2023

Increasing Organizational Value of a Private Healthcare Education Academy

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MBA, American University of Science and Technology, 2016

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Abstract

Amid the dynamic changes and innovations of the healthcare field, healthcare providers seek educational activities that enhance their growth and decrease their knowledge gap. Healthcare education organizations responsible for providing high-quality healthcare education, have opportunities to differentiate their programs to acquire, attract, activate, and retain healthcare providers. Grounded in the five forces of competition and the value chain theories, this mixed method formative program evaluation aimed to improve the business development program by developing a differentiation by quality strategy that will increase its competitive advantage. Participants included three decision makers and nine leaders in a healthcare education organization in the Kingdom of Saudi Arabia (KSA). Data were collected from semistructured interviews, focus group discussions, and historical data. The quantitative analysis was limited to a descriptive analysis of frequencies of occurrences. The qualitative analysis revealed eight themes related to advertisement and marketing, value perception, differentiation opportunities, threats and barriers, strengths, weaknesses, leadership, and customer experience. The descriptive analysis supported the thematic analysis. Four key recommendations presented to leadership included developing strategic alliances, new curricula, key performance indicators, and an advertisement plan. The implications for positive social change include the potential for increased quality of healthcare delivery, hence, increasing the quality of care for the population's health.

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Dedication

I dedicate this doctoral study to my mother; when I started the program, I was asked to write about why I chose to become a doctor. I answered back then, and I repeat it now, I did this for my mother who showed me that the sky is my limit. She made ends meet, and was able to hold herself and provide for us because she was educated. Mom, you have not gotten the chance to continue your PhD because you did not have the appropriate support to do so. I completed my doctorate because I have you.

Acknowledgment

I want to thank my brother Elie, who believed that I was the investment and did everything to support me, and be in the appropriate environment for success. I thank my Chair Dr. Roger Mayer who has been amazing throughout, present, supportive, patient, and enthusiastic. Moreover, I want to thank him because he helped me leverage my degree and the results are making a crucial difference. I thank my second committee member Dr. Charlie Shao whose expertise enlightened me and assured that I become a Program Evaluator; I am very grateful for my committee and their professionalism. I also want to thank Dr. Beverly Muhammed for her thorough revision of my work as the URR member, making sure I learn and am proficient in the Program Evaluation writing. I thank Walden University and all the faculty and staff who collaborated in my success.

A special heart-felt thanks is to Dr. Saud Alturki for his trust, his belief in my success, his support for my goal, his welcoming and inclusive team and his advocacy and loyalty for my progress.

I want to give a special thanks to my best friend Elise, who basically studied with me and tolerated my breakouts! You always said “Just do it” et voilà!

Every day, and every moment, I thank God for the strength, the potential, and the gifts he gave me, for the blessings I have, and for another achievement in my life.

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Section 1: Background and Context

The dynamic era of changes and healthcare innovations implies better adaptation and use of all available resources. As indicated by Cullen et al. (2019), alternating traditional didactic learning models with a student-centered teaching model help address the learning needs of healthcare professionals who expect accessible activities that enhance their knowledge and critical thinking. This alternation requires new skill sets for educators who can deliver cohesively in-depth content that addresses the knowledge gaps without redundancies (Cullen et al., 2019). As discussed by Bohnsack and Liesner (2019) and Scott and Goode (2020), healthcare professionals are attracted to curricula that enhance their growth, improved technology, and learning management systems, innovative approach to social media for healthcare education, and differentiation that offer them access to educational services at more cost-efficient and affordable prices. Healthcare education is crucial for the continuous development of healthcare providers. Breaks in communication affect patient outcomes (Fox et al., 2020). One of the crucial skills to teach healthcare providers is effective communication, which requires multidisciplinary and interprofessional team training.

Healthcare providers in all specialties around the globe require continuous professional development credits (CPDC) for their license validity. Healthcare continuing education is "continuous" learning that provides proof of competence as mandated by certifying boards (Cullen et al., 2019). However, the requirements and types of CPDC accumulated differ between licensing bodies. Since the continuous evolvement of

required competencies obliges healthcare professionals to have continuous learning (Cullen et al., 2019), the healthcare professionals' education needs are many, and they have an array of choices for healthcare education organizations. Thus, healthcare education organizations ought to address what attracts healthcare professionals to their institution, understand what programs interest them, and figure out innovative ways to retain them, engage them, and earn their trust and loyalty.

Historical Background

Continuing healthcare education improves practice, competence, and quality of care. High-quality healthcare education may positively impact healthcare providers' quality of care (D. Kang et al., 2021; Singal et al., 2020). The lack of education, competence, awareness of patient safety standards, the importance of measurements in healthcare systems, and the knowledge gap are a threat to providing communities with efficacious and high-value health care (H. Y. Kang & Kim., 2021; Kaplan et al., 2021; Singal et al., 2020). Most safety concerns are preventable by proper training and education (Singal et al., 2020). Healthcare education organizations can put a set of interdependent steps to increase the organization's value and the services provided. Singal et al. (2020) discussed the necessity of teaching residents to recognize preventable harm and properly report it, as part of their formation and training. Fox et al. (2020), Holtzman et al. (2020), H. Y. Kang and Kim. (2021), and Kaplan et al. (2021) highlighted the requirement to improve knowledge and critical thinking, and increase communication efficiency while promoting team collaboration. Thus, targeted and effective high-quality

healthcare training and education might have a positive impact on decreasing the knowledge gaps, acknowledgment of the importance of quality of care, improved awareness of issues that need to be monitored and reported, innovation in individualizing patient care, and increased patient safety outcomes (D. Kang et al., 2021; Kaplan et al., 2021). The output of this study will be to look at differentiations by quality that may address the challenges that healthcare professionals face in meeting their educational needs, their performance in the workplace after the training, and their engagement and retention in a private healthcare education organization.

Differentiation strategy building is the ability of the leaders to give the customers what they want. Pursuing differentiation strategies is creating unique services that address clients' needs; leaders have an opportunity to be involved in the development of these strategies and effectively integrate the components that address internal and external factors to assure success and sustainability (Akingbade, 2020; Islami et al., 2020; Porter, 1985). Organizations should also work on their internal strengths, seize opportunities, and mitigate risks, and leaders can only achieve this by effectively and efficiently utilizing their resources while addressing their customers' needs (Akingbade, 2020). Healthcare professionals seek to improve their knowledge gaps, and want educational activities that address their needs, engage them, and provide them with programs that are close to reality. Differentiation strategies are successful when leaders aim to align their goals with the needs of their customers and to position their organizations in a unique stand where they can carry out the mission (Akingbade, 2020; Porter, 1985). Healthcare education

organizations have the chance to develop strategies to differentiate themselves in the dynamically changing and evolving era of healthcare, while maintaining quality delivery of healthcare education, through well-developed, comprehensive, and inclusive trainings and education.

Organizational Context

In this program evaluation, I studied a small for-profit private healthcare education organization (referred here within to the "Organization") that provides educational programs, events, and consulting to clinicians and managers in a healthcare environment in the Kingdom of Saudi Arabia (KSA), and the Middle East and North Africa (MENA) Region. The Organization's vision is to be the organization of choice and a trusted provider for healthcare professionals in KSA and the MENA Region, who aim to invest in their professional growth and career advancement. The Organization intends to achieve its vision by committing to providing innovative, high-quality continuing education and development for healthcare providers in KSA and the Region while identifying opportunities to offer a variety of courses and training designed based on customers' needs (Chief Executive Officer, cooperation meeting, March 20, 2022).

The Organization's stakeholders have therefore identified the need for an improved strategy for achieving the Organization's goals. The aim of this formative program evaluation was to assess the existing business development program, validate the reasons for its success, identify areas for improvement, and recommend actions for its effectiveness. This aim will be achieved by developing a differentiation by quality

strategy that will increase the Organization's competitive advantage in healthcare education. The program I evaluated was the business development program with the goals to: (a) increase registrations in educational activities by 25% per year for the next 2 years; (b) develop standardized processes that will help increase by 10% per semester the number of events provided for the next 2 years; (c) conduct a gap analysis to identify opportunities for improvement and differentiation; (d) increase the value of the services provided by continuously delivering high-quality healthcare education activities that respond to clients' educational needs; (e) develop by the end of July 2023 policies that will support the differentiation by quality strategy; and (f) develop, by the end of this doctoral study, a differentiation by quality strategy which will help the leaders create a brand, and increase competitive advantage.

Problem Statement

Healthcare institutions struggle to improve their quality of care; insufficient education and competencies threaten to provide communities with efficacious and affordable health care. High-quality healthcare education can positively impact the quality of healthcare providers' care (D. Kang et al., 2021; H.Y. Kang & Kim, 2021; Singal et al., 2020). Effective, high-quality healthcare training and education are expected to decrease knowledge gaps, increase acknowledgment of the importance of quality of care, improve awareness of issues that require monitoring and reporting, creating innovation in individualizing patient care, and increasing patient safety outcomes.

Healthcare education organizations aim to address these gaps and improve their quality of education. When leaders keep focusing on linking their strategy with what attracts their customers to the industry, they focus on the goals, differentiate themselves, and offer uniqueness to their customers (Islami et al., 2020). Moreover, engaging healthcare professionals in their continuing education is crucial and leads to retention and loyalty (Cullen et al., 2019). Hence, the leaders of healthcare education organizations wanted to identify the essential components that will attract healthcare professionals, retain them, engage them, and make a difference in their way of delivering care to the patients. The specific business problem that was addressed through the program evaluation was that the leaders at the Organization were unaware of the need to immediately address the essential components of a business development program that contributes to achieving organizational goals through the development of a differentiation by quality strategy that will increase its competitive advantage.

Purpose Statement

The purpose of this mixed method formative program evaluation was to improve the business development program to align with the Organization's goals through the development of a differentiation by quality strategy that will increase its competitive advantage. The Organization is located in KSA and provides healthcare education to healthcare providers across the country and the MENA region, it even conducts international conferences. This for-profit organization is dedicated to finding ways to generate more profit while maintaining high quality services. The study's findings helped

develop an understanding of the Organization's culture, behaviors, and practices. The implications for positive social change included the potential for increased clients' trust in the services provided, improved customer's experience, and identification of best practices that positively affect healthcare providers' performance and quality of care.

Target Audience

This program evaluation targeted the business development department in the Organization responsible for improving sales, visibility, outreach, and branding. The program also targeted leaders involved in its implementation or who benefit from its outcomes. The served or affected stakeholders were; student clients who are healthcare providers (HCPs) attending the health education events offered by the Organization, selected external faculty contracted by the Organization, and employees. The decision-makers were the CEO of the Organization, the business development manager, and the general manager.

Research Question

The below main formative evaluation research question (program's research question) was formulated to address the research problem. The quantitative design was presented in a descriptive analysis; thus, hypotheses are not applicable.

Program's Research Question

How can leaders responsible for the business development program develop a differentiation by quality strategy to increase competitive advantage?

Interview Questions

1. How has your organization's strategy evolve over the past five years?
2. What roles do leaders responsible for the business development program have in developing a differentiation by quality strategy?
3. What have you done so far to develop a differentiation by quality strategy?
4. What barriers do you envision in developing a differentiation by quality strategy?
5. What aspects of the business require a differentiation by quality strategy?
6. Why did you decide to develop a differentiation by quality strategy?
7. What are the major advantages that you have identified existing in your competition that hinder your success and advancement?
8. What strategies have competitors used that create opportunities for you?
9. How could a differentiation by quality strategy increase competitive advantage, profit, and diversification?
10. What does a successful outcome look like?
11. What additional information can you provide?

Significance of the Study

Business leaders are responsible for the success and performance of their organizations. This program evaluation was significant to the Organization's leadership to help validate successful operations and address existing concerns, leading to strategy development, improvement action items, steady and sustainable growth, and the

establishment of derivative policies and processes. Increasing the Organization's value and the value of its services is expected to enable achieving its goals and vision for its differentiation and competitive advantage.

The results may contribute to social change by providing high-quality healthcare education which has implications for positive social change. The implications include identifying best practices that positively affect the quality of care, improving patient outcomes and safety, and improving services to the community. Additional implications for effective positive social change include identifying best practices for improving hospital quality and safety, improving patient services, and reducing costs. The focus on quality and safety goals may contribute to positive social change by creating an improved and sustainable culture for patient quality and safety within the Saudi Arabian community and the region.

Conceptual Framework and Program Model

Conceptual Framework

The theories that ground this study included the five forces for competitive advantage and the value-chain theories. Both theoretical frameworks were developed by Michael Porter. The five forces for competitive advantage was developed in 1979 then refined in 2008, and it includes strategies for differentiation and competitive advantages (Porter, 1979, 2008). The value-chain model was developed in 1985 and includes differentiation by creating competitive advantage through increasing the value of

subsidiary activities (Porter, 1985). In this study, I used the integrated models and evaluated the business development program through the lens of these frameworks.

In the five forces of competition, I focused on the constructs of rivalry analysis, threats of new entrants, bargaining forces of the buyers, and threats of substitution. In the value-chain model I focused on the primary activities (operations, marketing and sales, and services), and support activities (firm's infrastructure, human resource management, and technology development). The focus on these specific constructs supported the business problem and the purpose of the study, which lead to the development of the differentiation by quality strategy. The approaches were indivisible; removing any component would have restrained the efficacy of the study and prohibited me from achieving the goals.

The Program Logic Model

A program logic model (PLM) is a simple graphic and diagrammatical representation of the program's various elements and shared relationships (Mills et al., 2019; Smith et al., 2020). Logic models have been used for decades in program development and evaluations for the planning, execution, evaluation, and implementation of studies (Smith et al., 2020); they provide a map of how a program should work. The PLM is a visual aid that assisted me in determining how the components of the program under evaluation should flow and how to reach the desired outputs, outcomes, and impacts. The logical connections between the framework presented and my study approach necessitated using both quantitative and qualitative methods to assess the

program outputs and outcomes included in the program logic model. Differentiation by quality was the focus, with use, methods, and values as essential considerations supporting my approach.

The business development PLM was a pivotal step to articulate and use the frameworks in the program evaluation. On the right-lower-hand side (see Table 1 on page 12), I presented the contextual factors, internal and external, that could influence the program's outcomes. As depicted on the right-upper-hand side, the goal of the business development program was to develop a differentiation by quality strategy to achieve competitive advantage. These objectives were realistic but require time to achieve; hence, they were considered long-term outcomes.

Table 1

Business Development Program Logic Model

Inputs	Outputs The direct products of the program		Outcomes: Benefits for participation during and after the program		
What we invest? Resources dedicated to or consumed by the program	Activities What the program does with the inputs to fulfill its mission	Participants: Who we reach?	Short term	Intermediate	Long term
Partnerships Competitors Historical data Staff Leaders Database	Conduct Focus groups Semistructured Interviews Assess existing processes Develop Processes and Policies Standardized reports Train employees Increase Faculty skills Content quality Demand on events No. of events No. of classes taught No. of participants served No. of requests for activities Loyalty & satisfaction Diversity of services Strategic Alliances Use of existing partnerships Decrease No. of cancellations of events No. of participant's cancellations	Staff Clients Faculty Agencies & societies Decision makers	<u>Learning</u> Attitudes Change Skills of faculty Motivations	<u>Action</u> Improved quality of services Decision-making Policies Response clients' needs	<u>Conditions</u> Develop the differentiation by quality strategy to increase competitive advantage Improved market share Improved reputation and brand

Assumptions: Beliefs about the program and how we think it will work

- Systematic analysis of the situation is appropriate
- The assumption about the inputs are adequate and available
- The program will operate successfully and will be based on the evidence and research in the field
- The staff and participants will learn about the program and its desired impact through meetings supported by the CEO
- Funding will be secured throughout the program; there are no additional costs for the project
- Staff will be available to support in data collection and understanding of the problem and processes

Contextual Factors: Internal and External Factors that influence the program's outcomes

- Organizational culture & staff attitude: resistance to change and cultural milieu
- Economic patterns: financial limitations that can hinder the progress of the improvement
- Speed and the degree to which change will occur
- Program implementation duration may be long
- Background and experience of the participants
- Disadvantages with rivals: absence of IT infrastructure
- Disparity between the quality and standards of the events
- Risks and limitations

Closer outcomes can be achieved during the program evaluation or immediately after. The short-term outcomes tackled the learning area where attitudes change, skills of faculty, and motivation initiatives were addressed. The intermediate outcomes were actions that were implemented during the evaluation and lead to the long-term outcomes. These intermediate outcomes were crucial for the study's success; improve the quality of services, develop the decision-making, policies, and improve responses to clients' needs.

On the upper left side of the PLM, I presented the inputs that were analyzed at the program's start and the outputs - the activities conducted during the program evaluation based on the available inputs. The participants were those affected and benefited from this program evaluation. Lastly, on the lower left-hand side, I presented the assumptions about the program that I considered will benefit the program and increase its success.

Representative Literature Review

Literature review is not the review of the literature. The literature review is a foundation on which researchers base the research, explain the problem statement, justify the research's purpose, and support the research problems under study (Groccia & Ford, 2020; Saunders et al., 2015). To read critically, a researcher has to remember the problem statement and research questions, read with a critical eye to understand what is being presented in the sources, analyze the content to see if it meets the research's aim, and evaluate the source with the approach of intent to be used in the research (Saunders et al., 2015). The Bloom taxonomy (Spence, 2019) is a standard model used in education,

including literature reviews. Students and educators who move higher in the taxonomy reach a higher level of education and understanding of the subject.

Researchers keep questioning themselves when conducting the literature review and synthesizing the content. Review questions are crucial when reading, and it is helpful to keep a set of questions to ask oneself (Saunders et al., 2015). Researchers need to keep thinking of the purpose of their research when reading articles and find the most important parts of the literature that serve their goal. Then when synthesizing, the researcher rephrases and puts together the ideas that fit their research design, in an integrative, historical, methodological, and systematic manner (Groccia & Ford, 2020; Saunders et al., 2015). Researchers review the replicability of previous work, consider the read sources as a heritage from other authors that can support their current research, determine what to adopt from previous work, and evaluate what to move away from. Researchers conduct similar studies to compare behaviors of diverse cultures with different social norms or to prove new findings; they create a new content that will serve as a heritage for future generations; and, they are vigilant of their contributions' impact to the literature.

Healthcare education has multiple parameters and does not fit under a single discipline of education or healthcare. Groccia and Ford (2020) presented an in-depth review of the literature about healthcare education. The authors started their article with the following two statements that are 100 years apart:

- "If the sick are to reap the full benefit of recent progress in medicine, a more uniformly arduous and expensive medical education is demanded." (Abraham Flexner, 1910, p. 13).
- "Major challenges face today's health care system which health professionals have to be prepared." (Greiner & Knebel, 2003, p.1).

