcomes	6	9
4. Leaders' proactive engagement motivate employees to improve patient care.	6	9
5. Leaders' use of innovative tools to to measure and monitor quality of care outcomes	6	9
Total	30	45

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

Several participants' responses reinforced Fusch and Gillespie's (2012) performance improvement model, which suggests that culture and process workflows derived from evidence-based practice improved the quality of care and increase Medicare

payments. All participants added that education, training, and onboarding of employees are essential to provide safe patient care and increase patient satisfaction. Al. participants reinforced proactive education and training to all the staff, especially the contract and floaters, who are not familiar with their workflows. To fulfill continuous process improvement, leaders must motivate employees through constant engagement, making them feel valued, hence developing trust and rapport. All participants suggested that employees who understand their responsibilities, who feel valued, tend to commit to the change and apply themselves to improve the quality of care and increase Medicare payments. Those employees can serve as representatives when speaking with peers, and other stakeholders. All participants explained that they used technological tools to monitor and track the progress of their process improvement plan, thereby, can make necessary changes to the parts that failed. All participants reinforced change by delivering consistent messages to employees about how to view the upcoming changes to the hospital culture and practicing hospital-guided workflows.

Theme 1: Leaders Shaped the Organizational Culture

Hospital leaders shaped the hospital culture. Leaders shaped the hospital through its mission, vision, and policies, culture of safety, and teamwork and collaboration among different disciplines of healthcare. Table 2 is a display of the subthemes of theme one and percentage of use by participants. The mission and vision of the hospital is to avoid harm and improve the patients' health. All participants declared that they adhered to mission and vision of the hospital to mitigate mortality and promote healing.

Table 2

Subthemes of Theme 1

Subthemes	Percentage of use by participants
Adhering to mission, vision, and policies of the hospital	100%
Culture of safety	100%
Teamwork and collaboration among different disciplines of healthcare	100%

All participants noted that their goals were to decrease the risk of harm to the patients. P1 and P2 explained that the mission is to improve human life and not cause harm to the patients. P3 pointed out that she lived on the mission and vision to decrease harm to the patients. P4 added that the mission is to mitigate mortality and decrease the length of patient stay. P5 further explained that the mission is keeping on focus, by improving care and life. Likewise, all participants elucidated that the development and enhancement of policies and procedures helped the nurses gained knowledge on the extent of their roles on providing care to the patients.

Leaders hold staff development through live and online education and training, staff meetings, committees and council meetings. All participants elucidated that they have an education coordinator that conducts education and training to the employees. The education coordinator monitors and track the education progress of all clinical nurses to make that they satisfy the hospital standard. P1 explained that he empowered his staff to initiate protocols provided that his staff knew the reasons behind it. P3, P4, and P6 pointed out that she empowered her staff once information, expectations, and education

are provided to her staff. P5 noted that she gave autonomy to her staff "as long as she's been kept in the loop." Also, all participants participated on Zero-harm, Infection Control, and CSIP meetings, which were created to discuss mitigation of harm and celebrate good catches. Additionally, all participants discussed that they participated on daily safety huddle to acquire information on daily hospital operations by giving report and feedback to the hospital operations. Likewise, all participants explained that promotion of healing is another aspect of their organizational culture of safety. Patients that experience good patient care outcomes resulted in increased patient satisfaction, which can increase Medicare reimbursement.

P6 explained that the hospital culture of safety, with all the measures and initiatives in place, is important to make sure we are guided on meeting the Medicare criteria and preventing harm to the patient. All participants empowered their personnel to coordinates with infection control practitioners to monitor hand hygiene compliance. All participants pointed out that one of their hospital measures to stop the spread of hospital acquired infections (HAIs) is handwashing, which became part of the hospital culture to keep the patient safe from infection transmission. All participants empowered their personnel to coordinates with infection control practitioners to monitor hand hygiene compliance. P1 explained that he "empowered his staff to initiate protocols provided that his staff knew the reasons behind it." P6 pointed out that they empowered their staff once information, expectations, and education are provided to her staff. P5 noted that she gave autonomy to her staff "as long as she's been kept in the loop." Also, all participants participated on Zero-harm, Infection Control, and CSIP meetings, which were created to

discuss mitigation of harm and celebrate good catches. Additionally, all participants discussed that they participated on daily safety huddle to acquire information on daily hospital operations by giving report and feedback to the hospital operations. Likewise, all participants explained that promotion of healing is another aspect of their organizational culture.

All participants explained that they do leader rounding and promote hourly rounding their staff to monitor their condition. Patients that experience good patient care outcomes resulted in increased patient satisfaction, which can increase Medicare reimbursement. P2, P3, P4, P5, and P6 initiated personal connection with their patients and their families to rapport to improve patient satisfaction score. Likewise, other department leaders conduct patient rounding to determine patients' needs or issues that arise. All participants discussed that patient experience is one of their top priorities. All participants used hourly rounding and nurse leader rounding to provide the best patient clinical experience. Leadership rounding is a structured activity, whereby executive, nurse, and department leaders intentionally and purposefully engage with staff (and patients) to collect firsthand, actionable insights (Wickersham et al., 2020). This is an important and effective strategy for cultivating and improving employee engagement. Moreover, all participants elucidated that another aspect of their hospital culture is teamwork and collaboration among healthcare employees, which contributed to improve patient care outcomes. Leaders conducted multidisciplinary and staff huddles to discuss patient condition and find best practices to improve patient care outcomes.