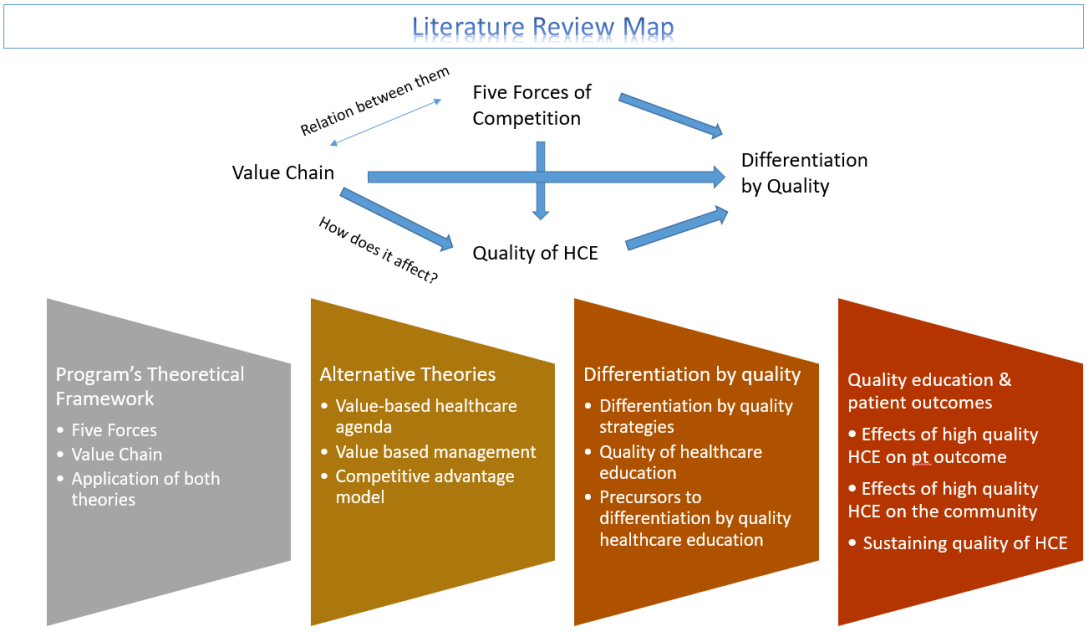
These statements indicate that healthcare professionals still have to be prepared and educated about their profession, regardless of the advances made in medicine; or, maybe, because of these advances, healthcare professionals need to be ready and up-to-date. In this study's literature review section, I reviewed empirical literature grounded in the conceptual framework, and model: I addressed the five forces of competition, the value chain model, their applicability to my study and alternative theories. The literature review section also included empirical literature about the problem topic: continuing professional development; quality education, patient outcomes, and quality of care; differentiation by quality in healthcare education. I also discussed the impact of high-quality healthcare education on the healthcare profession and population health.

The process of literature review can be overwhelming; however, there are two key steps before the start of articles collection, reading, synthesis, and writing of the literature review. The first step is to prepare a literature map, then a literature review tree. I prepared a literature map (Figure 1 on page 16) on a white board next to my work station; whenever I looked for articles, I referred to the map. The map helped me stay focused

and on point. Referring to the literature map allowed me to limit the articles to what was relevant to my study and to know when to stop searching and downloading articles.

Figure 1

Literature Review Map



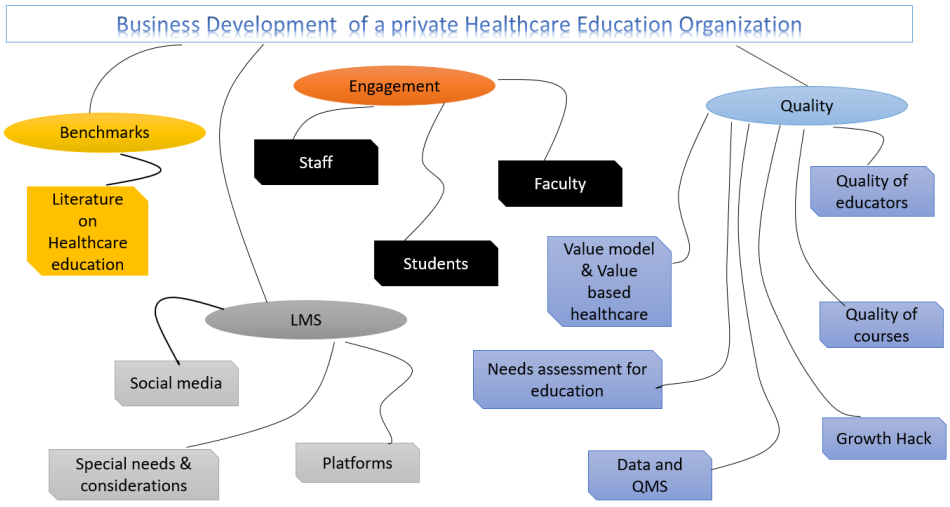
Note. I developed this literature review map at the start of the study while I was working on the Prospectus. It helped me categorize the literature part in the Prospectus and prepare the headings for the review of the literature section in the Doctoral Study.

The literature decision tree (Figure 2 on page 17) is a graphical representation for the search words I identified based on the literature map. I used the following keywords to conduct my search: *healthcare profession education*, *system of continuing professional education* (CPE), *CPE teaching methods*, *social media & healthcare education*, *special needs and consideration & healthcare education*, *platforms/learning management*

*systems used in healthcare educ*ation, *growth hack in healthcare education, engagement of staff in private healthcare education academies, retention and attraction of clients & healthcare education, quality of educators, quality of course, quality of data and quality management systems, needs assessment for healthcare education, value model, blended learning, logic model, formative evaluation, summative evaluation, qualitative research methods, quantitative research methods, mixed methods, five forces of competitive advantage, value-chain model, differentiation strategy, competitive forces & strategy, healthcare professional education & virtual patients, health professions workforce, criteria of healthcare education organization, strategic alliances,* and *partnerships with academic institutions & health agencies*.

Figure 2

Literature Review Decision Tree



Note. I developed this literature review decision tree at the start of the search for articles. I followed the general categories of the literature review map.

The databases I used are ProQuest, EBSCO, ABI/Inform, ScienceDirect, Elsevier, Google Scholar, and Thoreau. I have limited my search parameters to English written peer-reviewed articles published as of 2019. The only exception to this date parameter are the articles and publications of the theoretical framework and alternative theories, and the seminal articles and books. Since the work started in 2021, I did not have a track of the results per key word search, which was a limitation to develop the search log table as per the template provided in Appendix A. I recommend that doctoral students familiarize themselves with the search log table and collect the relevant information as soon as they start working on their doctoral studies.

Finally, I used the literature review matrix (see Appendix B) to keep a well-documented table with the reference written in APA 7th edition format, notes about downloads, where I used the information in my study, annotated bibliography, and summary of the article with important information relevant to my study. I also used the literature review map to create the headers; this way the headers of the matrix matched the folders' names under which I saved the articles.

Program's Theoretical Frameworks

The theories that ground this study include the five forces for competitive advantage and the value-chain theories. Both theoretical frameworks were developed by Michael Porter. The five forces for competitive advantage was developed in 1979 then refined in 2008, and it includes strategies for differentiation and competitive advantages (Porter, 1979, 2008). The value-chain model was developed in 1985 and includes

differentiation by creating competitive advantage through increasing the value of subsidiary activities (Porter, 1985).

In this study, I used the integrated models and evaluated the program through the lens of these frameworks while focusing on the constructs of competitor analysis of existing competitors, new entrants, bargaining forces of the buyers, threats of substitution, primary activities (operations within the unit, marketing and sales, and services), and support activities (firm's infrastructure, human resource management, and technology development). The focus on these specific constructs supported the business problem and the purpose of the study, which will lead to the development of the differentiation by quality strategy. The approaches are indivisible; removing any component restrains the efficacy of the study and prohibits me from achieving the goals.

Five Forces that Shape Competitive Advantage

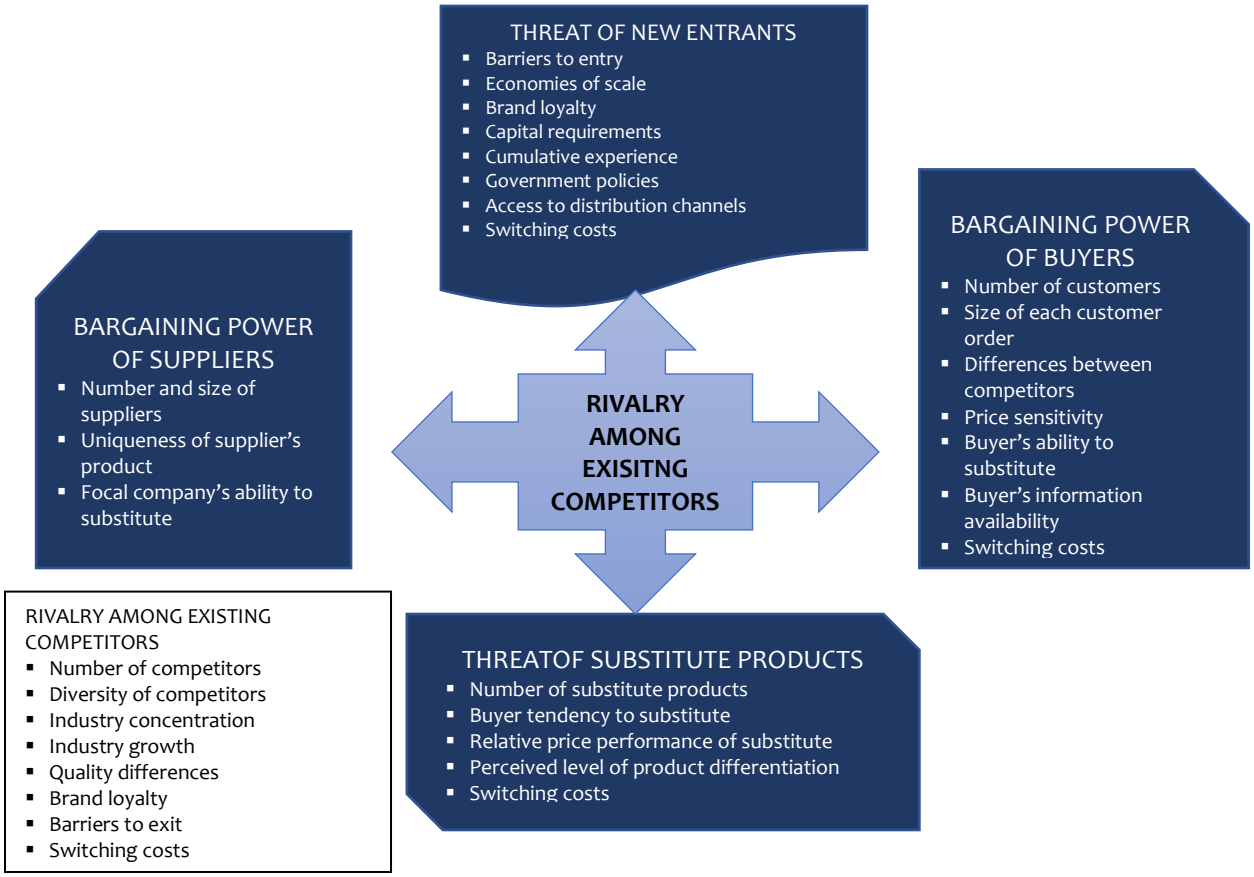
Leaders and strategists must understand competition, define it, and put a strategic plan that secures a company's growth while securing a competitive edge. The first theory that frames my study is the five forces of competitive advantage (Porter, 1979, 2008). Porter (2008) emphasized that strategists need to cope with competition, and yet, competition is not evident because, in many cases, the most prominent, damaging, risky force is not always noticeable to the leaders, especially when the rivals are not able to read each other.

The five competitive forces are used to calculate or analyze the industry's competitiveness. Porter (1979) identified these factors as: the threat of new entrants, the

bargaining power of customers, the bargaining power of suppliers, the threat of substitute products or services, and the jockeying among contestants (revised in 2008 to become rivalry). Figure 3 illustrates these forces and shows a summary of their components.

Figure 3

The Five Forces of Competition



Note. In this diagram I provide my visual summary of the Five Forces of Competition based on Porter's 1979 work. It contains summaries of the forces and major ideas under each.

Leaders have a duty to know how these forces work within their industries. Understanding these forces help leaders implement plans that will affect the company in many situations (Porter, 1979). Other essential factors to consider can directly or indirectly affect the competition, such as government policies, force majeure and natural disasters, industry growth rate, technology and innovation, and complimentary products. McMillan (2010) based his study on Porter's five forces and created the five forces for effective leadership, highlighting Porter's view that to compete does not eliminate leaders' role in creativity and innovation. Understanding these forces, with the effect of the factors, allow leaders to form their framework to use, and it helps them investigate the roots of the problem or competition and then build a barrier that is not easy to penetrate.

Leaders are on the lookout for competition. The essence of Porter's five forces model is to cope with the competition and understand the external environment analysis that allows them to formulate a solid strategy to increase profitability. Porter (2008) emphasized that the most potent force or forces determine profitability. However, profitability is not the only indicator of a company's success. Competition is perceived negatively, narrowly, and pessimistically (Porter, 1979). Identifying competitors beyond the obvious is key to a successful organization, and so is having an innovative approach to sustain the innovation competition (Harper, 2019). A company needs to stay on the lookout to be profitable; one organization's weakness is another's opportunity.

Organizations can position themselves in a powerful and impassable place, difficult for others to imitate or penetrate. The degree of competition varies with the five

forces. Porter (2008) highlighted that this extended rivalry defines a company's structure and strength and shapes the competition. It is crucial to understand and analyze the rivalry's subcategories, and to identify the degree to which an industry is fiercely competitive. It is also essential to measure the five forces and understand their analysis in parallel with the other factors (Dyer et al., 2020; Porter, 2008), the industry's overall dynamics, and the level of rivalry between competitors. Rivalry is one of the five competitive forces elaborated in Porter's model, and the overall result of the five forces determines the degree or the extent of the rivalry.

The customers determine if the new market entrants or rivals succeed. Customers tend to join companies with an extensive network or which produce a product that attracts many other buyers (Porter, 2008). Diversifying the services or products in a way that discourages the customers from buying from just anyone, offering something remotely similar to what they need, is crucial. Customers consider the switching costs when they want to decide on other products or services. Switching costs are buyers' lost costs when they change suppliers (Porter, 2008). If the customer is willing to spend money and time looking for alternatives and join new organizations without vouching for the reputation and the quality of services provided, they are accountable for this choice. Hence, the strategy to implement becomes that which attracts and retains the customers, the strategy that gives them what they want and need.

Incumbency advantages provide a differentiation by quality and cost. Incumbency advantages are ownership of services, products, or technology that are unavailable to

potential rivals (Porter, 2008). When an organization invests in creating a branded identity, tailored services, and specialized products, it attracts and retains its customers by making them feel comfortable and satisfied and improving their customer experience (Porter, 2008). Customers will not want to shift their work elsewhere as they become familiar with the organization and its services. While investing in increasing the barriers to new entrants and blocking rivals, the organization may have restrictions that hinder their progress no matter what they do.

Market selection is a crucial step to identify before entering any markets, developing any strategy, and competing with others. The strategic management process is defined as the process that an organization puts in place, based on which it will allocate its resources (Dyer et al., 2020). This identification and selection of the market secure early wins for the organization, providing it with a clear picture to formulate its mission. When selecting the market to venture into, leaders have to be aware of factors, not forces, which will sustain or hinder their success.

It is essential to avoid pitfalls when planning for competition. Leaders must consider these pitfalls as mistakes with visible attributes of an industry; industry growth rate, technology and innovation, government, and complementary products and services (Porter, 2008). Governance and government policies hinder an organization's progress and limit its opportunities, but governance is necessary to maintain rules and standards of practice. Government policies can be barriers to private organizations or aid new entrants when the market is open, and there is no limitation on who can enter the field (Porter,

2008). The limitation that a governing body can do is to mandate licensure for organizations and practices. However, entities supported by a governing body have a greater chance of success than others. Assuming that a growing industry is attractive is a common mistake (Porter, 2008), because growth expands equal opportunities for all competitors, not only for one company, and puts suppliers in a powerful position, not the organization itself.

Suppliers, such as technology suppliers, can monopolize the diversification and competitive advantage. In an era of dynamic technological changes, advanced technology and innovations are not enough by themselves to secure a competitive advantage (Porter, 2008). Advanced technologies are costly and do not guarantee profitability (Porter, 1985), and it will be challenging for a company to offer services using high technology at cost-effective prices. The balance remains with the equilibrium of technology integration and demand.

This equilibrium can be achieved with the integration of products and services. Porter (2008) named this equilibrium "complementary products or services." Complements arise from the benefit to the customer and what they get for this complement offered. Complements are not only within the organization itself; partnerships with other industries or organizations may better benefit the customer. These complements become profitable to the organization by the way they affect the five forces (Porter, 2008), for example, buying a car with an offer for a year's free insurance, a year's coupons for gasoline, and washing services. These services are not all offered by

the car dealer; however, the partnership or deals that this car dealer has with gas stations, and insurance companies, benefit customers on the one hand and make the business profitable on the other hand.

The competitive forces expose the drivers of competition. Leaders and researchers who understand the extent of competition beyond rivalry have a broader ability to detect threats and opportunities (Porter, 2008). This understanding leads to superior performance within the organization, value added to all its activities, services, and products, and an increase in the overall organization's value.

Value-Chain Theory

The study I am conducting aims to increase the value of the organization through the development of a differentiation by quality strategy. The five forces theory was elaborated in 1985 by Porter to include the value-chain model. Porter created this model in 1985 in his best-seller *Competitive Advantage: Creating and Sustaining Superior Performance*. Porter considered that everything done in an organization is subject to a series of events, a chain of activities, where value is added at each step and where the end product was an outcome with more value than when it started.