Leaders promote teamwork and collaboration among different disciplines of healthcare. P1 and P4 explained that they do multidisciplinary meetings, among all disciplines of care, on all their critical patients to improve critical care outcomes. P4 further explained that do daily multidisciplinary meeting with the trauma personnel to discuss additional interventions to improve trauma patients' care outcomes. P2, P3, P5, and P6 conduct shift huddle and line huddle, which involves other discipline of care to improve patient care outcomes. All participants further explained that the hospital is in the process of being a Magnet hospital, which will provide positive impact to the culture of the organization when it comes to quality improvement process.

All participants are involved on developing the magnet standards in the hospital to further improve the quality of care. P6 explained that "due to the hospital's demographics, which served wide areas, magnet status is needed to attract more physicians and nurses, to serve a bigger population." However, all leaders explained that hardwiring the culture to the contract employees and floaters is a challenge. All participants explained that contract employees, even the full-time employees, don't regularly check their emails, hence, creating a gap to the communication, which failed to address the intended message. P1 and P2 argued the need to standardize the hardwiring of the process to be able to absorbed by the intended recipient.

The findings of this research support the peer-reviewed sources in the literature review. Kogan et al. (2017) pointed out that the leaders of successful organizations define their organizations' mission, vision, and policies to ensure a successful organizational outcome. Managing value-based purchasing influences other facets of a hospital, such as

the systems, structures, and culture among employees (Lee et al., 2020). Leaders of health care organizations should attain the level of desired quality through the appropriate change process (Fokkema, 2016). Sustainability relies on economic stability and hitting the benchmark based on specific targets, and hence decision makers can use it to make informed decisions on a project (El-Halwagi, 2017). The provision of health care depends on the continuous loyalty and commitment of customers to improve financial outcomes (Afridi et al., 2020). A Magnet designation signifies that a facility is a distinguished hospital that meets the criteria for providing a high quality of care to patients in accordance with the Magnet status guidelines (Levenberg et al., 2019).

The findings revealed a culture of safety, which aligns with the literature review sources. Proactive prevention, surveillance, and interventions are essential to prevent the spread of HAIs (Aljamali & Al Najim, 2020). Chatfield et al. (2017) posited that handwashing is the most basic form of preventing the spread of infections in hospitals and that noncompliance may lead to the spread of HAIs. Additionally, CHG bathing can save a hospital $1.56 million per year based on a 93-bed intensive care unit (Musuuza et al., 2019).

The findings on culture of teamwork and collaboration among healthcare clinicians also aligns with literature reviewed sources. Teamwork and collaboration among employees foster positive outcomes to hospitals (Kang et al., 2020). The adoption of interdisciplinary rounding to patient care units has improved patient safety and engagement (Wickersham et al., 2020). Likewise, Wickersham et al. (2020) explained that interdisciplinary rounding has also improved communication and patient care.

Furthermore, the multidisciplinary approach enhances collaboration among health care teams to improve patient care (Urisman et al., 2018). Reliable information can produce patient trust that can lead to increased patient satisfaction (Shahid & Thomas, 2018).

Theme 2: Leaders Empowered Staff Through Evidence-Based Workflows to Mitigate Potential Issues

The hospital leaders have unified protocols and workflows based on evidence-based practice, which guide effective nursing practice. In healthcare, workflow is a process consisting of a series of tasks that must be completed to achieve a particular goal. Table 3 is a display of the subthemes of theme two and percentage of use by participants. All participants elaborated that they used standardized workflows and protocols in accordance with the evidence-based practice, by empowering their nurses to provide excellent care to the patients, in accordance to their clinical conditions.

Table 3

Subthemes of Theme 2

Subthemes	Percentage of use by participants
Protocols and bundles implementation based	100%
Proactive rounding with the patient and staff	100%
Validation of process outcomes	100%

All participants stated that the formation of nurse practice council helped improve the workflows and protocol development through inputs from staff nurses. Hospital X uses HAI bundle, in collaboration with infection control practitioners, to standardize their process on CLABSI and CAUTI management. Example, they used CHG wipes and

Biopatch for their intravenous line management. Auditing compliance to workflow usage is essential to prevent lapses of care. All participants claimed that auditing is important to prevent low compliance to occur. All participants claimed that they need to know all the lapses that were happening in their units to be able to fix on a timely manner.

P1 explained that workflow is important so that nurses know "the why behind it," and "once they figured this out, everything was fine." Moreover, all leaders explained that they have specific workflows on nurse leader rounding and hourly rounding to be able to improve patient safety and satisfaction in their units. All issues that discovered will be promptly escalated and discussed in their intended groups, committees, or councils. Example is nurse leaders rounding to inspect the intravenous lines, urinary catheters, and room cleanliness to mitigate nosocomial infection.

The findings of this research support the peer-reviewed sources in the literature review. Nambiar et al. (2017) explained that investing in hospitals without continuous workflow improvement is useless. Health care leaders lead the initiatives of hospital workflows and structures (LaPointe, 2016). Improving quality of care requires a planned workflow that involves a multidisciplinary approach (Kashikar & Arya, 2020). Workflow management stems from hospital leadership, and hospital leadership must enhance their workflows to cascade down to employees to achieve better patient care (Zheng et al., 2020). Therefore, hospital leaders must enhance communication to the employee level to be able to provide the standards of care across the facility. Effective workflow management promotes patient safety and minimizes risk in hospitals (Brady et al., 2017). Maintaining a hospital's high standards of care requires the completion of all the

components of the value-based purchasing domains, which can lead to excellent financial outcomes (Lee et al., 2020). Ferreira and Marques (2019) noted that hospitals are a complex structure with staff capable of delivering timely, equitable, and patient-centered care guided by evidence-based processes. Carthon et al. (2021) explained that the higher the quality of care rendered, the better the effectiveness and patient outcomes, including patient satisfaction.

Theme 3: Leaders Provide Appropriate Resources to Improve Patient Care Outcomes

Appropriate hospital resources are important to improve patient care outcomes. Table 4 is a display of the subthemes of theme three and percentage of use by participants. All participants explained that staffing and equipment are essential to improve the quality of care in the hospital.

Table 4

Subthemes of Theme 3

Subthemes	Percentage of use by participants
Education, training, and onboarding of employees	100%
Equipment and supplies management	100%
Staffing effectiveness	100%

All participants pointed out the importance of having good equipment to render excellent care to the patients. All participants explained that equipment and supplies in the facility served as a life-saver to prevent possible harm and death to the patients. P4 added that equipment in critical care areas can detect when the patients' condition is

deteriorating, hence, the healthcare personnel can intervene on a timely manner. Likewise, all participants posited that one of the important hospital resources are nursing staff, and proper staffing is necessary to improve the overall outcome of care.

P1, P2, P3, P4, and P5 pointed out that nursing turnover is prominent due to career growth and compensation issues. All participants explained that employee retention is their top priority to improve the quality of care and increase patient satisfaction. All participants pointed out that to adapt to the current short staffing issue, they hired contract staff and float pools to work on their units. However, all participants further explained that some of the contract and float pools that they acquired were not familiar with their current workflows, hence, they have to do a quick onboarding on their respective department to be able to acclimate the incoming staff. P1 noted that a "standardization of workflows across all units is essential to mitigate failure in the process." All participants pointed that the importance of employee onboarding to the quality of care and employees' turnover. P2 pointed out "career growth and compensation are the causes of employee turnover." P3 explained that "new nurses only stayed for 1 to 2 years, then move on to specialized." P5 noted that "compensation is the main issue of employee turnover."

The findings of this research support the peer-reviewed sources in the literature review. Garcia et al. (2019) explained that patient safety is dependent on physical and human resources. According to Sloane et al. (2018), nurses are an important part of health care, as they continuously transform the health care environment due to their presence in the patient care area around the clock. Likewise, nurses are the main source

of patient information for physicians (Sloane et al., 2018). Sloane et al. noted that, with better nursing resources, hospitals will have better patient care outcomes. Onboarding is crucial for the employees to be able to adapt to the current skills needed to improve the quality of care and mitigate employee turnovers (Kurnat-Thoma et al., 2017). Human resources and the service line department leaders must have a specific program designed to orient employees to improve their competencies to mitigate lapses in patient care, which could instigate safety issues (Kurnat-Thoma et al., 2017).

Employee training and development are an important part of the quality improvement process, as it enhances employees' skills to become efficient on their role (Kamalasanan et al., 2020). Champathes (2006) explained that coaching is important for correcting mistakes that employees make to generate positive outcomes. Moreover, having a well-developed employee's skills competency is an indicator of quality-of-care outcomes (Decock et al., 2022). These measures will help drive employee retention. Wei et al. (2018) found that using high-technology equipment can make the workflow more efficient and hence leads to better care. Maki and Zervos (2021) explained that the lack of equipment and resources to disinfect equipment and the lack of handwashing can lead to an increase in HAIs.

Proper nurse staffing is an important part of hospital operations to prevent harm to the patients (Griffiths et al., 2020). A proper staffing ratio is necessary to prevent overwork among nurses (Wang et al., 2021). Therefore, proper staffing and teamwork are essential to elevate the quality of care. Inadequate staffing can lead to burnout among employees (Dyrbye et al., 2019).

Theme 4: Leaders Proactive Engagement Motivate Employees to Improve Patient Care

Leaders' proactive engagement to motivate employees is critical and challenging, to improve the quality of care. Table 5 is a display of the subthemes of theme four and percentage of use by participants. All participants explained that they needed to be proactive to ensure high quality patient care. All the information pertaining to quality of care is disseminated to all nursing staff. Leaders conducted shift huddle to communicate the overall status of the department operations, especially patient care. Also, leaders conducted bedside shift report to assure patient safety. Likewise, the entire hospital leadership conducted daily safety huddle to determine any safety issues in the hospital.