The value chain model became a pillar analysis tool for strategic planning, especially since the model makes leaders think of processes and look at the organization as a whole. This system in any organization is divided into three main subsystems: inputs, transformation, and outputs (Dorri et al., 2012). These subsystems involve using resources (financial, human, material, equipment, assets, and management). Costs and

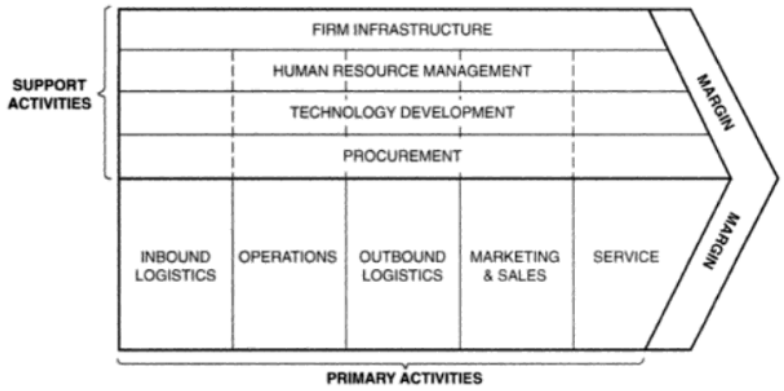
profits are then determined by how leaders of the organization operate and use these resources. Porter categorized these activities into primary and support. Even though the value chain makes leaders work together in the organization for the profit of the whole organization, Porter (1985) considered that competitive advantage could not be understood by looking at the organization in its entirety. Any organization's activities are designing, producing, marketing, delivering, and supporting its products or services. Each of these activities contributes to differentiation. When analyzing an organization, it is clear that the totality of this entity is the collection of its subsidiary activities. In my study, I worked with the marketing department to create a differentiation by quality strategy that will increase the organization's value and differentiate it from other private healthcare education organizations. For that matter, the value-chain model is optimal to be used as one of the frameworks of the study.

Porter (1985) started by discussing competition and referred to the forces that impact competition, which I elaborated on in the previous section. Since competition is the core of the success or failure of firms, leaders must determine the appropriate activities that will contribute to their performance. A well-elaborated competitive strategy will determine the organization's position in the market, and to complete the positioning, leaders have to assess their organization's attractiveness level in the industry (Porter, 1985). In other words, leaders need to be aware of the competitive forces and factors to include in their differentiation strategy to position themselves at an impenetrable level.

Primary and support activities have three subcategories of activities; direct, indirect, and quality assurance. Porter (1985) explained that direct activities have a direct impact on the value added to the company, indirect activities are catalysts to the direct activities and their continuous presence allow the organization to perform the direct activities (e.g., maintenance and research), and quality assurance activities start with the audits and control of other activities and help improve processes. Quality assurance is an integral role of the compliance programs within the institution (Burrows, 2006), and the risk to invest in compliance programs outweighs the financial losses and risk that an institution may face. Compliance programs offer the organization a chance to prevent misconduct, ethical dilemmas, and lawsuits, prepare the organization to the changes in demand, and provide evidence for authorities and clients that the leaders are serious and accountable. It is not enough to invest in the compliance programs and quality management (Hemme et al., 2020); it is crucial to prove that the program is alive, functional, sustainable, and proactive. Organizations with compliance programs have a better understanding of the work outcome, and can make informed decisions in their strategic planning with accurate data and information.

Figure 4

The Value-Chain Model



Note. From *Competitive advantage: Creating and sustaining superior performance* (1st ed., p 33–52), by M. E. Porter, 1985, The Free Press. This figure is available to public access and is used too many times in multiple studies and articles, there is no indication for a need to have special permission for use.

To understand the value chain and its impact on healthcare education, I summarized its definition as reported by Porter (1985) (see Figure 4). Porter believed that to diagnose competition, it is crucial to dissect the organization and understand which activities are responsible for the success or hinder the progress of a firm. Dissecting the activities in a firm leads to a long list of activities under the above-mentioned categories and subcategories. However, leaders must know how to segregate the list into activities that have a different economics, activities that have a high potential impact on differentiation, and activities that represent a significant or growing portion of the costs.

Experience and professional judgement are the key to a proper segregation and activity distribution. Leaders are actively involved in this process and determine with their distributed leadership (Leach et al., 2021) the assignments for each category that best represent the contribution and the priority to the organization. Porter (1985) stressed that the value chain is a general guide and model, and explained that firms have often gained competitive advantage by redefining the traditional roles of activities, such as involving their customers in their primary activities through training of customers, and thus, making customers marketing tools.

Everything a firm does is part of a primary or support activity. Prioritizing which activity to tackle first is the result of impact on the outcome and the leadership judgement (Porter, 1985). Prioritizing activities and action plans does not imply working in cascades. Plans can be implemented in parallel, which increases the teamwork, especially that the managers who would have to work together for the best outcome. Collaboration is one of the success criteria of distributed leadership (Leach et al., 2021). Value-chain enhances the collaboration between employees and departments, hence, enhances the quality of work, eliminates redundancies, prevents errors and time wastes, and increases efficiency and profit.

Application of Both Theories in Healthcare and/or Education

The awareness to the concept of value is increasing. Value is the framework for performance improvement (Porter, 2010), and has two primary forms: value for customers and value for companies (Lüdeke-Freund et al., 2020). Lüdeke-Freund et al.

(2020) explained that many theorists addressed the value of a business; however, the literature on applying the concepts is limited. The authors added that the value proposed by a company is embedded in the services and products it provides. Multiple researchers tried to explain how the value is created, how stakeholders are included in this value creation, and how to sustain the created value (Lüdeke-Freund et al., 2020; Porter & Lee, 2021). Lüdeke-Freund et al. (2020) invited all authors addressing value to research how to have a sustainable value creation that applies to any context of business model research and closely study the beneficiaries of this value creation. The authors emphasized that value creation is not related to profitability but has many other components to be addressed.

Value is created in multiple ways. Porter (1985, 2010) explained that an organization's value increases by increasing the value of the organization's subsidiary departments, looking at the organization as a whole, and working on each entity, which is known as the value chain. Lüdeke-Freund et al. (2020) presented that value is created from applying the business operations through the optimal use of resources and capabilities. The value creation and measurement of its increase are only explained and understood after the meaning of value is defined by the organization under study (Lüdeke-Freund et al., 2020; Porter, 2010).

Value-chain and the five forces of competition defer from the value in ethics and belief systems. Their value is about weight, importance, success, innovation, visionary, and successful competition (Carlton et al., 2017; Hernandez et al., 2019). To reach the

aforementioned, the senior management and board-level executives must embrace the value model (Hernandez et al., 2019). Calton et al. (2017), Groccia and Ford (2020), and Hernandez et al. (2019) explained that value-chain focuses on decreasing costs while maintaining or improving the quality of services; thus, it is an output-focused model. Whereas the value-chain works on the company as a whole, implementing urgent actions on the model's supporting activities rather than its primary ones is more efficient, solves a lot of internal problems, sustains productivity, avoids waste, and invests in having the correct people in the correct positions with the proper authority and accountability.

The value-chain model is a modern pedagogical model for university and postgraduate education. Dorri et al. (2012) demonstrated that value-chain is a network of activities centered on teaching, research, and community service. The outbound activities in the model revolve around curricula design, delivery of quality education, assessment, research and development of educational activities, and provision of outreach activities to the community. The application of this model to the healthcare education becomes straightforward; the model’s inbounds and outbound are the same, yet, the impact on the community is higher with the involvement of population health and healthcare education programs that target the population and increase awareness.

Healthcare education is a market. It is similar to other markets; it has customers, competitors, shares, positioning, barriers, and new entrants (Walters & Jones, 2001). If healthcare education is a market and has these components, the five forces of competitive advantage apply to the study of this market. The value strategy is linked to the customer’s

satisfaction and quality is strictly related to the value and satisfaction (Walters & Jones, 2001); the value chain model increases the value of the company. Both theories are complementary in the creation of value and differentiation by quality in healthcare and in education; hence, the integration of these theories in my study is crucial to achieve the goal of this study.

Alternative Theories

Literature is full with theories on management, healthcare value, education, and competitive advantage. I decided to use Porter's two models because they are intrinsic and support my study. Having the same author for both theories helped me avoid pitfalls and contradictions from the literature. The theories are complimentary; Porter based the value-chain model as an extension to the five forces for competition; hence, the logic and analysis are inline and stem from the same philosophy. However, other theories could have been used for the healthcare and education for value creation and competitive advantage.

Value-Based Healthcare Agenda

Michael Porter expanded his value-chain model and developed many frameworks that addressed competitive advantage. However, in 2006, he started linking the value-chain model to the healthcare systems, and in 2010, he published the value-based healthcare (VBHC) agenda. Porter (2010) described "value" and emphasized that value defines the framework for performance improvement in healthcare. In addition, he emphasized that it should always be patient-centered. Since value is an outcome of the

organization's performance (Porter, 2010), increasing an organization's value is measured through cost efficiencies, quality of services, and customer care; thus, using multidimensional variables. There is no single outcome in healthcare, and there are multiple ways to increase the value of the services and the overall organizational value. The VBHC agenda is widely and internationally used, and has an impact on healthcare. Although it has been used in education, literature is scare on its applicability in the healthcare education field.

The value agenda is designed to provide a path for achieving high quality and high-value care with cost-effectiveness. Porter and Lee (2021) published a playbook for developing an integrated practice unit (IPU) as an integral part of the value-based agenda. The article addressed the healthcare systems' dysfunction. Implementing the IPUs benefits the organizations and adds value to the services provided with higher patient and family satisfaction. IPUs are a multidisciplinary team that works together for holistic patient and family care. IPUs create volume, increase satisfaction, retention, and loyalty, and reduce the chance of miscommunication. IPUs and value agenda are not only limited to the healthcare organizations; they have been recently included in healthcare education, as they create a competitive advantage and revolve around the patient's needs. An organization with IPUs reflects that it is a value-driven organization to the community. The VBHC agenda, and the IPU construct specifically, would have been an excellent framework to use for this study, especially because it is recent and well known in the

healthcare industry. Because literature is limited on the VBHC's use in healthcare education I refrained from using it in my study.

Value Based Management

The idea of value management started in the late 19th century until McTaggart et al. (1994) used the terminology "value-based management" (VBM). VBM's central focus is to create value for the company to maximize shareholder value. The three constructs of the theory are creating value, managing for value, and measuring value (McTaggart et al., 1994). The VBM provides organizations with logic and a systematic model to improve shareholders' value (Bannister & Jesuthasan, 1997). Stakeholders' primary concern is the ability of the company to receive a return on its investments and make a profit.

VBM allows the company to evaluate its ability to generate money and the return on the invested capital while it guides the leaders on how to face the increased competition and demand of the market (Fioresi de Sousa et al., 2020). The goal of each investor and stakeholder is to make a profit and have a successful business. However, success is not only measured in financial profits. Cost-accounting systems are used in hospitals; yet, they are not markers of performance. Instead, there are models to pay for performance based on these systems (Triantafillou, 2022). Value in VBM is an equation for cost, profit, and loss; the model simplifies the financial value and works around maximizing the profit for the shareholders. My study aims to increase the value of the organization (positioning, reputation, and brand) through the differentiation by quality of its services. The goals of my study cannot be achieved using the VBM alone, as it has the

stakeholders at the center of the model, while the healthcare population and the community's health are at the center of my study's interest.

Quality Education, Patient Outcomes, and Quality of Care

In this part of the literature review, I covered the skills that healthcare education organizations need to be attentive to, and add in their curricula, to secure a differentiations by quality strategy. I started by examining the team, multidisciplinary, and interprofessional concepts and how best to train them. I then addressed the clinical leadership, advanced practitioner, and distributed leadership skills important for healthcare providers. The third point is addressing the sustainable healthcare and ideas on how to incorporate it in the curricula.

Team, Multidisciplinary, Interprofessional.

A healthcare team's diversity is a strength for an improved patient outcome. The impact of healthcare professional education (HPE) directly affects patient outcomes and is indirectly achieved with the employees' outcomes as team's diversity is the standard of practice in today's healthcare profession (Zajac et al., 2022). The aim is to reach positive outcomes for the patient and the community, but many factors hinder the execution. For instance, burnout is an indirect loss, and research proved that burnout is negatively correlated to engagement (Schaufeli & Bakker, 2004); if the engagement increases quality and value, hence the income, burnout leads to financial loss. Leaders also will have to look at this loss in terms of sick time: how much overtime is needed to cover the increased sick time, the limit of overtime allowed, and how to calculate the value of sick

leave versus overtime and justify increases in salaries and benefits or hiring more staff. Leaders must have the financial and business acumen to collect the necessary data to justify additional full-time equivalence. However, these skills are not innate; teaching leaders how to have a business and financial acumen is not straightforward and is one of the responsibilities of a healthcare education organization.

Factoring the financial and business acumen in the leadership training is important, but there is a higher need to train healthcare professionals on human management. Team diversity management is a standard practice but the training on teamwork and collaboration is still outdated and underused, and many teams are not well equipped to address the challenges emanating from dysfunctional teamwork (Zajac et al., 2022). Leaders will have to address the harmony of interprofessional, multidisciplinary, and teamwork to develop safe environments, and forge trust and effectiveness which lead to success and better patient outcomes, while reducing stress and burnout.

Burnout leads to disengagement, which leads to patient dissatisfaction. Nevertheless, this is not the only relationship that leads to loss. Burnout increases the risks of clinical errors, increasing litigations, and costing money that could have been used to improve the work at that organization and in the community (Tingle, 2022). The logical action appears to decrease burnout, and leaders would want to know how to overcome these preventable challenges.

Human resource management (HRM) is crucial to increasing satisfaction, preventing errors, and increasing patient satisfaction; hence HRM needs to be conducted

proactively. Talent acquisition is a talent; it is not easy to identify, assemble, and develop employees who will have loyalty, added value, and impact in the organization and on the community (Nowak & Scanlan, 2021). Leaders ought to have succession plans, and stay ahead of the vacancy curve, so that the overall performance of their units, departments, or organization does not fluctuate. Effective succession planning implies the continuing training, recruitment, development, exposure, mentoring, and coaching (Nowak & Scanlan, 2021). Healthcare education organizations have the opportunity to develop comprehensive, hands-on training, involving front line staff, managers, and human resource departments, to keep them ready for the expected exit, washout (leaving because of exertion and burnout before the average years in a discipline), and shortage of healthcare providers, while engaging everyone and maintaining their retention and motivation.

Innovation in healthcare education encourages healthcare education institutions to develop unique and attractive contents that differentiate them from other institutions. The problem remains in identifying when to offer these programs as there is no clear understanding of the training that needs to be done before, during, or after residencies (Cobb et al., 2020). Because interprofessional work improves patient outcomes (Omilion-Hodges et al., 2021; Zajac et al., 2022), it will be wiser to start from the undergraduate level. If all healthcare disciplines collaborate to train their members on interprofessional work, the results and impacts will be measured and substantial immediately from the time the team joins a healthcare institution. Omilion-Hodges et al. (2021) and Sifaki-Pistolla et

al. (2020) stressed the importance of trust amongst the healthcare provider teams, demonstrating that collaboration with the plethora of knowledge, skills, and expertise will reduce waste, unnecessary tests, and eradicate errors and duplication of work. Interprofessional work also allows members to be transparent, hold each other accountable through peer-to-peer accountability, brainstorm on cases, have more critical thinking, and, more importantly, decrease burnout.

Interprofessional training and interprofessional work also affect differentiation and competitive advantage. Competing with other organizations in the same industry create a coordinated value chain which increases competitive advantage through interrelationships (Porter, 1985). This interrelationship is also known as strategic alliances where organizations venture in coalition forms and partner to serve the same market share covering a broader spectrum of the demand.

Clinical Leadership, Advanced Practitioners, and Distributed Leadership.

Every discipline in healthcare has hierarchy and leadership; however, not all of these disciplines receive the proper training for low, middle, intermediate, and high levels of leadership. Few medical schools and residency programs offer their students leadership training, especially that it is difficult to add this training to the loaded medical curricula (Cobb et al., 2022). The impact of clinical leadership on health outcomes has gained increasing interest in health systems worldwide (Duignan et al., 2021). This lack of training results in limited leadership amongst physicians, accidental leadership learning, and resistant behavior, which limits their collaboration. Between 2009 and

2019, no studies were conducted on the advanced practitioner role in allied health professionals, and there is a paucity in the literature with objective evidence to identify the need for clinical leaders (Duignan et al., 2021). In my search for articles about leadership competencies and patient outcomes published between 2019 and 2022, I found 27 results, 25 of which are about nursing leadership competencies and training in their roles to improve patient outcomes. The opportunity for healthcare education organizations is to develop accredited educational programs, for allied health and physicians, to incorporate the advanced practitioner roles, and train healthcare providers, since the undergraduate levels, on the career paths in healthcare, combining clinical practices and leadership roles.

Fostering leadership skills and training lead to authenticity. Authentic leadership in nursing proved to be significantly related to nurses' safety actions, decreased nurse-assessed adverse events, and increased care quality (Labrague et al., 2021). Healthcare leaders are responsible for identifying the "advanced practitioner roles" in each of the healthcare disciplines, so that specialized education and training can be delivered to these professionals as clinical leaders. Specialized education and training can help clinicians' progress in their careers with a higher level of influence and impact on care quality and outcomes.

Even though the nursing profession focuses on advancing the practice, the role of the nurse researchers is challenging. The nursing profession focuses on advancing the practice, which may be why there is a lack of clinical leadership research among non-

nursing disciplines, and nurses are more involved in training leaders (Duignan et al., 2021). Most nurse researchers are involved in clinical practice, teaching, and research (de Lange et al., 2019). For nurses to advance in the profession, they require support and mentoring from their leadership. They have to stay in clinical practice to quickly identify the problems that need improvement (de Lange et al., 2019) and apply the results of their research with the front liners and the multidisciplinary teams for the ideal benefit of the patients. The downside of publishing in renowned journals is that these articles do not reach the intended audience: front-line practitioners who should revert to them to improve their care (de Lange et al., 2019). The role of healthcare education organizations in this matter is to teach researchers how to identify clinical problems and study them to achieve evidence-based practice (EBP). Another role of healthcare education organizations (HCEO) is to train healthcare professionals at all levels on how to use evidence-based practice, look for current peer-reviewed articles, and critically read these articles. An additional role of HCEO is to provide access to research and databases to healthcare professionals.

The associated competencies and benefits to clinical leadership are then related to leadership skills, research, and teaching, and they need to be taught at multiple levels of the healthcare team. Paarima et al. (2022) proved that nurse managers have moderate knowledge about the needed competencies for their positions, and they determined that ineffective leadership has severe consequences for patient and staff outcomes. In fact, training the first-level managers in clinical leadership is crucial for improving care and

patient outcomes, as nurse managers have a key role in supporting and equipping advanced practitioners with leadership competencies (Duignan et al., 2021). Advanced practitioners are clinical leaders who progress in the profession and have a higher impact on care quality and outcomes.

Clinical leadership skills are essential for healthcare professionals to improve the quality of care and the personal and the team development. Clinical leadership channels effective team behaviors and skills, resulting in an optimal outcome by providing safe and efficient care, as highlighted by governmental reports and the academic literature (Cobb et al., 2020; Duignan et al., 2021). The complexity of the multidisciplinary and interprofessional healthcare teams is unique and can be considered complex interventions, like open heart surgery. The harmony of the work is taught and not inherent, and the more a team works in synergy and harmony, the better the outcomes and the care. The first attribute is the willingness to work nonstop (de Lange et al., 2019). The mindset to be educated in clinical leaders is how to take care of themselves, balance their work-life balance, maintain their well-being, and work 24/7. This skill is not easy; many healthcare professionals washout because they cannot do this balance. Healthcare education organizations would benefit from incorporating well-being training in their curricula and train the individual and the team on the best practices of mindfulness and shared responsibilities.