Table 5

Subthemes of Theme 4

Subthemes	Percentage of use by participants
Communication	100%
Better compensation	100%
Valuing working behavior, transparency, and inclusion	100%

Leader on each nursing unit built their bulletin board to communicate all pertinent information to the staff. Likewise, the hospital has a nursing council, infection control and zero-harm meetings regularly to discuss quality and safety issues, metrics, and good catches to improve quality outcomes. All participants initiated abundant and timely education and training to update nurses on current practices to improve nursing competencies. Likewise, leaders conducted proper onboarding to new hires to alleviate fears and become competent on a targeted timeline.

All participants discussed that their nurses were empowered to give inputs to improve the quality of care through nursing practice council and staff meetings, hence making them feel valued to the organization. Likewise, all participants explained that nurses are recognized through accolades and monetary incentives through professional growth and extra shifts worked to increase motivation. All participants added that they have the Daisy award and rewards recognition for nurses.

P6 created the Sunflower award for nurses' recognition. P3 created the "Cheers for Peers" as a form of unit recognition. P4 bought Chick-Fil-A meals for all his personnel to keep them motivated. Furthermore, nurses have monetary incentives for educational and career growth. All participants noted that they trust their employees regarding their competency and skills to take care of the patients and empowering them to execute all the existing workflows that they have in place in their unit. All participants discussed potential issues in a prompt manner through huddles, staff meetings, committee meetings, and council meetings to alleviate fears and confusion among the staff. All participants arranged with education personnel to educate the nurses on any new initiatives and methods to keep them updated.

Leaders seek alternate care, in the absence of intended equipment and supplies, in collaboration with physicians and other healthcare personnel, to mitigate potential clinical issues from happening. Moreover, leaders explained that they mitigate resistance to change, by holding the nurses accountable for their action, and empowering them to do their job, and trusting them, in accordance with their roles. If they have a fall out on the process, leaders will reeducate them on doing the right way to keep them motivated,

hence keeping the patient safe. P6 explained that she spent time with her nurses to discuss their performance.

The findings of this research support the peer-reviewed sources in the literature review regarding motivation. The motivation aspect includes clear work expectations, better incentives and rewards, defined workplace culture, valuing working behaviors, and productive working beliefs (Gilbert, 2007). Effective communication between leaders and caregivers is essential to improve rapport and trust (Yang et al., 2018). Effective communication in health care is important to improve quality of care, decrease costs, and increase daily operating efficiencies (Yang et al., 2018).

Zhang et al. (2006) explained that motivational process link work motivation model to improve employees' job performance for better patient care outcomes. Brimhall (2019) noted that, in order to foster inclusion in the workplace, leaders must encourage engagement and openness toward employees to help them acclimate to the working environment and to promote an exchange of ideas, build trust, and drive innovation and job satisfaction, thereby resulting in better outcomes of care. Brimhall showed that inclusion drives innovation and engagement, resulting in innovation, which drives high quality of care.

Compensation can be a driver of employee motivation (Qomariah et al., 2022). Likewise, compensation is an effective measure to improve employee retention (Khalid & Nawab, 2018). Thompson (2017) noted that incentives are an internal tool used in health care organizations to create changes and improve service outcomes. Kelbiso et al. (2017) found that the quality of nursing care is dependent on the quality of life.

Compensation can drive health care organizations to achieve successful outcomes through employee performance (Khalid & Nawab, 2018).

Theme 5: Leaders Use of Innovative Tools to Measure and Monitor Quality of Care Outcomes

Technology plays an important part in healthcare in Hospital X. Technology drives patient and employees' analytics to improve the quality of care. Table 6 is a display of the subthemes of theme five and percentage of use by participants. All participants explained that the introduction of technology, helped the staff care for the patient so that timely intervention was initiated. Technology made them more efficient on doing their jobs. All participants explained that with the aid of technology, nurses can determine the status of a patient on a timely basis through the aid of software application to render immediate care to the patients. They can track what patient needs personally regarding their care. Likewise, all participants noted that the hospital has the Next-gen Analytics for Treatment and Efficiency (NATE) applications which determines which critical patients need immediate interventions. With this application, morbidity and mortality can be avoided. Likewise, hand hygiene data analytics are also implemented to improve infection prevention. With the aid of technology leaders and nurses alike can determine which goals or measures are falling off, hence, nurse leaders can develop action plans to keep the process back on track.

Table 6

Subthemes of Theme 5

Subthemes	Percentage of use by participants
Monitoring and measuring outcomes	100%
Efficiency	100%
Effective decision-making	100%

With the aid of Integrated Clinical and Operational Navigation (ICON) application, as all participants explained, leaders can now develop and monitor action plans on a prompt basis instead of waiting for the next 30 to 60 days to accomplished. All participants discussed that they used ICON applications to track their skin assessment and fall interventions. Furthermore, with the aid of iMobile and COAST communication tools, the flow of communication within the hospital improved.

The iMobile phone as well as COAST can reach the nurses on a timely manner to render prompt care to the patients, especially patients that are in critical condition. However, proper use of iMobile must be implemented, as P4 and P5 explained that it caused stress to their nurses due to alarm fatigue, as they have to battle toggle between multiple alarms combined with iMobile system. All participants explained that with these technological tools in place, all metrics pertaining to quality of care were relayed to the nursing staff on a timely manner, hence, preventing fall off in the process of care.