Learning on the job is the norm in healthcare; however, there are multiple areas to address in the training of healthcare teams. Interprofessional education (IPE) positively

correlates with improved patient outcomes (Alrasheed et al., 2021). These IPEs develop leadership skills that positively impact the workforce's caliber, reducing turnover and hence, reducing the associated costs. Literature is rich in healthcare leadership competencies and the common characteristics that can be observed and measured. Some of these characteristics are: clinical embeddedness; expertise; visibility; role modeling; facilitator of care; active membership in multidisciplinary teams and hospital committees; active involvement in committees that work on guidelines, policies, and procedures; initiating and improving patient care through service development; influencing practice through education and mentoring; assigning roles; developing team direction; motivating members; encouraging communication and collaboration; establish a positive working environment; and acting as advocates for patients (Cobb et al., 2020; Duignan et al., 2020). Each of these competencies can be incorporated into an educational event: webinar, workshop, simulation, role-playing, in-services, and any other educational method. A healthcare education organization that identifies these needs, plans for the delivery of the highest clinical leadership programs, and forges alliances with disciplines and healthcare organizations, will create a differentiation by quality that is unique and not easily duplicated, fortifying the barrier for new entrants.

Patient outcomes measures reflect the leadership's performance. Leadership patient-related outcomes are measured with 30-day mortality, patient safety, hospital-acquired injuries, patient satisfaction, physical restrain use, pain management, readmission rates, and waiting times (Duignan et al., 2021). Organizational commitment,

incidence and complaints rates, and an organization's readiness start with the clinical leaders; healthcare professional education must provide the tools and proper training to healthcare providers since their junior years of practice to help them transition in their career advancement and promotions in leadership roles.

The complex dynamic of the multidisciplinary team exceeds the limits of clinical practice. The variety of professional backgrounds in the healthcare organization's leadership is evident; the leadership triad – Chief Executive Officer (CEO), Chief Medical Officer (CMO), and Chief Nursing Officer (CNO) – are professionals from different backgrounds who should understand that their roles are complementary and not mutually exclusive; interdependent, and crucial and that their loyalty and duty is towards the patients, their families, and the community (Burns et al., 2020; Porter, 2010; Porter & Lee; 2021). The struggle in the power triad leads to imbalance, adverse patient outcomes, and patient safety events (Health, 2018; Singal et al., 2020). Koerich et al. (2020) defined the triad of power in healthcare to be based on healthcare education, patient safety, and quality of care, where the proper integration of healthcare education that includes patient safety and quality needs to be unified across the institution, in all disciplines, and at all levels. Burns et al. (2020) mentioned a power triad between disciplines in their struggle to determine the primary caretaker responsible for the patient's care and decisions. Distributed leadership incorporates inclusivity, collectiveness, and collaboration suitable for healthcare's complex and interdependent nature due to professional jurisdictions and background training (Leach et al., 2021). Training healthcare professionals in returned

demonstrations, simulated scenarios, internships and residencies, and forum discussions about the leadership triads and the implications of practicing distributive leadership is another competitive edge that healthcare educational organizations can address to increase the quality of their programs and differentiate themselves from other traditional didactic training.

Sustainable Healthcare.

Sustainable healthcare is an emerging, yet crucial concept in the medical practice. The United Kingdom has implemented this concept in its licensing programs for doctors qualifying or registering in the United Kingdom (Tun, 2019). Sustainable healthcare is an understanding, and application of a concept that is cross-sectional in the medical practice. Its applicability is not limited to one area, domain, specialty, or department. Clinical educators, medical schools, and healthcare education organizations are responsible to teach healthcare providers on the practice of the principles of sustainable healthcare (Tun, 2019). Maxwell and Blashki (2016) believed that doctors have an essential role in incorporating the teaching on sustainability in the curricula, thus, leading the positive change in the future medical practices. Incorporating the concept and principle of healthcare sustainability will allow healthcare providers to have high quality care now and improve the chances for the community in the future (Maxwell & Blashki, 2016; Tun, 2019). The limitation so far is in the literature of this subject; methods of teaching sustainability and how to add it in the curricula have been completed (Bell, 2010); however, the literature is limited on the benefits of these methods and the impacts on

healthcare practices. Healthcare education organizations who identify the needs for education on healthcare sustainability and equity, and find the appropriate way to teach them, while conducting their own research on the topic will have more impact on the profession and the community. These are unique opportunities to incorporate in the healthcare education organization's strategy for differentiation by quality.

Differentiation by Quality in Healthcare Education

In this last section of the literature review, I discussed the differentiation strategy and why it is important for leaders to develop and implement differentiation strategies. I also discussed the differentiation by quality, and I addressed, as per the literature, means and solutions to adapt to increase the quality, especially in healthcare education.

Differentiation by Quality Strategy

Differentiation strategies are powerful tools that lead to competitive advantage. Differentiation strategies have potent benefits; their development and implementation give a coherent direction to the organization for better strategic decision-making and provide guidance to the leaders to know clearly what their goals will be and how to achieve them (Akingbade, 2020). Because leaders of any organization want to make profit, having a clear understanding of competition and differentiation helps plan to increase profits, position their organization, and survive in the market. Differentiation strategies allow the organization to earn its success and attain an economic value (Islami et al., 2020). The proper use of differentiation strategies can create a higher threshold for new entrants and block the rivals' advancement.

Developing the appropriate differentiation strategy requires setting the goals for the organization. Porter (1985) explained that organizations need to either offer a product or service at the lowest price, or to differentiate the product or service in ways that are appealing, and which are perceived to be unique by the client. If the clients value this differentiation, they will buy the products or services at whatever cost, because they value the uniqueness of the products or services. When the clients are ready to pay for their preferred product or service, no matter the price, the buyers' bargaining power is reduced. Pursuing a differentiation strategy guarantees the sustainability of the business, and increases its performance (Islami et al., 2020). Leaders need to understand how the differentiation strategy will link their organization to the attractiveness of the industry, and how it will position the company in the market (Porter, 1985). Hence, the leaders who decide to develop a differentiation strategy have to understand the benefits for product differentiation, service differentiation, and mixed differentiation for products and services.

Product differentiation and service differentiation have a lot of commonality and few differences. Product differentiation takes multiple forms; it can be related to taste, design, brand, quality and distinction, delivery, and special features at best prices (Akingbade, 2020; Islami et al., 2020). Product differentiation hooks the clients and makes them loyal to the brand, and the product becomes a preference. Service differentiation has the same properties of the product differentiation; however, services are intangible and do not result in proprietorship (Akingbade, 2020). Service

characteristics are linked to ease of service, venues, appeal, customers' training and engagement, and after-sales services. These characteristics influence the value-chain activities and create uniqueness, which, when combined with the higher price, will lead to higher profit margins (Islami et al., 2020). Service differentiation is linked to service quality; the value of a service to the client (Akingbade, 2020). It is driven by four factors; 1) the need for this service and its reliability, 2) the delivery of the service by the employees; their responsiveness and empathy; their tailored and individualized care; and their competence and diligence, 3) the consistency of the employees' behavior, and 4) the environment in which the service is provided. In the value proposition, leaders will analyze which types of customers the organization will serve, who is the target audience, what are the channels to reach them, how they are going to meet their needs, and what are the relative prices, premiums, parity, and discounts that can be applied (Islami et al., 2020). When leaders understand the differences and benefits of product versus service differentiation, they can bundle these differentiations in their strategy, and focus on the perceived value and the value proposition.

Implementing the best differentiation strategy requires an understanding of the mission, and the available resources. The primary and common goal to all strategies is to position the company to effectively and efficiently achieve its mission (Akingbade, 2020). A company's higher performance does not imply a higher return on investment, or higher profit. As discussed in the "Quality Education, Patient outcomes, and Quality of Care" section and in the theoretical framework, the value of products and services are

perceived and measured by the clients' feedback, opinion, perception, loyalty, and satisfaction.

What to do to Increase Quality in HCE and Differentiate

Strategic Alliances and Partnerships. Strategic alliances and partnerships are coalitions that lead to differentiation and uniqueness. These coalitions are long-term alliances but are not mergers; they are partnerships that help both entities widen their scopes by using each other's expertise (Porter, 1985). Forging alliances help healthcare education organizations expand their scope of work and block competition by increasing their standards and acquiring exclusivity, long-term agreements, and unique accreditations for their educational programs.

Academic practice partnerships align education and practice. Knight et al. (2020) presented a summary from the literature supporting the benefits of partnering an academic institution with a healthcare organization and community centers. The authors provided the example of the improved nursing practice based on the integrated education with the healthcare system and the community improving the health outcomes. Partnering and allying with national, regional, and international organizations increase the trust in the programs provided and the credibility of the healthcare education organization in the market, positioning it at a higher level amongst competitors.

Patient Activation and Community Involvement. Self-management is synonym to patient autonomy in making decisions in their health; it can be either medical or behavioral, role management, or emotional. Almutairi et al. (2020) defined self-

management as the “individual’s ability to manage the symptoms, treatment, physical and psychological consequences and the lifestyle changes inherent in living with a chronic condition” (p. 2). In a constantly changing environment, where patients have access to smartphones, devices, and internet, it is hard to keep research and new evidence-based practices from patients; it is also hard to keep patients and their families away from their healthcare plan. The term “patient activation” was first used by Hibbard and Greene (2013) who defined it as “the skills and confidence that equip patients to become actively engaged in their healthcare – and contribution to health outcomes, costs, and patient experience” (p. 207). Patient activation and patient engagement are interchangeably used in the literature; however, they are two different concepts. Patient activation includes the patients’ willingness and ability to make and take independent actions towards their health (Hibbard & Greene, 2013). This includes the patients’ understanding of their role, and it is different from compliance (following advice) or patient education (Almutairi et al., 2020). Patient engagement integrates patient activation, in addition to an active action taken by the patient towards an improved treatment plan and execution (behavior change, prevention actions, education, and training others) (Hibbard & Greene, 2013). Patient activation becomes the sum of engagement, education, training, knowledge, confidence, compliance, and willingness.

There is a tool developed to measure patient activation. The tool is patient activation measure (PAM) which is a self-administered tool to indicate the level of confidence of the patients in their own activation in managing their health (Almutairi et

al., 2020; Lightfoot et al., 2021). Engaging patients in their health management is a growing model in all healthcare disciplines and is a part of patient-centered care (Lightfoot et al., 2021). Literature proved that patient activation is linked to improved health outcomes (Allen et al., 2021; Lightfoot et al., 2021). Limitations to activation are in older age, lengthy hospitalization, disability, and inability to use technology (Lightfoot et al., 2021). Highly activated patients are more likely to adhere to the treatment, perform self-monitoring, have healthier behaviors, and therefore have better health outcomes (Hibbard & Greene, 2013). Moreover, Hibbard et al. (2017) conducted an extension to their initial study and calculated the PAM demonstrating that it is possible to increase the PAM scores of the patients and make them more engaged, more willing, more activated with more appropriated knowledge and tools, to help them reach the adequate level of self-management. Efforts from healthcare professionals are constant to help patients be compliant, knowledgeable, confident, and engaged; these efforts can be bundled with new technologies and the use of technology devices; thus, innovations and novice approaches are necessary to improve treatment plan development and implementation. The PAM has 13 questions that are assessed using a five-level Likert scale (*strongly agre*e to *strongly disagree*). Healthcare education organizations can partner with community centers and teach community members, public health staff, non-governmental organizations, community leaders, and other prominent and influential community members, about the PAM assessment, and how to improve the PAM scores, monitor them, and improve the overall population health.

Recent strategies used to improve patient activation and community's involvement include direct-to-customer advertising (DTCA) and shared decision making (SDM). Allen et al. (2021) explained that DTCA and SDM are successful strategies for improving prescribing guideline-directed medical therapies. Exposure to these strategies improve clinician-client communication and clients' exposure to treatment options. Shared decision making allows clinicians to work closely with their patients to reach optimal healthcare which aligns with the patients' values and preferences. For example, patients who value self-care, can be involved in their plan of care, through the shared decision making to reach a behavioral change and implement better self-care strategies, comply with medication regimen, have good diet, and exercise more. Thus, interventions to improve behavioral management are expected to have a direct impact on patient and condition's outcomes. Patients who have the knowledge, confidence, and skills to manage their disease have better practices of self-management behaviors (Almutairi et al., 2020). Patient activation techniques depend on interventions from the healthcare team which are delivered in-person (individual or focus groups), through telecare (including web-based training), telephone calls, or a combination of delivery methods. In their integrative literature review about patient activation concept, Almutairi et al. (2020) gathered that numerous patient activation approaches can be used: skills building, motivational interviewing, patient empowerment, patient-centered tailored care, and theoretical-based model including health belief model, social cognitive theory, and social ecological theory.

The new direction of incorporating digital technology in patient activation is referred to as the fourth industrial revolution. The fourth industrial revolution has the ability to improve the quality of life, while limitation is the access to or affordability of this digital technology; hence, challenge of inequity (Woodside & Amiri, 2018). Another challenge is for the leaders who have a difficulty keeping up with the change or anticipate change. Even with the limitations, it is empowering for the patients to use the technology and apps to improve their education and to be able to make informed healthcare decisions.

The role of healthcare education organizations in patient activation and community involvement is crucial and wide. Healthcare education organizations can address techniques, interventions, needs, and plenty of other aspects, to train healthcare providers on the concepts of patient activation. Healthcare education organizations can also have an impact on the population health and be part of the training for the patients to allow them to be more knowledgeable and confident in their skills to manage their health. Healthcare education organizations have the opportunity to develop applications and material that will help the population. Another opportunity for healthcare education organizations is to conduct free clinics for patient education by increasing their exposure in the community, identifying leaders in the community who will act as references for their peers, which will have a positive social change and a corporate social responsibility.

Big Data, and Digital Technology in Healthcare Education. Big data is trending in healthcare. Big data is now invading all types of industries, especially the

healthcare industry, which is a rich field for data provenance (Onyemachi & Nonyelum, 2019). Data sources are variable and can be collected from everywhere; in fact, tons of data can be collected from only one visit to a healthcare facility or doctor (Anom, 2020), and data can be extracted from patients' records, any patient encounter or test, and even social media (Onyemachi & Nonyelum, 2019). The use of big data in the healthcare industry varies in the intent, purpose, modality, and outcomes; however, what is expected is that big data relies on technology.

The definition of big data in healthcare varies in context, but it constantly refers to the amount of patient information and data collected. Anom (2020) defined *big data* as a technology that analyzes large data sets to provide helpful knowledge and insights, determine trends, and make predictions. Onyemachi and Nonyelum (2019) referred to big data as the vast amount of structured, semi-structured, and unstructured data that has the potential to be mined for insights and information. Moreover, Onyemachi and Nonyelum (2019) explained that 4Vs characterize big data; volume (amount), variety (different data formats), velocity (frequency of collection and analysis), and veracity (consistency and trustworthiness). Sousa et al. (2019) conducted a retrospective analysis of the literature addressing big data use and human resources; the authors highlighted that big data connects the world and serves as an efficient tool for decision-making in complex and unpredictable cases, providing healthcare professionals with a plethora of knowledge to make rapid and critical decisions.

Healthcare advancements and innovations in digital technology changed how medicine is practiced. Big data technology depends on machine learning (ML) and artificial intelligence (AI). At the same time, AI and ML feed from big data (Anom, 2020). The cycle is continuous and cannot be broken. Human experience and patient care produce data and input to machine learning and artificial intelligence algorithms. In turn, algorithms are used to predict patterns and make a diagnosis, changing the way healthcare is delivered. In all scenarios, there is a quadruple aim in using big data. The quadruple aim is to reduce cost, enhance healthcare outcomes, and increase patient and provider satisfaction (Cobb et al., 2020). Companies aim to decrease costs while increasing profits. In healthcare, profit exceeds the monetary value; profit is a sum of high-value quality care, improved care delivery systems, equity, accessibility, and improved people management. Healthcare leaders need to understand this quadruple aim and the meaning of profit in healthcare systems and invest in methods to improve the understanding of big data, digital technology, and new ethical challenges arising from this technology.

Improvements in the healthcare discipline depend more on humans than on technology. Backhouse and Ogunlayi (2020) explained that the 20/80 rule applies with 20% dependence on technology and 80% improvement dependence on humans, where communication, clarity, and common language are at the essence of the 80% human quota for healthcare improvement. Even though technology dependence is only 20%, technology is at the essence of healthcare delivery systems, starting with electronic health

records (EHRs), passing through the use of ambient devices and intelligence (Martinez-Martin et al., 2021), and reaching the cloud and social media (Anom, 2020). Healthcare organizations heavily depend on the algorithms and data generated from digital technology, and biomedical ethics principles are affected.

Big data technology changed the provider-patient relationship. Patients and providers spend more time using digital technology to make decisions (Char et al., 2018), which Anom (2020) refers to as the fiduciary relationship between physicians and patients. On the one hand, physicians use digital technologies to make faster decisions; they depend on algorithms to rule out differential diagnosis faster, allowing them to see more patients fewer times. On the other hand, patients have more access to the internet, platforms, applications, and other digital technology and can find their answers faster. For example, they can check their blood results using an application and refrain from seeing a doctor if they understand the results or have a relative or a friend in the healthcare field check them, or they can access healthcare forums (free platforms or paid telemedicine). This interaction is beneficial at some point and in some cases. However, communication between the primary provider and the patient is becoming dangerously scarce, and misinformation from scattered sources will risk the patient's health. It is one thing to want to improve the population's health and have more patient activation, and a different thing to create chaos in the healthcare management and delivery that will harm the patients.

Big data is primarily passive data, but it can also be active. Passive data is collected automatically without the active participation of the users (Maher et al., 2019). Big data has significant potential for patient care delivery (Maher et al., 2019). The biggest challenge revolves around how this data will be used for the benefit of the patient (Currie & Hawk, 2021); however, the ethical challenges arising from the use of digital technology and big data technology are many, and they arise from data acquisition, storing, and handling (Anom, 2020; Bresnick, 2017; Onyemachi & Nonyelum, 2019). Researchers like Anom (2020), Sousa et al. (2019), and Char et al. (2018) discussed the ethical challenges of big data, digital technology, and their interference with the biomedical ethical principles; of autonomy, beneficence, non-maleficence, and justice. However, ethical challenges from big data exceed the principles and open an opportunity for healthcare leaders to revisit the ethical guidelines and definitions to apply to today's dynamics.

Healthcare ethics is a competency. Principles of biomedical ethics are covered in all healthcare professions' curricula. However, time spent on training healthcare professionals in these competencies is limited, and training comes on the job. Resistance starts with students who do not understand the need to learn such competencies (Cobb et al., 2020); thus, healthcare education organizations are the first lines of defense and must address these ethical and legal challenges from undergraduate levels for all healthcare professionals. One of the essential skills to bundle with ethics about big data is quality improvement (QI). Quality improvement is feared by those who do not understand it;

however, when QI becomes a synonym for principle sets that solve problems (Backhouse & Ogunlagi, 2020), healthcare providers start to understand its importance and see the benefits for the beneficence of the patients (providing better patient outcomes). One of the QI principles is to use data collection and analysis methods consistently, while another principle is about using the data to improve the quality of care and service provision (Backhouse & Ogunlagi, 2020). These two QI principles are strictly related to big data technology.

Big data technology is a catalyst. Big data allows healthcare organizations to create platforms to translate data into actionable intelligence (Anom, 2020). The application of big data is vast; Anom (2020) performed a comprehensive literature review that allowed us to understand the major five applications:

1. Predict patient deterioration and clinical events
2. Reduce readmissions; frequent readmissions lead to inefficiencies in care delivery and increase costs. Big data and AI technologies are used to identify at-risk patients based on their treatment history, key clinical data, and readmission trends based on patients' clinical and or social characteristics (gender, age, race, ethnicity, lifestyle, presence of chronic diseases, health status, physical functioning). The high readmission rates in hospitals can be controlled by using advanced predictive analytic tools to identify high-risk patients prior to readmission and address problems with personalized and patient-centered care in their homes.

3. Research and clinical decision support
4. Analyzing EHR
5. Reducing missed appointments: Identifying patients likely to skip an appointment without advanced notice can improve provider satisfaction, reduce revenue losses, and provide organizations the opportunity to offer open slots to other patients; thus, increasing speedy access to care

Big data, digital technology, equity in technology access to the patients, ethical considerations, quality improvement, analyzing EHRs, conducting clinical research, and many other subjects can be addressed by healthcare education organizations, targeting healthcare providers, healthcare leaders, IT teams who work in healthcare systems, and the community. This understudied area is an opportunity for healthcare education organizations to differentiate with a high bar that cannot easily be imitated, replicated, or penetrated.

Technology, LMS, VR, ML, AI, Simulation, and Educators. The quality of healthcare education depends on multiple factors; other than the quality of the content itself, there is a need to focus on updated, attractive, accessible, and affordable technologies and pedagogical designs. The first component to focus on is the Learning Management System (LMS) they use. LMS are platforms that facilitate teaching by incorporating modules with expanded functionality to facilitate the integration of online tools for hybrid, flipped, blended, and distance learning (Annamalai et al., 2021). Posadzki et al. (2019) demonstrated the evidence to support the effectiveness of online

digital education in improving learners' knowledge; however, they also showed that there is inefficient and insufficient quality and quantity of evidence for other learners' outcomes, such as attitude and skills.

The challenges of the LMS are considerable but can be mitigated. The main challenges for the students are related to the security of the system, prompt management of technical difficulties, and having safe and strict supervision of the faculty and educators' engagement and teaching (Annamalai et al., 2021). The challenge to the faculty relates to maintaining updated and rich content, using exciting learning activities, and engaging with the attendees while helping them leverage what they learn and making sure they can apply it in their work (Annamalai et al., 2021). Mitigation of the challenges is the responsibility for the healthcare education organizations, who can integrate mobile applications into the LMS, provide maintenance and technical team support, and make supporting programs available to the students for a better learning experience, such as plagiarism and referencing programs.

Other technologies and designs that enhance healthcare education experiences are simulations, virtual reality (VR), augmented reality (AR), and artificial intelligence (AI). The innovation and advancements in medicine, technology, and globalization made it essential to generate strategies focused on scalable, efficient, and high-quality health professions education (Kyaw et al., 2019b). Kyaw et al. (2019a) defined VR as "a technology that allows the user to explore and manipulate computer-generated real or artificial three-dimensional multimedia sensory environments in real time to gain

practical knowledge that can be used in clinical practice" (p. 1). The authors also explained that VR offers a range of other educational opportunities, such as the development of cognitive and nontechnical competencies. VR increases the level of retention of information and allows users to complete their workflow 50% faster (Rojas-Sanchez et al., 2022). VR is widely investigated and is invading multiple disciplines. The areas of opportunity in healthcare education are promising and broad. However, some factors, like the lack of readiness, absence of acceptance, and presence of resistance, can hinder the use of VR and AR, especially when these factors are manifested by education leaders who do not adapt to the full potential of these technologies (Elmqaddem, 2019).

Artificial intelligence is gaining more attention and is used more frequently in healthcare. AI is believed to positively impact and improve any process in the healthcare delivery system (Bohr & Memarzadeh, 2020). However, ethical and legal debates exist about using AI in healthcare and medicine (Currie & Hawk, 22021). It is important to remember that AI is a tool and the choice of how and when it is used remains human. The attention needs to be focused on the intention of the invention and to make sure the data used to feed the AI algorithms are not biased (Currie & Hawk, 2021). Healthcare institutions are fighting to keep up with the rapid evolution of technology, and healthcare education organizations have an advantage from these opportunities to educate healthcare leaders and practitioners about them. Moreover, there are opportunities to build individualized systems using AI and implement them in healthcare education.

Digital technologies have taken healthcare education to another level. VR, AR, and Simulation or mixed reality (MR) provide an authentic replicable experience in a safe environment while increasing the interaction, preserving the feeling of reality, and providing the ability to reproduce and mimic aspects of clinical care (Gerup et al., 2020; Lame & Dixon-Woods, 2020). AR and MR effectively help healthcare educators achieve modern teaching objectives, equipping healthcare providers with the skills, knowledge, and tools in a safe environment to transfer their acquired knowledge into the clinical context (Gerup et al., 2020). However, inequities and disparities create an ethical challenge in the use of digital technologies in healthcare education.

The challenge in healthcare education is to find the correct topics to teach to the correct audience using the proper tools. While improving healthcare quality is central to improved healthcare outcomes, educational opportunities in low and middle-income countries are limited (Scott et al., 2019). Digital technologies are essential and exponentially increase skills and expertise, especially since errors and mistakes are made in simulated environments, and healthcare providers can avoid learning on the job. In areas where these technologies cannot be afforded, healthcare education organizations have the opportunity to remediate using the best they can. MR is one of the best and most efficient educational designs, where many scenarios and situations are reproduced and rehearsed. Healthcare educators can to be innovative and creative with their limited resources. HECOs in developed areas can partner with low-income areas to improve the

learning experience, share their resources, and work on having more equity in the access to technology in healthcare education.

The basis of all teaching designs revolves around the educators' expertise and content quality. No matter how much technology improves, educators have a significant role in healthcare education. It is essential to have competent educators with clinical experience (Cobb et al., 2020); moreover, it is crucial to have healthy teachers to transmit learning successfully (Maksymchuk et al., 2020). Healthcare educators need the experience to develop curricula, train in skills and practice, teach soft and hard skills, and know how to balance their lives and maintain their well-being. Healthcare educators also must address the needs of healthcare practitioners and individualize their learning (Topola & Miller, 2021). Maksymchuk et al. (2020) conducted a study and proved that the healthcare competency of future teachers could be successfully developed under the following pedagogical conditions:

- Enhancing future teachers’ motivation;
- Creating learning space;
- Designing the content of training based on interdisciplinarity;
- Accomplishing pedagogical tasks with healthcare content;
- Organizing students’ extracurricular activities based on their diversification;
- Implementing healthcare self-development during professional training.

These competencies will allow healthcare educators to incorporate innovation and new digital technologies in their teaching methods. They also foster the roots of pedagogy and allow institutions to have vital programs. Healthcare education organizations have a chance to implement strategies to maintain the well-being of their educators and faculty, trust and enhance their skills in content development and delivery, and oversee the delivery of educational programs to maintain high standards and a higher reputation.

Section 2: Project Design and Process

In Section 1, I introduced the study's historical background and organizational context. I identified the problem statement, purpose statement, main research question and interview questions, and the target audience. I also presented a theme-based literature review that supports the need for the study and its importance in the healthcare education business. I emphasized the value proposition that will increase the quality of services, which in turn will create diversification. In Section 2, I described the method and design and the process of the formative program evaluation, and addressed the sampling process, data collection, data analysis plan and techniques, and the credibility of the study. To conclude this section, I discussed the ethical research practices to be maintained throughout the research.

Research Method and Design

Research Method

The purpose of this mixed method formative program evaluation was to improve the business development program to align with the Organization’s goals through the development of a differentiation by quality strategy that will increase its competitive advantage. In this formative evaluation, I aimed to help the leader increase registrations in educational activities by 25% per year for the next 2 years, develop a standardized process to increase by 10% per semester the number of events provided for the next 2 years, conduct a gap analysis to identify opportunities for improvement and differentiation, increase the value of the services provided, develop policies that will

support the differentiation by quality strategy, and develop the differentiation by quality strategy to increase the competitive advantage. The implications for positive social change included the potential for increased clients' trust in the services provided as a result of response to their educational needs and increase of the customer's experience, as well as identifying best practices that positively affect healthcare providers' performance and quality of care.

I used a mixed-methodology to answer the following formative evaluation research question: how can leaders responsible for the business development program develop a differentiation by quality strategy to increase competitive advantage? This mixed method was appropriate for this study because it used a combination of the quantitative and qualitative approaches for a better understanding of complex research problems and phenomena and participant's perception (Talwar et al., 2021). Mixed method permits to address complicated research questions and collect richer and stronger array of evidence which help construct validation, reliability, generalization, and duplicability, and compensate for the weaknesses of each method (Yin, 2018). The data collected in the quantitative approach enrich those gathered in the qualitative for a better explanation of the information provided by the participants (Beach & Kaas, 2020; Manzoor, 2020). The qualitative research was conducted to explore the phenomena, primarily focusing on interviews and focus groups, and the quantitative approach was a limited descriptive presentation of archival data.

Quantitative researchers seek to characterize variable characteristics and/or examine cause-and-effect relationships. Quantitative analysis helps generalize the findings related to a large sample (Ahmad et al., 2019, Manzoor, 2020). Good integration of a robust quantitative methodology increases the value of the study, and the quantitative approach help researchers explain , control, measure, and be outcome-oriented; however, the quantitative method is not suitable for getting specific answers related to human behavior (Henson et al., 2020; Manzoor, 2020). The quantitative method alone was not sufficient for this study.

Researchers use the qualitative research method to answer the "why" of the research problem, seek to explore and interpret the meaning and context regarding behaviors and environments, make sense of what human behavior adds to the study, or tries to explain how one phenomenon influences the other (Aspers & Corter, 2019; Nassaji, 2020). Manzoor (2020), Maxwell (2019), and Percer et al. (2020) explained that findings may not always be generalized when the sample is limited. I had a limited sample formed by the decision makers at the organization; thus, I took into consideration that I may not reach data saturation and may be unable to generalize the findings from the interviews. Both quantitative and qualitative methods use empirical data; they do not contradict or conflict; they are complementary and work better together (Ahmad et al., 2019; Aspers & Corte, 2019; Manzoor, 2020). The mixed methodology remains best suited for my study. To answer the research question: How can leaders responsible for the business development program develop a differentiation by quality strategy to

increase competitive advantage? I needed to use both quantitative and qualitative methods. The combination was complementary and helped me explore and analyze the participants' perception with an objective evidence and analysis of the historical data and work with the leaders to formulate a differentiation by quality strategy that will improve the business development program and increase its competitive advantage.

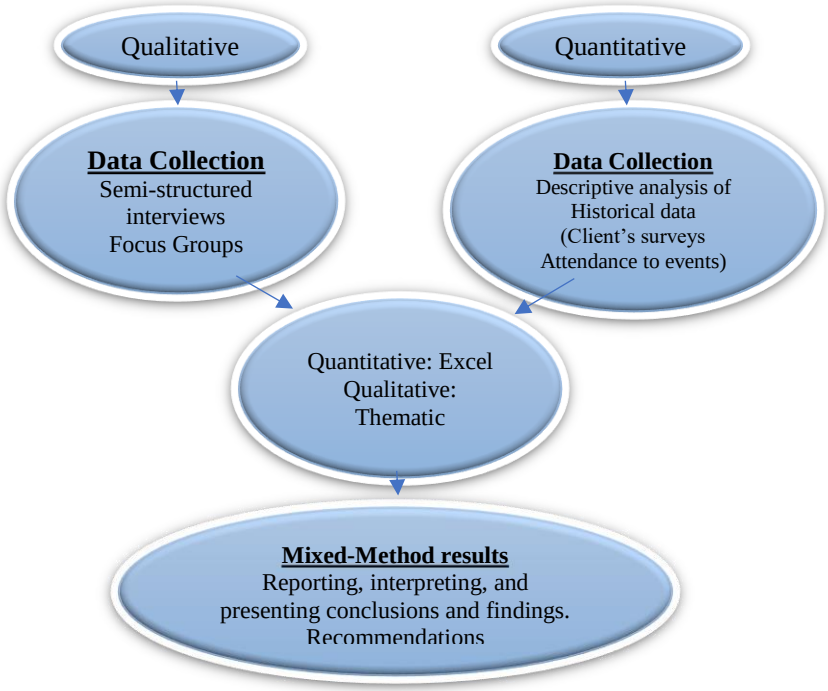
Research Design

To address the research question in this mixed method, and to compensate for the weaknesses of qualitative and quantitative methods, the specific research design included a convergent parallel design. The convergent parallel design allowed me to analyze and interpret the results together to provide a more comprehensive response to the research question. I completed the methodological triangulation when I compared how the data from the qualitative and quantitative methods supported or differed from each other. For the convergent parallel research design, I used multiple sources of evidence to answer the research question and construct validity and reliability through methodological triangulation. I started by developing a case description to explain the complex background situation of the organization following the explanation-building technique based on my interview with the CEO. Yin (2018) explained that convergent evidence from multiple sources is required for methodological triangulation, which leads to validity, and a corroboration of the same findings. Moreover, Yin emphasized that convergent analysis uses multiple measures of the same phenomenon, which increases the confidence of the study.

Convergence designs are used to study complex problems in their entirety and in all their dimensions (Almeida, 2018). Almeida (2018) explained that convergent designs use two parallel phases of quantitative and qualitative analysis. In the quantitative strand, the researcher measures the properties and objective aspects of the problem, whereas in the qualitative strand, the researcher tries to understand and describe the subjective aspect of the problem. According to Demir and Pismek (2018), a convergent parallel mixed-method design allows the researcher to gain an in-depth understanding of the topic. Based on Almeida (2018), Alrawashdeh et al. (2021), Demir and Pismek (2018), and Yin (2018), I developed a research design flowchart (see Figure 5 on page 69). The flowchart reflected that I concurrently conducted the quantitative and the qualitative elements, in the same phase of my research, weighing the methods equally, collecting the data in parallel, analyzing the components independently and simultaneously, and then interpreting the results together.

Figure 5

Research Design Flowchart



Note. Figure 5 is an illustration I created to show of the flowchart convergent parallel mixed method design I used in my study.

The components of my qualitative design included semistructured interviews, and focus groups. The open-ended questions I used in the interviews included:

1. How has your organization's strategy evolve over the past five years?
2. What roles do leaders responsible for the business development program have in developing a differentiation by quality strategy?
3. What have you done so far to develop a differentiation by quality strategy?

4. What barriers do you envision in developing a differentiation by quality strategy?
5. What aspects of the business require a differentiation by quality strategy?
6. Why did you decide to develop a differentiation by quality strategy?
7. What are the major advantages that you have identified existing in your competition that hinder your success and advancement?
8. What strategies have competitors used that create opportunities for you?
9. How could a differentiation by quality strategy increase competitive advantage, profit, and diversification?
10. What does a successful outcome look like?
11. What additional information can you provide?

Besides the original open-ended questions, I included follow-up questions to allow the participants to expand on their ideas and comments. To capitalize on the experience of the focus groups, I accommodated the participants according to their backgrounds, and I asked questions about the business development program that were pertinent to their expertise.

For the quantitative data I used historical data and client feedback surveys. The historical data and client feedback is presented as descriptive quantitative analysis where I summarized the findings in tables and showed percentages, and frequencies. Given that the educational events are different in types, categories, and capacity, I was not able to calculate average attendance. The scope of my quantitative examination was limited to

descriptive statistics. I did not examine the relationship among variables, I did not test hypotheses.

Data saturation is when no new themes emerge from the collected data. Data collection will end when a sense of saturation arises (Aspers & Corte, 2019). The size of the organization defines the sampling in this study. Islami et al. (2020) recommended that researchers work with managers to identify participants who will contribute to the study; thus, I worked with the CEO to determine who the participants in the interviews will be and with which member I should be conducting the focus group discussions. Having appropriate participants expedited data saturation. Even though the pool of the participants was defined, I made sure to explain to the potential participants, through the recruitment email, that they were free to accept to participate or refuse; no employee had any obligations to participate in the interview or focus groups. However, the employees in the organization under study have a high sense of belonging and wants to actively participate to find solutions that will improve the business. I conducted semistructured interviews with only with those who influence the system and are decision makers, namely, the CEO, General Manager (GM), and Business Development Director. This sample was representative of the Organization but not necessarily of healthcare education organizations in the country. In this study, the sample's purpose is to help develop an initial understanding of the business (Ahmad et al., 2019). Hence, second follow-up interviews were needed to reach data saturation, which was considered when no new information arose from the processes.

Data Collection and Analysis Techniques

A mixed method formative program evaluation was used to conduct a rigorous assessment of the existing processes and identify potential areas for improvement and implementation. The formative evaluation is a rigorous assessment process to identify potential and actual influences on the implementation process, a set of questions that help improve the program and uses mixed methods to create a richer dataset for interpreting study results (Elwy et al., 2020; Mora, 2019). Houston Independent School District (2019) defined *summative evaluation* as the evaluation after an activity or plan to determine its effectiveness, using a mixed methodology, but can mainly rely on quantitative to measure the outcomes. The summative evaluation helps prove whether the program we worked on met the expectations and reached the required outputs, outcomes, and impact. While formative evaluation focuses on the activities, outputs, and short-term outcomes, and summative evaluation focuses on the intermediate and long-term outcomes; both evaluations aim to improve the outcomes of a program on an ongoing basis, help in the continuous evaluation and implementation of corrections throughout the process, and help describe the quality and effectiveness of the program (Mora, 2019).