The findings of this research support the peer-reviewed sources in the literature review. Technology continues to shape society (Tian et al., 2019). Technology is a tool that is critical for health care executives and administrators to influence patient outcomes. Information technology is essential to connect costs, access, and quality of care (Mindel

& Mathiassen, 2015). Health care leaders are applying technology in the form of electronic health records (Mindel & Mathiassen, 2015). Tian et al. (2019) noted that electronic health records technology involves using analytics, informatics, safety, cloud computing, and telemedicine. With proper execution, health data technology will drive efficiency in the health care industry. Manca (2015) explained that monitoring and evaluating the change process ensures the execution of processes proceeds as planned. Monitoring and assessment are useful tools for determining whether the change process works successfully in comparison to other methods (Manca, 2015). Tian et al. (2019) elucidated that new technology leads to better interaction with hospital employees.

Findings Related to the Conceptual Framework

I used performance improvement model (Fusch & Gillespie, 2012) to explore the leadership strategies on improving the quality of care and increasing Medicare payments. The core principle performance improvement model is to find the gap in the process and changing or removing all processes that do not create value for the organization. The theory is based on leadership's ability to map the processes of a particular organization and assign measurable units to the steps in those processes, diagnose issues and gaps within those processes, suggest improvements, and continuously monitor performance based on those redesigned processes (Fusch & Gillespie, 2012). The process improvement model is consistent with the research included in this study.

Study participants substantiated performance improvement model. All participants explained that to improve the quality of care and increase Medicare payments, they have to mitigate mortality and promote healing as defined by their

mission statement. Moreover, all participants noted that workflows based on evidence-based practice is essential to practice safe nursing care. All participants elaborated that not all employees adhere to the workflows, as they have challenges with their contract and floater nurses, that just moved in for immediate assignment. Therefore, all participants recommended proper onboarding, education, and training to be able to be to acclimate with process of care. P1, P2, P3, P4, and P5 pointed out that one of their challenges is staffing, as their staff left, either because of career growth or low compensation. P6 pointed out the hospital has the tendency to grow due to the demographics that it served. Likewise, all participants explained that their hospital is about to be Magnet certified facility, which will strengthen the organizational culture and process of care. All participants elucidated the importance of technological tools which aid them on monitoring and tracking their process improvement goals. All participants agreed that it made their job easier as they can decide based on the data. All five themes described in this research represent the leadership strategies on improving the quality of care and increase Medicare payments in hospital: (a) leaders shaped the organizational culture, (b) leaders empowered staff through evidence-based workflows to mitigate potential issues, (c) leaders provide appropriate resources to improve patient care outcomes, (d) leaders' proactive engagement motivate employees to improve patient care, and (e) leaders use of innovative tools to measure and monitor quality of care outcomes. All participants employed these tactics and were successful in improving the quality of care and increase Medicare payments in hospital.

Applications to Professional Practice

The specific business problem for this study was that some hospital leaders lack strategies for improving the quality of care and increase Medicare payments. The results of this study reveal the strategies that unit leaders at midsize urban acute care hospital in Houston, Texas U.S. fulfill this goal. The findings are applicable to performance improvement model because they include specific suggestions to improve the strategies of improving the quality of care and increase Medicare payments in hospital.

The results of this study incorporated the resulting suggestions for hospital leaders to improve quality of care and increase Medicare payments, where exceeding CMS standards to improve financial outcomes was the focus to implement a standardized messaging system to address organizational culture and processes across the organization, and make improvements as deemed necessary. Other suggestions included exploring ways on retaining employees through personal engagement and transparency on their job roles, with the leaders. At this moment, lucrative compensation and career growth outweighed the motivation of being a valued employee, hence, hospital leaders must find a way to retain and attract employees. Leaders must make initiatives of recruiting employees by offering competitive salaries and benefits that are on par with the market, to improve staffing and patient care. Offering better compensation could land the best talents available. Furthermore, modifying the job roles which makes it more attractive to applicants. Moreover, other recommendation is frequent employee engagement, through staff meeting, huddles, or individual meeting, which involves transparency from the leaders, foster effective communication. Additionally, adopting

and developing continuous process improvement among all personnel, by identifying and mitigating risks, to improve patient care outcomes.

These findings are paramount to improved quality of care and increase Medicare payments as they exemplify strategies that other researchers have expressed are important to maintaining positive financial outcomes for the hospital. Various researchers acknowledge a connection between how organizational leaders strategically develop processes that improve the quality of care and increase Medicare payments. Motivated employees tend to perform better which contributes to high quality of care. The findings of this study can guide hospital leaders who struggle to improve the quality of care and increase Medicare payments in an acute care hospital. Following the suggested approaches can aid hospital leaders experience a successful strategy on improving the quality of care and increase Medicare payments, leading to successful financial outcomes.

By providing high quality of care to the patients, the hospital can increase Medicare reimbursements by hitting the required goal from CMS to achieve excellent incentives to improve financial outcomes (Kocakulah et al., 2021). Likewise, with the development of protocols and workflows based on evidence-based practice (Angwin & Meadows, 2015), can mitigate morbidity and mortality and promotes patient healing.