The research design is a logical sequence that connects the research question to the conclusions (Yin, 2018). The research design developed for this study served as a blueprint. This blueprint's main purpose was to help me avoid situations where the evidence did not address the research question. As I undertook a program evaluation, I had difficulty analyzing the data and linking them to the complex research problem. I

faced some difficulties understanding what I collected, and interpreting these data. Moreover, it became difficult for me to keep a focus on the intended product of this formative evaluation, which was the formation of a business development program. Smith et al. (2019) explained that logic models help address the "what" and the "how", and Mills et al. (2019) explained that logic models help plan and implement the outputs to reach the outcomes. In this formative evaluation, I used the program logic model to address the "what" and the "how," plan and implement the outputs to reach the outcomes, identify the inputs I needed to used, and align with the Organization's goals through the development of differentiation by quality strategy that will increase its competitive advantage. Logic models are analysis techniques that operationalize a chain of occurrences over a period of time, and that help the research explain how the program takes place (Yin, 2018). The model has cause-effect patterns and helps the researcher define the goals of the study, as well as highlighting the inputs and activities to be evaluated or measured, and the short, medium, and long-term outcomes that the program will result in. The interventions done in the activities will lead to direct and immediate outputs. These outputs will become inputs for the outcomes. For this study, I developed the PLM (see Table 1 on page 12), which I explained in general in Section 1 and elaborate in this section.

The inputs of the business development program logic model were the historical data (used in the data analysis), the partnerships and competitors (the Organization started to conduct the partnerships and competitors' analysis once this study was started),

the staff working at the Organization, and the leaders. Understanding what is invested in the Organization allowed me to have outputs that reached staff, clients, decision makers, associated faculty and agencies. To reach these participants, I conducted focus groups with the staff employed in the institution (three focus groups with a total of 9 employees), and I conducted semi-structured interviews with the three identified decision makers in the organization. The employees who participated in the focus groups were managers and coordinators. I gathered the managers in one group and the coordinators in another. I conducted the third focus group with the team at the other location in Jeddah. I had to have one group for the Jeddah team as they are newly opening and starting in that region. I needed to understand their challenges and ideas to improve the exposure and the business in the Jeddah branch. I also assessed the processes in the Organization, developed strategies, policies and procedures, and standardized reports. I trained the middle managers to secure sustainability and consistency of the work.

The aim of the activities was to increase the faculty skills, content quality, demand on and attendance to the educational events, number of events, and number of attendees per event, loyalty and satisfaction from the clients, partnerships, and variety of services with a higher boundary to new entrants and competitors. The Organization's leaders also wanted to decrease the buyer's bargaining powers by differentiating the services offered, and decreasing the cancellations in the educational events. The short-term outcomes were related to the learning skills of the faculty, staff, and leaders, and their increased motivation for the improvement of the Organization. This short-term

outcome is also reflective of change management. The team is used to working in a certain way, which does not necessarily reflect the high quality of work or help them achieve the Organization's goals. Moreover, the leaders acknowledged the absence of processes and that they have been working based on their intuition; the work is being done based on habits and needed to be standardized and improved. The intermediate outcomes were related to actions taken by the leaders to improve the quality of services, decision-making policies, and improved processes that will enhance the response to clients' needs. The long-term outcomes were related to the Organization's condition's change where a differentiation by quality strategy will be developed and implemented by the leaders, which is expected to increased market shares and an improve reputation and brand. It is crucial to keep in mind the assumptions that positively affected the success of the formative program evaluation and the contextual factors that might hinder its successful progress or even block its implementation.

The details of the data collection tools are elaborated in Table 2 on page 76, the research design alignment table.

Table 2

Research Design Alignment Table

Research Question/Method & Design	**Data Collection**	**Data Points (Quantitative)**	**Proposed Data Analysis**
RQ: How can leaders responsible for the business development program develop a differentiation by quality strategy increase competitive advantage? Method: Mixed Method Design: Concurrent mixed method	Semistructured interviews Focused Groups Historical Data Student feedback surveys	Historic data: no. of activities, no. of students, no. of event cancellations, reasons for cancellation Student feedback surveys: Likert scale survey completed by students at the conclusion of each program that identifies scores for satisfaction with the activity, content, as well as customer's service satisfaction rate.	Descriptive statistics: Frequencies, percentages Thematic analysis

Initial Meeting and Cooperation Process

As part of the portfolio capstone – program evaluation, an initial meeting was conducted with the CEO and then followed by another meeting between the CEO, the Committee Chair, and me. A letter of cooperation was signed by the CEO, before the start of prospectus writing. At the same time, the CEO asked me to sign a non-disclosure agreement as the observations and data are private and confidential. In the collaboration meeting, I agreed with the CEO on the way he wanted to be updated of the program

evaluation and progress of the study. The CEO asked to have periodic meetings when milestones were approved by the Chair. The first meeting was conducted before the submission of the prospectus in the system, to share the problem and purpose statements, and explain the program logic model. The CEO was impressed and approved on the work done, and expressed his understanding of the program evaluation and the study done. The CEO also helped me make the decision of which program to work on. He chose to work on the business development program to have an organizational strategy as long term outcome from the study.

Data Collection Instruments

This study is a mixed-method formative program evaluation. I used multiple data collection instruments: (a) me as the primary researcher, (b) the semistructured interviews, (c) the focus groups discussions, and (d) the historical archival data. I was granted access to historical archival data from the Organization on the date when the CEO signed the letter of cooperation. Access included records of courses and webinars, event attendance, events reports, satisfaction surveys about the events conducted, and logs of customer service requests and replies from the past two years. I accessed these data files and compiled them after receiving IRB approval.

Additionally, I used the interview protocol (see Appendix C) and the focus group protocol (see Appendix D) as auxiliary instruments in collecting my data. Using these protocols allowed me to remain neutral, ensure that participants are treated equally, keep participants on track and focused on the topic, and enhance consistency by starting the

semi-structured interviews and the focus groups with the same core questions. The protocols also allowed me to guide the participants' interaction during the interviews and focus groups and elaborate on the answers dependent on their roles in the Organization and level of authority.

Data Collection Process

After receiving the IRB approval I interviewed three key leaders in the Organization, and conducted three focus groups with a total of 9 employees. Sampling should be thought of as a key component of study design (Denzin & Lincoln, 2018). My choice to interview only three leaders depended on their roles and their levels of authority and influence, and on the decision of the CEO given the size of the Organization. This sampling technique is a purposeful sampling. Luciani et al. (2019) mentioned that purposeful sampling is also known as purposive sampling; which means that purposeful sampling helps the researcher avoid data collection till data saturation. I also chose to have a purposeful sampling because, as recommended by Shaheen and Pradhan (2019), purposeful sampling will help in the selection of sources of information that would answer the research question. Purposeful sampling is generally small in size, which may put in question the utility and credibility of the data collected (Shaheen & Pradhan, 2019). However, samples can be added at later stages, in case needed and secondary interviews may be conducted to address the missing information. The purpose of the one-on-one interviews is to explore the leaders' perception on the topic and gather their input on the best outcomes (Luciani et al., 2019).

In preparation for the semistructured interviews, I prepared the interview protocol (see Appendix C) that guided me on how to conduct the interviews. Before the start of the interviews, the potential participants signed a consent form; interviewees were informed of the freedom to stop the questioning or withdraw from the interview at any time, potential participants were also given the freedom to accept to participate in the interviews. All three participants agreed to participate by sending a reply to the recruitment email stating that they consented; I reviewed their informed consent and answered clarification questions before I started the interviews. They all stated their motivation to have an input in the study for the benefit of the Organization. I ensured that participants were fully aware of the interview process and treated them equally. The participants were also informed about the confidentiality statement and were made aware that no identifiers will be used that show their names or the name of the Organization. I informed the leaders who were interviewed that I will refer to them as L1, L2, and L3, in transcriptions, and if needed in the analysis of the findings.

Based on Saunders et al. (2015) and Yin (2018), I identified that I have to use semistructured interviews because I was planning to:

- Interact with leaders to understand their vision, perspective, and understanding of the Program
- Have a structure to follow with defined probing, target, and follow up questions.

- Have the flexibility to vary the use of the questions between participants because of their role, level of authority, level of involvement and engagement, and level of influence in the Organization.

I scheduled the interviews through virtual video meetings and recorded them to refer to them when transcribing. I took notes during the interviews on ideas that needed further elaboration and asked follow-up questions whenever needed. The interviews averaged approximately 30 minutes, except with the business development manager, which took around an hour, mainly because of his direct role in the study. After I finished the interviews, I transcribed them into Word Documents and shared each transcript individually, with the respective participant, as part of member checking. Member checking is a technique for validating participants' responses (Naidu & Prose, 2018). Member checking consists of sharing the original transcripts with the participants to confirm that the findings resonate with their individual interviews and provide the researcher with needed corrections whenever needed, ensuring that the documented findings accurately capture their perspectives and answers (Butler et al., 2021). Following a member-checking format, I allowed the participants to confirm my conclusion of the interview and address any missing information to validate the collected data. All three participants reverted with their approval on the transcripts. I then scheduled a 10 minute follow-up interview to review my summary of the interpretation of the interviews.

Concurrent with my scheduled interviews, I scheduled three focus group discussions with the program management team, coordinators, project managers and

customer service personnel (total of 9 employees). The focus groups averaged approximately 45 minutes each. The focus groups provided insights into the collective activities performed by staff because the groups included people who have first-hand experience in and information about the organization under study (Busetto et al., 2020; Zafarghandi et al., 2019). The members participating in the focus groups submitted their consent via email as a reply to the recruitment email. Luciani et al. (2019) recommended the use of focus groups to assess employees' understanding of the strategy and have their input on the suggested research question; in this case, I wanted to understand their perspective on how to create a differentiation by quality strategy, and what elements they perceived important to include or address in that strategy. These focus groups also helped me gain insight from the employees and answer the research question, while understanding interrelationships between the employees and the leaders. I have prepared a focus group protocol (see Appendix D) that helped me remain impartial, encourage the attendees, listen to their thoughts, and create a supportive, and comfortable environment for information sharing.

The historical data is archival, did not need collection, and had low logistical demand. However, compiling the data and creating a descriptive analysis was time-consuming and lengthy. I accessed the Organization's server and created an Excel sheet where I pasted the data I was finding. In the Excel sheet, I followed a logical pattern where I entered the date of the event, duration, name of the event, type (in-person, hybrid, or online), category (webinar, workshop, course, or conference), details of the faculty and

attendees, and the status of the attendance. The clean Excel document allowed me to generate Pivot tables which I used to present the descriptive analysis using frequencies and percentages. I also accessed the feedback surveys from the customers. However, unfortunately, the number of evaluations was very limited and did not allow me to have a comprehensive analysis with statistical significance (see the findings in Section 3).

Data Analysis Technique

The overall study's data analysis technique was the logical model. As I described in Section 1, logic models are analysis techniques that operationalize a chain of occurrences over a period of time and help the research explain how the program takes place (Yin, 2018). The program logic model allowed me to interpret the data logically, focusing on the inputs and outputs to reach the desired long-term outcome of developing the differentiation by quality strategy.

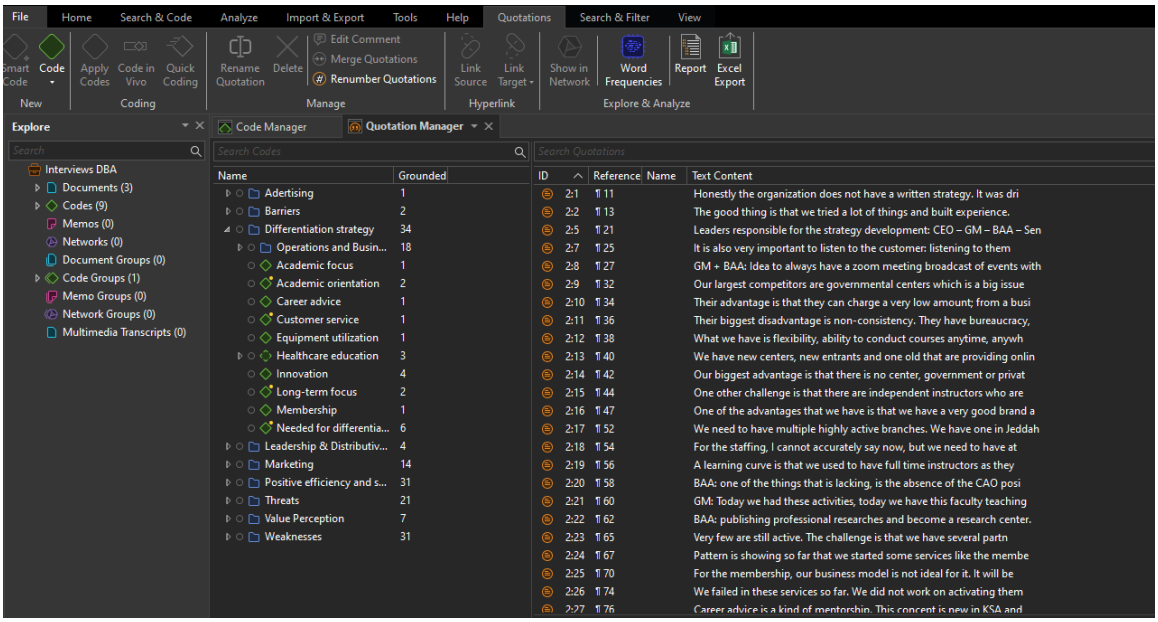
Data from interviews and focus groups were analyzed through thematic and methodological triangulation. I followed Yin's (2018) five-step process for thematic analysis. First, I compiled the data from the interviews and focus groups by transcribing them. I referred to the recordings of the meetings and focused groups to manually convert the recordings into text; I transcribed them in separate Microsoft Word documents. I had a total of 24 pages which I uploaded in ATLAS.ti Scientific Software Development GmbH version 23.1.1.0.

The second step was to disassemble the data. Based on the ATLAS.ti, I was able to collect a total of 127 quotations and 330 codes from the first run – these 330 codes are

referred to as raw codes, presented in Table 3 on page 102. ATLAS.ti uses embedded AI software to generate the codes. Moreover, each code is linked to the quotation from the uploaded transcripts (see Figure 6). Because I analyzed the data from the lens of the Five Forces of Competition and Value-Chain theories, I did extra parallel manual work of disassembling the data. I numbered each statement in the transcripts, which I then used in the reassembling and arraying steps. The reason I did this is that I wanted to see the emerging themes based on the codes from the ATLAS.ti, but I also wanted to check how to present the findings under the constructs of the theories. I elaborate more on this in Section 3.

Figure 6

Screenshot from ATLAS.ti Showing Codes Linked to Quotations



The third and fourth steps of thematic analysis were the reassembling and arraying steps. For the codes generated in ATLAS.ti, I started to read the code and its

respective quotations and created “Documents” to gather codes that talked about similar general ideas. I did this exercise 5 times until I could refine the Documents and convert them into themes; eight main themes emerged from this analysis. In the other Word document, I copied and pasted the statements/quotations under the constructs of the frameworks, wherever they were applicable, even if they were repeated. The study of the reassembled ideas helped me interpret the meaning and outcomes of the research. At the end, in step five, I wrote the conclusion based on the outcomes of the qualitative analysis. Gathering the quotations under the constructs helped me present a logical conclusion of the findings supporting the quantitative analysis and completing the methodological triangulation.

Researcher Bias

Researchers’ errors and biases stem from human nature. The biases vary based on the researcher’s personality, environment, and the degree of affinity to the organization under study (Chenail, 2011). Biases are explained in the overestimation of own ability, unpreparedness to conduct the research, having an extreme passion for the subject under study, which shifts the lens through which the evidence is seen and interpreted, lack of transparency, uncomfortable feelings in the field, being judgmental about the work and the people, having a sense of superiority and inability to see things clearly, and language barriers (Chenail, 2011; Houghton et al., 2013; Saunders et al., 2015; Yin, 2018).

I did the reflexivity exercise to assess my biases. Reflexivity is the self-awareness of the process, and being conscious of biases, values, and experiences that may influence

my study (Chenail, 2011; Dowling, 2007; Hyncer, 1985; Luciani et al., 2019). I then addressed my bias concerns with the CEO and the Committee Chair and created a plan to follow for collecting, analyzing, and interpreting data. The interview questions, interview transcriptions, and thematic analysis, were checked and reviewed by the Committee Chair before submission to the second Committee Member and URR.

Reliability, Validity, and Triangulation

When choosing a research method, researchers start thinking about the tools and designs for data collection to use. Each research design is linked to multiple sources of evidence (Yin, 2018). For the program evaluation, there are six appropriate sources: documentation, archival records, interviews, direct observation, participant-observation, and physical artifacts (Graue, 2015; Saunders et al., 2015; Yin, 2018). Each of these sources has its advantages and challenges; however, they are not mutually exclusive. They are not complete or robust on their own; they are complimentary (Yin, 2018). It is crucial to complete the data collection from each source separately, and it is essential to master the competence of their respective analysis, but if used in combination, the quality of the research is increased and the reliability is constructed (Graue, 2015; Yin, 2018). The multiple source use is the first principle of data collection described by Yin (2018).

For the power of results and reliability, the multiple sources of evidence need to be analyzed using triangulation. Triangulation's strength is embedded in expanding the opportunity for learning about phenomena, constructing validity, increasing reliability and confidence (Graue, 2015; Yin, 2018). Triangulation has four types; data triangulation

(data collected from multiple sources), investigator triangulation (data collected by at least two researchers), theory triangulation (contrasting the perspectives of different theories' positions), and methodological triangulation (collecting data through at least two different methods) (Graue, 2015; Yin, 2018). Methodological triangulation is most frequently used in the research field (Graue, 2015). I conducted a methodological triangulation using multiple sources of evidence and two different research methods to construct validity and reliability by comparing the findings from the qualitative to the findings from the qualitative method. The quantitative descriptive analysis supported the outcomes of the focus groups and the perception of the interviewed leaders. Because the elements of the quantitative supported the qualitative findings, I confirmed validity and reliability, and I will remain available to work with the CEO to develop the strategy that enhances the work in the Organization. One of the themes that emerged in the thematic analysis is about the value perception from the participants about the Organization. However, there are no elements in the quantitative analysis that support this perception, mainly because the feedback from the clients are missing, and those filled do not have a statistical significance. For that reason, I will continue working with the CEO to put together processes to align the perception with measureables in reality, and ascertain that the employees participate in developing these processes and implement them to achieve organizational success.

While the first principle of data collection, as explained by Yin (2018) was to perform triangulation, the second principle is to have a database. A proper database is

mandatory to refer to during the study and when writing the findings and analysis. Maintaining the chain of evidence is the third principle of data collection. The primary purpose is to construct validity; it allows the readers to track the research question to the findings and understand the analysis (Yin, 2018). The last principle is exercising care when using data. Confidentiality and reliability of the information are major concerns (Yin, 2018). I collected the data from the Organization's archives, accessing its server; thus, I did not have to download anything on my computer or drive. I created the Excel document to compile the data needed on my personal vault, located in my personal drive, and I will store this document for five years before discarding it. I chose to construct validity by using different methods, and maintaining a chain of evidence, while exercising care in using data.