Implications for Social Change

The implications for positive social change include high-quality services that might lead to faster recovery and the potential to decrease mortality and improve people's lives during hospital visits. By implementing standardized workflows and protocols,

based on evidence-based practice, the quality of care will get better, hence patient satisfaction will increase. The excellent quality of care can be attributed to the knowledge and expertise of the staff guided by transformational leadership style of the nurse managers. Likewise, having a good business reputation in the community could lead to increase patient population, which could lead to positive financial outcomes for hospital. Furthermore, having an excellent business process and reputation, can increase the stakeholders' trust to the organization, therefore more nurses will likely apply to work on a reputable and respectable organization, hence, business expansion could happen. Business expansion with abundant resources can provide better healthcare services to the surrounding communities.

Recommendations for Action

Five recommended steps for action include the following: (a) find and develop effective processes that will reach the employees to improve hospital culture, (b) establish practices opportunities for effective utilization of workflows, (c) develop and identify initiatives that will attract and retain employees, (d) seek ways to motivate employees, (e) seek safe and secure ways on utilizing technology applications. Hospital leaders would benefit from pursuing these incremental advances by setting attainable goals with a realistic timeframe for accomplishing them. Continuous monitoring, reassessment, and adjustment will determine if the initiatives are producing the desired result.

The first recommendation is to find and develop effective processes that will reach the employees to improve hospital culture. Employing organizational culture can

mitigate organizational risk. Leaders could implement this by educating and reinforcing the hospital mission with all stakeholders. Once the direction is made clear, hospital leaders can develop a communication template for effective messaging across the hospital. Leaders could request ideas and feedback from employees on the communication modes that are effective to them, as they will be the recipient of the message. Inefficiencies in hospitals cause mortality (Wei et al., 2018). Internal messaging can be in the form of group meetings, emails, one-on-one meetings, or education. Likewise, leaders must implement an inclusive style of leadership to motivate employees to buy-in into the hospital culture. An effective flow of communication can lead to employee satisfaction and can increase the confidence of nurses (Shahid & Thomas, 2018). Effective communication helps to protect patients from serious harm due to medical errors arising from misdiagnosis, wrong-site surgeries, or erroneous medication administration (Shahid & Thomas, 2018).

The second recommendation is to establish practices opportunities for effective utilization of workflows. Leaders must create a climate where all employees have a consistent positive approach for continuous quality improvement. Leaders must be proactive on continuous quality improvement process in order to continuously enhance the clinical workflows so that the employees can take care of the patient in a safe manner. Develop standardized of workflows across all nursing units is essential to avoid confusion on taking care of the patients based on their conditions and develop a standard tool to measure its effectiveness and compliance. To improve the workflow, hospital leadership must initiate process improvement plans by enhancing the flow of useful

information to the employees (Zheng et al., 2020). Likewise, spontaneous auditing of hospital leaders to determine the process that needs improvement. Validating intended outcomes is essential to be able to track the progress of a goal (Fusch & Gillespie, 2012). To maintain balance, leadership can validate effectiveness the process improvement tasks for both unit leaders and staff at any given time. Kirrane et al. (2017) explained that individuals' willingness to change only improves when the change workflows are effective, and the employees' perception is geared toward learning development.

The third recommendation involves develop and identify initiatives that will attract and retain employees. Since we are in the era of "Great Resignation" brought upon by the pandemic, employee turnover is rampant, hence, recruiting employees is a challenge. Organization must be creative in order to recruit and retain employees. Leaders must anticipate employees' fears in relation to clinical aspects of their job, and be purposeful within their power to control the situation. During this uncertain time, hospital leaders can mitigate employee turnovers by ensuring employees feel they are valued by the hospital leadership. Likewise, hospital leaders must be transparent about the employees' future in the hospital regarding their roles. Hospital leaders must listen to and respond promptly to the concerns of employees, which will benefit them in the long run. This transparency and responsiveness, combined with the leaders' active listening, can mitigate employees' fears, which can bring negative ramifications to patient care, if not addressed properly. Additionally, hospital leaders need to coordinate with compensation personnel in a prompt manner to keep the employees' compensation on par with competing hospitals to prevent employee resignations. Khalid and Nawab (2018)

posited that employee participation with compensation decisions relating to their job role makes them feel valued by the organization, resulting in higher chance of employee retention and performance. Moreover, expanding service lines on specialty areas, provided all cost and benefits are justified, so that nurses that are aspiring to grow have a place to transfer within the hospital, instead of out-migrating to competing hospital, hence, mitigating employee turnover. Furthermore, proper staffing can contribute to faster patient throughput, therefore, decreasing patient length of stay and overhead costs. Wang et al. (2021) suggested that the staff-to-patient ratio must support staff being able to provide the highest and safest care to patients, as the staff-to-patient ratio gets larger, patient care might become compromised and hence impact quality and safety. Also, proper onboarding of new hires, floaters, and contract employees must be enhanced to prevent lapses on providing high quality patient care.