Credibility, Dependability, and Trustworthiness

Credibility is to make sure that errors are minimized and the data collected is correct. Credibility is achieved through the internal validation of the data and the information collected from the interviews and focus groups (Yin, 2018). I maintained the credibility and trustworthiness of the data I collected through the member's check and repeating/rephrasing what I understood from the participants in the interviews, and by asking them if I properly understood of their ideas. The dependability of the data collected in this study is secured by the planned methodological triangulation and the parallel, independent analysis and interpretation of the findings from the mixed method.

Transferability

The program evaluation I conducted is individualized and customized to the Organization. However, the conclusions, the recommendations, and the themes addressed in the literature review are transferrable to other healthcare education organizations who can benefit to develop their own business development programs. It is crucial to mention that, as agreed with the CEO, and as per the signed nondisclosure form, I will not share confidential and private business secrets that may negatively affect or harm the Organization.

Ethical Research

After IRB approval was obtained, I approached participants for the semistructured interviews, received their consents, and then started the data collection. To build trust with the participants, I explained the research and its purpose as detailed in the interview protocol, refrained from using identifiers or sharing personal bias, and provided participants with the same time for the interviews and focus groups.

I informed all research participants that their participation in this study is voluntary, and no monetary incentives will be paid. Participants had the freedom to withdraw from the study at any time with no judgment or retaliation. The informed consent reiterated the voluntary nature of participation, the confidentiality of the information collected, and the participants' acknowledgment of participation. I obtained written approval to access data from the participating organization after signing a non-disclosure agreement. I did not start collecting and analyzing the data before receiving the

Walden IRB approval on the proposal. The final IRB approval number is 03-17-23-1054284. Moreover, the data will not be downloaded on my personal computer. The CEO provided me with an access to the Organization's secure drive. I accessed this data and built my database on Excel before I started the descriptive analysis. The Excel I created is saved in my personal vault in my drive; I will be the only person to have access to it, and I will save this sheet and the transcripts and coding of the interviews and focus groups for 5 years to protect confidentiality of participants.

Summary

I presented in Section 2 the research method, design, and the ethical consideration. These first two sections formed the proposal which was submitted to the committee, URR, and IRB for approval before I was allowed to start my work on Section 3 of my doctoral study. I successfully passed the Proposal phase and was successful in the Proposal Oral Defense. I then started working on Sections 3, where I identified the emergent themes, based on my data analysis. I also completed the descriptive analysis based on the available historical data. I then wrote the conclusions of the analysis, recommendations for stakeholders' action, and recommendations for studies.

Section 3: The Deliverables

Executive Summary

In Section 2, I explored the research method and design, focusing on the purpose of the study. I also discussed the data collection process, analysis techniques, and ethical considerations. In this section, I described this formative program evaluation with its intended purpose and highlighted the study's goals. In addition, I provided an overview of the quantitative (descriptive analysis) and the qualitative (interviews and focus groups) findings. I presented these findings in one part under "Presentation of Findings – Mixed Methods" because the study is complex. The aim was to help the leaders identify the problems in the business development program and find solutions to improve it to develop a differentiation by quality strategy. Providing the Organization's leaders with clear findings allowed me to give them with recommendations for actions that are easy to follow and implement. After I presented the findings and recommendations for action, I added a section on future studies. This communication plan will help me share with the stakeholders the assessment, the results of this study, and the recommendations for how this formative evaluation may bring change to the Organization. At the end of this section, I highlighted the implications for positive social change and the skills and competencies I have acquired from my academic training and work experience.

Purpose of the Program

This mixed method formative program evaluation aimed to improve the business development program to align with the Organization's goals by developing a

differentiation by quality strategy to increase its competitive advantage. The Organization under study is located in the Kingdom of Saudi Arabia (KSA). The Organization provides healthcare education to healthcare providers across the country and the MENA region; its staff conducts international conferences and provides other services which I elaborated in the historical context section). This for-profit Organization's leaders are committed to excellence and continuously work to generate more profit while maintaining high-quality services. The program evaluation results provided vital components to help develop an understanding of the Organization's culture, behaviors, and practices. The results also suggest that the business development program is ineffective in meeting the Organization's needs and requires dedication, activation, and follow-up to close the loops on established projects; however, the inefficiency is not only related to the business development department, but has multiple underlying issues in the operations, infrastructure, human resource management, and technology. At the Organization's current development stage, the leaders can differentiate their services. The branding and reputation of the company are well-established. However, more focused and targeted work is needed in marketing, advertisement, operations, human resource management, the firm's infrastructure, and technology development to meet clients' needs, attract and activate clients, and create trends.

Goals and Objectives

This formative program evaluation targeted a small for-profit private healthcare education organization providing educational programs, events, and consulting to

clinicians and managers in a healthcare environment in KSA, the MENA Region. The specific goals of this formative program evaluation included: (a) increasing registrations in educational activities by 25% per year for the next two years; (b) developing standardized processes that will help increase by 10% per semester the number of events provided for the next two years; (c) conducting a gap analysis to identify opportunities for improvement and differentiation; (d) increasing the value of the services provided by continuously delivering high-quality healthcare education activities that respond to clients' educational needs; (e) developing by the end of July 2023 policies that will support the differentiation quality strategy; and (f) developing, by the end of this doctoral study, a differentiation by quality strategy which will help the leaders create a brand, and increase competitive advantage.

Overview of Findings

I performed this formative program evaluation to determine how leaders responsible for the business development program can develop a differentiation by quality strategy to increase competitive advantage. The formative evaluation is completed to assess the Organization's performance, highlight its successes while recommending strategies to increase its growth, identify areas for improvement, and recommend strategies to correct and improve inefficiencies. The findings of this study showed that the root problem was in three major domains, including (a) database management, software, and Customer Relationship Management (CRM), (b) the business development and marketing team and advertisement activities, and (c) the operations and resources

allocation. I had to clean the data for the years 2021 and 2022 and compile it in one standard Excel sheet to standardize the process of data collection and to be able to extract beneficial information that helped me understand the Organization's performance and the customers' needs. While conducting this study, I completed some essential work related to the outputs of the program logic model. Based on the archival data and thematic analysis, I completed the partnerships' analysis and the five forces assessment for competitors' analysis and formulated the draft for the gap analysis that leaders can use in the future. The event registrations were decreasing, and the main hindering factors were marketing and advertising strategies and execution, the relevance of the events to the audience, and the quality of customers' data in the database.

In contrast, there were no full-time, dedicated staff whose attention was on creating social media traffic and trends and exposing the continuous activities of the Organization. There was no dedicated full-time chief academic officer responsible for executing, implementing, and following up on the projects initiated by the CEO, strategic planning, and quality assurance. On the other hand, with the problem of data storage and the inability to use it properly, the marketing team could not conduct targeted announcements and growth hacks. As per the clients' general feedback, the services' quality was good, but there were areas for improvement.

Presentation of the Findings – Mixed Methods

I used two key methods in my data analysis: methodological triangulation and thematic analysis. Yin (2018) explained that when researchers use multiple methods in

analysis, they add value to their study and construct validation. I conducted a convergent parallel design, which allowed me to analyze and interpret the results together to provide a more comprehensive response to the research question. The convergent parallel design was solid to ensure the evidence addressed the research question and supported the methodological triangulation. I used the program logic model as an analytic technique to link the data to the proposition. For those reasons, I presented the qualitative and quantitative findings together. However, I present an elaboration on the extensive qualitative analysis at the start to clarify how I developed the themes, what they were, and how the literature supports them. The result categories match the constructs of the theories that ground this study. The areas for improvement I found relate to the following:

- Primary activities: Marketing and Sales, Operations, and Services
- Support activities: Firm Infrastructure, Human Resource Management, and Technology Development.
- Missing Rivalry Analysis
- Absence of strategies to decrease the buyers' bargaining power
- Absence of strategies to minimize the threats of new entrants and substitute products/services.

Primary activities are "primary," which indicates that they are the backbone of every business. Porter (1985) explained that leaders must look at all subsidiary activities in the value-chain model to understand an organization because each activity contributes

to differentiation. More importantly, Porter highlighted that prioritizing activities and action plans does not mean working in a cascade but having parallel action plans handled by departmental leaders who will work together to reach the best outcome.

I presented the study's findings under the general headings of the frameworks' constructs related to the study. I evaluated the business development program; hence, I expected most of the results would relate to Marketing and Sales. The business development program is one program in the Organization. However, the work addressed in that program crosses with the work of all other departments. Hence, it is insufficient to present the findings for only Marketing and Sales activities under the primary activities. I also needed to address the issues related to Operations and Services. In addition to the primary activities, I addressed the secondary activities related to firm infrastructure, human resource management, and technology development because I could see their relation under the themes I discovered in the qualitative analysis. These relations are logical; marketing alone will not increase sales, and mid and high-level leaders must practice a distributive leadership model to enhance sales and increase profitability.

In the conceptual framework sub-section in Section 1, I explained that I needed to work with two frameworks. The analysis of the five forces of competitive advantage allowed me to identify the key elements to increase competitive advantage and the value-chain model allowed me to assess the Organization's activities. In the five forces of competitive advantage, I identified themes related to the rivalry analysis, the buyers' power of bargaining, the threats of new entrants, and the threats of substitute products

and services. The threat of suppliers is almost nonexistent, given the nature of the business. Before presenting the findings, it was crucial to present a description of the Organization because of its complex scope. Yin (2018) explained that sometimes description strategy helps explain complex situations; hence, I gave a summary of the Organization's historical context to help readers understand the findings and the recommendations.

Historical Context of the Organization

To maintain the confidentiality of the Organization, I cannot describe in detail the history of its foundation. However, I must explain that the Organization has three primary business models. The Organization has two branches; the headquarters (HQ) in Riyadh and the branch in Jeddah. Both centers have the same business models. The Education Model consists of a well-established international trauma education program for doctors, nurses, and paramedics, a simulation and life support education program, a certified quality and safety program, a program for national and international conferences, and a program for webinars, workshops, and independent healthcare education. The Consultancy Model provides leadership and accreditation consultancies to other healthcare organizations. The Support Model comprises a membership program, a research assistance program, and a career advice clinic.

The Organization was founded in 2018 with the international trauma education program, promulgated in another entity by the CEO around 30 years ago. In 2019, the Organization started to expand its scope and was hit by COVID as soon as it was starting

to become stable. Watkins (2013) described the STARS model. The STARS Model is an acronym for the five common business situations: start-up, turnaround, accelerated growth, realignment, and sustaining success. Watkins (2013) explained that leaders pass through all these organizational phases. Watkins also explained that these phases could coincide in an organization in different programs.

I found the international trauma program booming and in the sustaining success phase. Whereas the simulation program was in start-up and the life support program was in accelerated growth, the international conferences were still in a start-up phase, and the webinars, workshops, and other services were in a turnaround phase. The consultancy and support models were in start-up. At the end of 2022, the Organization started recovering from the pandemic and launched an innovation in healthcare education using artificial intelligence and technology. This technology development was still in the start-up phase but was gaining much attention and creating increased opportunities.

During data collection, I understood the historical context and the challenges the Organization endured. The pandemic shortened the start-up phase, and the Organization went into a forced turnaround phase. At the time of the study, the Organization was in an accelerated growth phase with many solid points and opportunities, but it also had a high risk of failure and threats. In four years, the Organization survived many hurdles, and leaders relied on their intuition and expertise to manage the business. At the accelerated growth phase, leaders recognized the urgent need for a written strategy, policies, and processes.

During the turnaround phase, leaders needed to save the business, reenergize demoralized employees, make fast decisions under time pressure, go deep enough with painful cuts and difficult choices, face the fact that change was necessary, and have the buy-in of the team, and most importantly, realized that a small amount of success goes a long way. The diversity of the programs and their phases, along with the newly started healthcare innovation technology program, indicated that the Organization was in an accelerated growth phase.

The accelerated growth phase requires managing a rapidly expanding business, putting in place structures and systems to permit scaling, and integrating many new employees (Watkins 2013). The Organizations' leaders must identify the potential growth opportunities and motivate employees to take on projects within this accelerate growth phase. The most significant risk for failure in this phase is that leaders will be inclined to stretch themselves and those who work for them (Watkins, 2013), which is a risk and a threat to accelerated growth, if not done correctly. To develop the differentiation by quality strategy the Organization's leaders must consider all phases of each program independently. The leaders will also want to include different corrective, improvement, or mitigating elements in the strategy adequate to each business model's growth phase. At this accelerated growth phase, the Organization was highly advised to address all the findings from this study and include these findings and recommendations in the differentiation by quality strategy to increase competitive advantage and mitigate the threats against new entrants and threats of substitute products and services.

Analysis of Data

The research question of this study was: How can leaders responsible for the business development program develop a differentiation by quality strategy to increase competitive advantage? The results of the quantitative analysis consist of a descriptive analysis of the data collected from the archives. There are no assumptions as there are no statistical tests conducted. I analyzed the archival data and feedback surveys in Excel, I generated Pivot tables which made it easy for me to present the results in the study. The descriptive analysis was frequencies and percentages. I retrieved the archival data from the Organization's cloud server and compiled it in Excel to analyze. I presented the results of the descriptive analysis throughout the following subsections as they pertain to the relevant constructs.

The qualitative analysis included data collected through semistructured interviews and focus groups. The qualitative analysis also included thematic analysis and the methodological triangulation. In this section I presented the study results under the pertinent constructs from the frameworks. Under each construct, I presented the relevant quantitative data, whenever applicable, and the summary findings from the qualitative analysis. When I assembled the data, I transcribed the responses from the interviews and focus groups. I then numbered each statement or quotation. I then reassembled the codes under the identified constructs. In this manner, I could present the relevant findings under the constructs in the subsequent paragraphs.

In parallel with my qualitative analysis, I completed a thematic analysis following Yin's (2018) five steps process. In the first step, I assembled the data by manually converting the interviews and focus group findings into text. I conducted three independent semi-structured interviews with the CEO, the General Manager, and the Business Development Manager. A total of nine employees participated in three focus groups; the first group included managers and leaders of the Organizations' programs (programs described in the historical context part), the second group included coordinators and the last group was with the Jeddah team. After transcribing the data, I had 24 pages of transcripts which I uploaded to the ATLAS.ti version 23.1.1.0. The ATLAS.ti software uses an embedded AI tool to generate the codes based on the data from the quotations – it generates a code (titles), for the group of quotations that address the same general idea. When I first uploaded the transcripts, I got a list of 330 codes, which I refer to as raw codes. Table 3 on page 102 shows the raw codes count from this step. The software also links the generated codes to the quotations from the transcripts. Table 4 on page 102 shows the count of quotations per interviewee. The interviews quotations generated the raw codes shown in Table 3 under Interviews. The focus groups discussions generated codes that are integrated with the codes under Interviews. However, a few codes appeared only from the focus groups (see Table 3 on page 102).

In the interviews, I followed the interview protocol (see Appendix C) and started the interviews with the core questions from the protocol. The overall discussion was to address the need for differentiation by quality strategy, identify the threats that hinder the

Organization's progress, and identify the new vision for the Organization, which includes how the leaders perceive the success of the Organization. The discussions in the interviews and focus groups helped me understand the Organization's culture, strengths, and weaknesses. Moreover, I identified the reasons for the inefficient business development program and found possible solutions based on the team's vision and ideas. More importantly, I collected recommendations from the team on elements for the strategy and what, in their opinion, hindered the Organization's competitive advantage. For the interview transcripts, I conducted a member check; I sent a summary of each interview and asked participants to confirm my understanding of their answers.

Table 3

Raw Codes Distribution from Interviews and Focus Groups

Code	Count of codes
Interviews	220
Business Management	45
Business Strategy	31
Collaboration	2
Communication	2
Competition	10
Constraints	15
Efficiency	3
Evaluation	1
Healthcare Education	3
Inefficiency	1
Marketing and Advertisement	12
Obstacles	12
Planning	4
Professional Development	25
Quality	2
Success	31
Trust	1
Uncertainty	13
Weaknesses	7
Focus Groups	110
Advertisement	13
Barriers	27
Feedback	11
Marketing	43
Negative Efficiency	11
Positive Efficiency	5

Table 4

Count of Quotations per Interviewee

Participant	Count of Quotations
L1	25
L2	24
L3	34

For step two, I disassembled the transcripts in ATLAS.ti software and generated the raw codes per Table 3 on page 102. For steps three and four, I did the manual work of filtering. I read the codes and their respective quotation and started reassembling them under categories in "documents" in the software. I gathered similar ideas together. I had to repeat this step five times to clean the data and have a total of eight categories. When I reached the eight categories, I focused on each and was able to generate the key major theme.

In step five, to reach the conclusions, I kept analyzing from the lens of the two frameworks, and I found eight key themes of opportunities to improve the business development program. The key themes found were advertisement and marketing, value perception, differentiation opportunities, threats and barriers, positive effectiveness and strengths, leadership, negative effectiveness and weaknesses, and customers' experience. I presented the results of the qualitative analysis throughout the following subsections as they pertain to the relevant constructs, but before I presented the mixed method findings, I found it necessary to explain and elaborate on the key themes.

Key Themes and Their Support in the Literature

In this section, I defined the themes, provided references to support the themes' choice concerning my study, and showed the Table of codes and respective reference counts. The code is not the exact wording used by the participants but a general description of the idea. The count of code refers to the number of times the code was referred to in the quotations extracted from the transcripts. References refer to how many

quotations included something related to the identified code. The Major detail is the higher category I reached, corresponding to the theme. The Minor details are grouped codes that led to the emerging theme. When necessary, I elaborate on the tables under each theme. Otherwise, I include the explanation wherever they are applicable in either the primary activities, secondary activities, or recommendations.

Theme 1 – Advertisement and Marketing: The business development program focuses on advertisement and marketing primary activities. Porter (1985) explained in the value-chain model that each activity, whether primary or support, helps the leaders work together to increase the organization's market position. The marketing team has many responsibilities that are not limited to only improving an organization's market position. Leach et al. (2021) determined that the collaboration between leaders in distributive leadership is crucial and feedback from everyone is important. As shown in Table 5 on page 105, the participants in the interviews and focus groups identified that, while the Organization had a well-defined brand and marketing strategy, the advertisement activities were weak and needed the involvement of everyone to reflect the high volume of events conducted in the Organization. Moreover, the three interviewed leaders identified that the Organization does not have bundles of strong products to market and advertise. The leaders also realized the need to have a higher priority to work on differentiating their products and services so that the business development team has a chance to build stronger advertisement and marketing strategies, attract more clients, and retain them. Table 5 on page 105 shows the details of theme 1 with the count of its codes.