The fourth recommendation is to seek ways to motivate employees. Hospital leadership must employ transformational leadership style, to motivate employees through continuous and consistent engagement. Kowalski et al. (2020) explained that leaders' behaviors affect the attitudes of employees, which directly affect performance. Demotivating employees must be taken out of the equation to improve the quality of care. Transformational leadership tends to increase the quality standards by empowering employees to solve problems to achieve those goals through proper communication and coaching (Pearson, 2020). Mitigating loss of empowerment due to critical workloads is paramount, through leadership support, by properly staffing the department, so the staff can do their job effectively and safely. Likewise, transformational leaders promote

employees' satisfaction, thereby reducing employee turnover (Labrague et al., 2020). Wu et al. (2020) added that transformational leaders help prevent stress on nurses and maintain a positive working environment. Moreover, transformational leaders lower staffing ratios, open communication, completion of goals, and team collaboration can be attributed to high hospital value-based purchasing (Spaulding et al., 2020). Educating and training all the employees on all aspects of care and evaluating their progress. Likewise, retraining employees, once faults were discovered, improve employee skills and competence, hence, increase employees' morale. Likewise, employing leadership transparency to the staff through proper evaluation, to measure their performance, in order to uplift proper understanding of their job roles. Additionally, leaders must consistently make personal connections with employees outside of clinical realm to foster personal rapport. This gesture fosters a feeling of being valued as a part of a family, hence, fostering positive working environment.

The fifth recommendation is to seek safe and secure ways on utilizing technology applications. Since technology application is widely used in the hospital, safe and careful usage is paramount. Healthcare operations worldwide were affected by cyber-attacks (Alami et al., 2019). Williams et al. (2020) pointed out that 90% of health care providers have encountered cyber-attacks. The rise of cyber-attacks is prominent among healthcare industry to steal patients' identities; hence, proper information technology security is necessary to protect the patient information and other important hospital data. Williams et al. posited that cyber-attacks cost the health care industry $6 trillion, which is projected to increase fivefold after the COVID-19 pandemic. Pullin (2018) suggested to employ

cyber security as it is the best defense against cyber-attacks. Meinert et al. (2018) suggested that organizations must adhere to data protection policies to mitigate the risks of technological innovation to keep organizations valuable in the long run. Conversely, technology is a barrier to employees as well (Amarantou et al., 2018). Careful usage of high-technology communication system is important to prevent communication fatigue, which could put a stress to the nurses. P4 and P5 explained that their nurses were stressed due to alarm fatigue as using the iMobile system and other technological tools, as they have to deal with those alarm paging system at the same time, therefore, they advised their nurses to refrain from using unless necessary.

All participants in this study will be provided with the summary of the study's findings through hardcopy and email. Plans also include publishing this study in the ProQuest Dissertations and Theses Database. I plan to disseminate the findings through leadership conferences or process improvement committee meeting that developing action plans to improve patient care. Recommendations will be initiated through practical application by the employees into their daily activities and during staff meetings. Organization seeking to promote their quality improvement process program in an acute care setting can avail themselves to the findings in this study.

Recommendations for Further Research

I conducted this qualitative single case study to explore leadership strategies on improving the quality of care and Medicare payments in hospital. Researchers should conduct further research based key delimitations of this study on number of hospitals, sample size, and type of participants. The study participants I interviewed worked as

nurse managers in the hospital located in Houston, Texas United States. Future researchers could extend to multiple hospitals with differing job roles in other areas of the United States, as hospital leaders in other areas may have differing lived experiences. Moreover, the study findings might not be appropriate to other hospitals, hence, future researchers could conduct case studies using other departments within acute care hospitals that has potential impact on the quality of care.

I suggest that future researchers continue exploring the leadership's strategies on improving the quality of care and increase Medicare payments and adhere to some of the delimitations of this study, as opportunity to gain new knowledge emerged. Future researchers could use purposeful sampling to identify hospital leaders from different disciplines who can provide rich data based on the goal. Also, future researchers might use the mixed-methods or a quantitative approach by obtaining numerical data on the topic. Furthermore, future researcher could collect data from a hospital's employees via focus groups, observation, or surveys as deemed necessary, to explore employees' lived experiences on strategies to improve quality of care and increase Medicare payments in the hospital. Collecting rich data from employees with different backgrounds could also help fortify the research.

Reflections

My doctoral degree journey was quite challenging and satisfying. From my first year, I had a challenging prospectus experience, as I had to developed multiple prospectuses prior to chair approval, as my idea leaned on clinical instead of business aspect. My doctoral degree challenge continued to linger, as my first chair decided to

retire, hence, I need to find another chair that would continue to support my journey. The chair that I initially picked declined my request, until the committee appointed Dr Marilyn Simon, who agreed to be my chair. Dr Simon was very supportive and prompt on all her responses to my inquiries. Dr Simon, supported me fully to get my proposal and IRB approval passed the URR and IRB committee. My Walden approval number is 03-08-22-1001178.

Then the COVID-19 pandemic occurred, which I juggled between very hectic working schedule taking care of COVID-19 patients and working on my research. I struggled with the first prospective organization that I want to conduct my research as they did not respond to me at all; hence, I almost spent a full semester of finding a new partner organization. I finally found another partner organization that was willing to help me to complete my research, which is my place of work. The new partner organization's approval process of IRB-exempt application took only several days, which is amazing, as the facility has a specific software algorithm called CARRIE, that process all research applications. During my participant recruitment process, 6 nurse managers agreed to participate and 1 nurse manager declined the invitation.

During my lengthy interviews with the participants, I was very impressed that all participants understood the mission statement of the organization. I was in awe on the amount of leadership role and effort a nurse manager does on a daily basis to improve the quality of care in the hospital. Despite their hectic schedules, they still managed to put me on their schedules. With all these efforts, I realized how much I appreciated their roles on keeping the staff motivated and keeping their patients safe and satisfied with their care.

All the participants that I interviewed were very accommodating and respectful. They took their time to thoroughly answer all the questions in a calm demeanor. They were all very humbled and knowledgeable on their subject matters, one of the participants called her charge nurse, during the interview process, to make sure that she did not miss anything on one of her responses. They honestly answered all my questions to the best of their abilities based on their lived experiences to their daily unit operations. During the videoconference interview, I could see a huge smile on their faces indicating that they are happy with their profession, and very proud of being a part of the organization that implementing strategies to improve the quality of care outcomes, especially during pandemic times, which challenged their leadership abilities.

My experience with my doctoral journey was truly satisfying, as I learned a lot from both my chairs and overcame all the challenges I faced through hard work and dedication. I will cherish this memory for the rest of my life. I realized that to improve the quality of care in the hospital, collaboration and communication are essential across all disciplines, on top of their excellent workflows, to be able to have an excellent quality and financial outcomes. I am willing and excited to share my journey with future researchers.

Conclusion

In conclusion, improving the quality of care and increasing Medicare payments are essential to the profitability and survival of healthcare business. High-performing hospitals that meets or exceeds the value-based programs, enforced by CMS, were rewarded financially. However, hospitals that failed to meet the required standards of

care, that CMS mandates, will receive penalties, which affect their financial outcomes. Hospital that cannot achieve CMS goals could lose the trust of their stakeholders, which could divest to other business. During the course of my research, five themes emerged in relation to the data analysis process: (a) leaders shaped the organizational culture, (b) leaders empowered staff through evidence-based workflows to mitigate potential issues, (c) leaders provide appropriate resources to improve patient care outcomes, (d) leaders' proactive engagement motivate employees to improve patient care, and (e) leaders use of innovative tools to measure and monitor quality of care outcomes. These findings indicate that leaders that implement high quality of care and increase Medicare payments in the hospital, can contribute to the financial success of the hospital and surrounding community.

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Appendix: Interview Protocol

Interview Protocol	
What you will do	**What you will say—script**
Introduce the interview and set the stage	The purpose of the study is to explore the hospital managers strategies on improving the hospital's quality of care and increase Medicare payments. This interview may take up to 60 minutes. You have the right to withdraw consent at any time. I will provide a summary of findings at the conclusion of the interview. I will contact you to review all interpretations as part of the member checking process within a week.
• Watch for non-verbal queues • Paraphrase as needed • Ask follow-up probing questions to get more in-depth	1. What are your organization's strategies to improve the quality of care?
	2. How do these strategies relate to the mission and vision of your organization?
	3. How did you measure the effectiveness of your quality of care improvement strategies?
	4. What did you find worked best in your quality of care improvement strategy?
	5. What have you found to be the least effective in your quality care improvement strategy?
	6. How did you communicate the issues to your employees about your quality care improvement strategy?
	7. Please explain your employees' capability to review and apply tasks to improve the quality of patient care implementing your strategies.
	8. What were the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments?
	9. How did you address the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments?
	10. What additional information would you want to share about the strategies your organization used to improve the quality of care?
Wrap up interview thanking participant	Thank you for your participation. This concludes today's interview session.
Schedule follow-up member checking interview	I would like to follow up with you in a week so that you can review my interpretations of your responses to ensure accuracy. Does (date/time) work for your schedule?

Follow–up Member Checking Interview	
Introduce the follow-up and set the stage	Thank you for your participation. As a reminder, the purpose of the study is to verify that your responses regarding the strategies on improving the hospital's quality of care and increase Medicare payments are correctly interpreted. This follow–up interview may take up to 30 minutes. You have the right to withdraw your consent at any time.
Share a copy of the succinct synthesis for each individual question Bring in probing questions related to other information that you may have found—note the information must be related so that you are probing and adhering to the IRB approval. Walk through each question, read the interpretation and ask: Did I miss anything? Or, what would you like to add?	1. What are your organization's strategies to improve the quality of care? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	2. How do these strategies relate to the mission and vision of your organization? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	3. How did you measure the effectiveness of your quality of care improvement strategies? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	4. What did you find worked best in your quality of care improvement strategy? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	5. What have you found to be the least effective in your quality care improvement strategy? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	6. How did you communicate the issues to your employees about your quality care improvement strategy? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	7. Please explain your employees' capability to review and apply tasks to improve the quality of patient care implementing your strategies. Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	8. What were the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.
	9. How did you address the key obstacles to implementing your strategies for improving the quality of patient care and increasing Medicare payments? Then a succinct synthesis of

	the interpretation – perhaps one paragraph or as needed.
	10. What additional information would you want to share about the strategies your organization used to improve the quality of care? Then a succinct synthesis of the interpretation – perhaps one paragraph or as needed.