Table 5

Details under Advertisement and Marketing Theme

Major/Minor	Count of Code	References
Advertisement and Marketing		
Market Competition	15	175
Weakness in Marketing	10	19
Ineffective Marketing	21	24
Brand Awareness	1	51
Business development	4	19
Business Growth and product development	2	173
Customer Satisfaction	2	9
Efficiency	3	9
Email Problem	1	5
Geographical Location	2	2
Absent Key Performance Indicator	2	107
Targeting	1	28
Advertisement	6	89

In addition to the inefficiencies, the Minor details in Table 5 also reflected what the participants think the problems in Advertising and Marketing are. They identified that they did not have key performance indicators (KPIs) to measure the efforts done in advertisement and marketing (see Marketing and Services part below for more details). The participants also mentioned having a problem with the mass email service. They cannot effectively reach the database of clients and cannot target the audience as per their needs and specialties (which is referred to as a growth hack). Moreover, the locations of centers are in 2 cities; however, KSA is a very big country, and its rural areas are in high need of healthcare education. Everything is located in the Capital, Riyadh, and healthcare

providers try to go there to attend their continuing education. An expansion would deem necessary and a higher opportunity for the Organization.

Theme 2 – Value Perception: The participants in the interviews and focus groups perceived the Organization as one of KSA's best private healthcare education organizations. This perception was based on hearsay, verbal feedback from the clients, and referrals to them by other entities, including governmental entities. Porter (2010) explained that value is a framework for performance improvement; however, he differentiated between customer value and company value. Lüdeke-Freund et al. (2020) found that multiple researchers tried to explain how value is created and sustained in a company, and they did mention that the value starts with the perception of the team. If the team perceived a high value of the Organization, the valuation was not quantified and was based on perception and personal input. I found that the team was motivated to pioneer the field. However, they lacked the means and the direction to create this value, and they have identified in the interviews and focus groups the reasons that hindered their progress. L1's vision of a successful outcome was to have the Organization internationally known and contribute to advancing the science of healthcare education. In the L2's opinion, the Organization's future success will be achieved when the Organization becomes "a game changer" in the market and when its work can affect the response to the demand in the market. In this theme, "Value Perception," the participants perceived the Organization as highly valuable with no objective data. The minor details in Table 6 on page 107 summarized the team's perception.

Table 6

Details of Value Perception Theme

Major/Minor	Count of Code	References
Value Perception		
Consistency	1	1
Importance of Organization	2	1
Perception of stage and position	1	17
Prestige	1	3
Quality	2	245
Resources	1	13

As shown in Table 6, the participants thought that the Organization was highly important in KSA, prestigious, with high positioning in the market, and provided high-quality services. The participants viewed that they had the resources to achieve this high value. However, as I mentioned before, no quantifiable findings support this value perception. Further explanation is presented in the subsequent parts of the data analysis.

Theme 3 – Differentiation Opportunities: The participants from the interviews and the focus groups identified that the Organization has multiple opportunities to differentiate its services and products and diversify the content and target audience. Akingbade (2020) explained that differentiation strategies are powerful tools with potent benefits and that their development and implementation set a better direction and results for the company. Islami et al. (2020) demonstrated that differentiation strategies allow the organization to earn and sustain its success. The participants are aware of the types of services they provide, and they are also very aware that they need to develop additional

services and content to compete in the market. The participants shared their ideas of what additional services and content can be developed; I added their ideas to the recommendation part of the study. Table 7 shows the details of this theme.

Table 7

Details for the Differentiation Opportunities Theme

Major/Minor	Count of Code	References
Differentiation Opportunities		
Lack of Diversity of events	2	8
Diversification Development	2	26
Product differentiation	1	27
Need for Differentiation	6	11
Operations and Business Management	18	104
Business strategy	15	114
Customer Behavior	1	5
Customer Needs	2	9
Demand	2	2
Academic focus and orientation	3	7
Healthcare Education	3	44
Innovation	4	35
Long-term focus	2	1

The minor themes in Table 7 showed the subjects mentioned by the participants. They identified the need for differentiation, development of products and events with diversification, and focusing on clients' needs. The participants also identified the necessity of innovations, more healthcare education topics, and a long-term focus on the strategy to differentiate for competitive advantage. The interviewed leaders discussed more the opportunity to have an academic focus and orientation in the Organization, and

to include the differentiation by quality strategy in the operations, business management, and business strategy.

Theme 4 – Threats and Barriers: The participants discussed challenges and experiences that reflected threats and barriers for the Organization. Porter's (1979, 2008) main focus in the five forces of competition was to identify the threats that limit competitive advantage and increase rivalry, mainly the threats of new entrants, threats of substitute, and threats from buyers and suppliers' bargaining powers. Haper (2019) referred to these threats and explained that the ability of leaders and teams to identify competitors beyond what is obvious is the key to success in the organization. In other words, organizations have to objectively assess what makes competitors better than they are and work on developing rivalry in the products and services. Table 8 on page 110 shows the details of this theme.

Table 8

Details of Threats and Barriers Theme

Major/Minor	Count of Code	References
Threats and Barriers		
Academic Honesty	1	1
Cancellation	2	152
Missing Details	1	43
Communication	4	9
Confusion	1	5
Criticism	1	3
Disinterest	1	3
Economic pressure	1	26
Inefficiency	2	9
Lack of Awareness	2	27
Negative Perception from community	2	2
Pricing	1	72

During the communication with participants, I realized they mentioned the threats as barriers but did not necessarily understand that competitors had better services and products than they did. This theme is related to theme 2 of value perception because the participants also perceive the threats and barriers as external factors that are not directly related to the Organization. The participants in the focus groups think that the value of the Organization is higher than the competitors', and thus, there is nothing they can do. I have added this topic in Table 8 as the lack of awareness. The interviewed leaders, however, realized that the Organization has an opportunity to objectively assess its value, opportunities, threats, and other items that relate to the other themes. As shown in Table 8, the participants mentioned the external factors in the economy, pricing of events,

disinterest in what they are offering, the levels of cancellation of events or participants' registration cancellation, and the negative perception of the community in KSA about the private healthcare education organization. Interestingly, in KSA, governmental organizations operate at very high standards and are powerful, which increases the barrier for private organizations. I elaborated more in the analysis of the findings in the subsequent parts.

Theme 5 – Positive Effectiveness and Strengths: The strengths are crucial to the SWOT analysis before developing a strategy. The interviews and focus group discussions allowed me to see that the team can identify its strengths; however, sometimes, they cannot see that they need to work on these strengths to improve them. While leaders need to address internal and external factors (Akingbade, 2020; Islami et al., 2020; Porter, 1985), leaders must also pay attention to their internal strengths and utilize them effectively and efficiently (Akingbade, 2020). There is no point in knowing your strengths and capabilities and not investing in them to have more positive effects. One of the most powerful internal powers that the Organization must address is how to utilize its human resources. Table 9 on page 112 shows the details of this theme.

Table 9

Details for the Positive Effectiveness and Strengths Theme

Major/Minor	Count of Code	References
Positive Effectiveness and Strengths		
Content and Programs	5	47
Adaptability	2	52
Development	22	232
Resilience and Flexibility	1	33
Success	10	34

Table 9 also shows the details of the positive effectiveness and strengths theme. The interviewees explained that the Organization has no problem developing content and educational or training programs. However, the problem is marketing and attracting clients (refer to theme one and primary activities). All the participants recognized that they have high adaptability to rapidly evolving environments, and the Organization's history proved its resilience and flexibility. *Success* is a topic that was frequently mentioned along with development. All participants perceived that the Organization's employees can develop standards and compete in the market, which made them successful.

Theme 6 – Leadership: The CEO of the Organization has been described as a visionary, and he and his team's aspirations show a large spectrum of opportunities to become one of the most prestigious institutions in the KSA. Paarima et al. (2022) demonstrated that ineffective leadership severely affects patient and staff outcomes. Even though the Organization is a Business for Healthcare Education, the impact on social

change is strictly related to the patients and community. The CEO is a healthcare provider who knows firsthand what it takes to train high-quality healthcare providers. The challenge in the Organization's leadership is the lack of business acumen to deal with the operational aspects of the business. Porter (1985) highlighted that the value chain is a guide for leaders, who must prioritize which activities to address first, why, and how to act on them and use their judgment. Collaborative leadership is explained by Leach et al. (2021) and indicates that leaders from different backgrounds will have better success and business management when they collaborate. Collaborative leadership is one crucial model missing in the Organization. The participants expressed their respect and even their affection for their leader, some were aware that there was something missing to be able to work to their fullest potential, and others did not realize that. Table 10 on page 114 shows the details of this theme. The Minor themes presented in Table 10 are discussed in the data analysis section, specifically in the Support activities: Human Resources. I also presented the recommendations relevant to this theme in the recommendations part.

Table 10

Details for the Leadership Theme

Major/Minor	Count of Code	References
Leadership		
Process optimization deficiency	1	8
Repetition of work	1	11
Inefficient Resource management	2	13
Change Management	1	1
Dependency on intuition	1	14
Need for Distributive leadership	2	39
Administrative Burden	1	13
Limited Personnel	1	13

Theme 7 – Negative Effectiveness and Weaknesses: The thematic analysis of all discussions revealed that the leaders were aware of the waste of resources (human and financial) and of the weaknesses in the Organization's profile. The only business profile is available in the website. The website content is not updated and does not reflect what the Organization offers to the clients. The clients cannot see in the website what the Organization has that would meet their interests, or the diversity of high-quality services and events that will meet their needs. Leaders must assess their weaknesses and reduce waste. They must also identify the competitors' weaknesses (Harper, 2019); one's weakness is another's opportunity. Competitors look for weak links and areas to excel. Every organization should minimize the threats of substitution and work on all five forces of competition (Porter, 1979), which is a recommendation for the Organization. The key to success is to be aware of the negative effectiveness and weaknesses, accept them, embrace the impact, avoid blame, and take the lead in implementing corrective actions,

including the establishment of strong foundations for the Organization (which are identified in the outputs of the program logic model). Table 11 shows the details of this theme.

Table 11

Details for the Negative Effectiveness and Weaknesses Theme

Major/Minor	Count of Code	References
Negative Effectiveness and Weaknesses		
Lack of Automation / technical difficulty	2	31
Database inefficiency/waste of manpower	2	8
Email Management inefficiency	2	16
LMS and System inefficiency	2	36
Lack of Processes	1	11
Business Inefficiency	2	32
Business Model	1	9
Communication with clients	1	1
Expertise non-utilized	2	40
Financial Stability	1	13
Influence	2	1
Lack of Diversity	1	34
Lack of Market research	1	7
Lack of awareness and knowledge	2	11
Fatigue	1	11
Lack of Coordination	1	11
Lack of Focus	1	11
Lack of follow-up	2	11
Lack of planning and implementation	2	11

The lack of automation, technical difficulties, database issues, waste of manpower, email inefficiencies, and LMS and system inefficiencies are elaborated in "Support Activities." All other minor topics are discussed in the primary activities,

rivalry, and absence of strategies to minimize the threats of new entrants and threats of substitutes.

Theme 8 – Customer's Experience: Customer experience is the concern of any company. Customers determine the success of new entrants, rivals, and the organization's success (Porter, 2008). Differentiation is to give the customers what they want; in creating unique services, customers will be loyal and willing to spend for the service no matter the cost (Akingbade, 2020; Islami et al., 2020; Porter, 1985). Customer needs drive innovation and differentiation; customer satisfaction reflects high-quality services. Table 12 shows the details of this theme.

Table 12

Details for the Customer Experience Theme

Major/Minor	Count of Code	References
Customer Experience		
Positive Feedback/satisfaction	3	9
Importance of Evaluation	2	22
Online web feedback	1	8
Listen to clients	1	19
Customer service	1	9
Customer needs	1	9

The Organization's leaders wanted to know what the clients' feedbacks were. However, the qualitative data analysis was lacking, and I could not gather statistically significant information. I elaborated on this problem in the subsequent sections and addressed the need for a revised process to collect the clients' feedback in the recommendations. In Table 12, I identified a minor theme, "Positive

Feedback/satisfaction," from the qualitative analysis. This minor theme was related to the participants' perception and the verbal feedback they received from clients during events.

Primary Activities Related to Marketing and Sales, Operations, and Services.

Marketing and Sales: In this study I evaluated the business development program; the data collection and analysis focused on marketing and sales activities. As per the archival data and interviews, the marketing department sends out 25-30 announcements every month in addition to the monthly activities calendar disseminated by email on the day of salaries. The experience of the business development manager showed that the registration is higher when the calendar is sent at the payroll time. Currently, there is no data to support the marketing and advertising activities, mostly advertised activities, and how many announcements are sent before the activity dates. Noticeably, the trauma courses and life support courses are conducted continuously and frequently.

Table 13

Completed Events Count for Years 2021 and 2022

Course Category	Count
Life Support Courses	623
Trauma Courses	182
Surgical Skills Events	66
Other Events	37
Preparatory Courses	6
Conferences	3
Total	917

In two years, a total of 1,035 events were conducted. However, 917 (88.59%) of the scheduled events have been completed. Table 13 on page 117 shows the overall distribution of events per category. The life support courses are conducted frequently (623 courses out of the 917 total completed events). One factor is that they are short (averaging 4 hours for the basic ones), and depending on the number of attendees per course, one instructor can conduct the course with a maximum of six students. Another important factor is the availability of an in-house instructor in each center who can conduct up to two courses a day if needed.

Moreover, life support courses have been mandatory in healthcare organizations globally. The Saudi Commission for Healthcare Specialties (SCFHS) mandates all healthcare providers to have a valid BLS for valid licensing and specialized and advanced courses according to the specialty. The international guideline for the renewal of these courses is two years. Hence, these courses are self-sustaining and in high demand. Most of the centers for life support training are located in the capital, and they all have a high demand to cover the needs of all healthcare providers in the KSA. The competition in the market may affect the number of life support courses conducted in the Organization; however, even though the Organization does not provide Continuing Professional Development Credits (CPDC) for the basic courses and charges higher than other organizations, the power of buyers' bargaining is minimized because of the reputation and the high standards of the Organization. The interviews and the focus groups showed that the reputation of the Organization in these courses is high, and the clients are

satisfied with the immediate accommodation of their needs, the quality of the course, and the immediate receipt of their certificates.

The SCFHS also mandates advanced and specialized trauma training for healthcare providers working in trauma services (e.g. ICU, surgical Critical Care, and Orthopedics), in the Emergency Department, and all Emergency Medical Technicians and Paramedics. The recertification of these courses is every four years. The Organization is the exclusive center that provides these courses and is KSA's headquarters for these specialized trauma training programs. The number of courses conducted yearly does not meet the market's demand. However, 42 certified trauma training centers have been inaugurated in the KSA and each report back to the headquarters. The data of these trauma training centers are private for each independent center, and I was not given access to their databases to include in the analysis.

Table 14 on page 120 shows that 16,454 students inquired about or registered in events in the Organization in 2021 and 2022. Students who approached the Organization either ended up attending an event, or not. Table 14 on page 120 shows the status of students and I explained the categories subsequently.

Table 14

Status Count of Unique Users in the Organization in 2021 and 2022

2021 & 2022	All status
Canceled	251
Delayed	4
Don't know	57
NA	317
No	751
Yes	15074
Grand Total	16454

Attendance status "canceled" listed in Table 14 is when the Organization canceled the registration due to cancellations or postponing the event. The attendees were then rescheduled for another date, refunded, or allowed to attend another event (payment adjusted accordingly). In 2022 some cancellations were because students were not eligible to take some courses. After all, they did not have prerequisites for the course. The delayed status is for only four applicants who did not go through with the activities at all. The "don't know" status is for data that was not clear; I could not identify what happened with those students, whether they participated in the event, got refunded, or attended a later date or another event. The NA is for the entries of lists of candidates who inquired about events or were part of nominations from their organizations to attend an event in the Organization but who did not. The no status is for the candidates who registered in events but did not attend them. The majority of the entries did not have a reason for being absent. The general other reasons for absenteeism are marked with absent/no show, sickness, change of date requested by the candidates, family issues or death in the family,

replaced by another colleague, work interview scheduled at the same date of the event, exam scheduled at the date of the event, forgetting about the course, late to attend and rescheduled with a penalty, took another course instead, has visa issue and could not fly in for the event, or having to travel out of the country. The team identified these reasons for absenteeism in the focus groups. However, the team did not remember all the reasons for the absenteeism, but highlighted that one major reason is related to the manual work done to send out the event's instructions (the evening before the event); hence, some participants did not show to the course as they did not know of the timing, schedule, or details of the location. The customer service employees did not have a log to mark the absences. Some students were reimbursed when the policy allowed; however, the data was not saved by the accounting team.

The problem in the emailing system identified in the thematic analysis is related to the "barriers" and "weakness" themes. The current identifiers for the candidates are the email addresses. I discussed the technology-related issue in the relevant section. Regarding marketing, the Organization still has no method of creating unique customer IDs. The validation of the demographic information is not possible with the available resources. The data collected showed that names, specialties, email addresses, and credentials are non-consistent and missing in large parts. The marketing department needs a clean database to target the audience and conduct a growth hack properly.

In the free webinars, I noticed many registered students did not attend the event, whereas another group attended without prior registration. The discussions with the team

clarified that these events were planned in short periods and were not well announced; however, the students who were attending shared the webinar link in their social media groups, and thus, many joined at the time of the event. For example, in 2022, two webinars were scheduled suddenly, for free, without prior marketing. However, the attendance was very high. I found that these events occurred at a critical time in the year when medical students and interns were applying for their match and placement in hospitals. The first event addressed interview preparation; 449 registered, and 197 (43.87%) did not attend. An additional 299 (54.26%) attended the webinar without prior registration. The total attendance was 551 attendees. The second event was about CV writing: 215 registered for the event, of which 126 (58.6%) did not attend. An additional 20 (18.34%) attended the event without prior registration. The total attendance at that event is 109.

The interesting finding I observed is that students who register for free were not accountable and had no sense of obligation to attend the events even though they were for their benefit. Moreover, I noticed that the period when specific events were completed for free attracted many healthcare providers. The same subjects and additional ones were developed into hands-on workshops within the same time frame the following year. The registration was null in the capital. However, many requested that these workshops be conducted in rural areas.

Table 15 on page 123 represents the observation I presented. In 2021, 9083 students attended events in that year. There were 8901 (97.99%) students registered and

attended, and 182 attended events without prior registration, representing 2% of the total. In 2022, 5991 students attended events. During that time, 5668 (94.6%) registered and attended and 323 attended without prior registration, totaling 5.4% of the total. This phenomenon is a reflection of the word of mouth. Further studies and analyses can be done to reflect the effect of word of mouth on the Organization's reputation.

Table 15

Students Attending Events without Prior Registration

Year	Total unique users who completed the events	No. of registered and attended	No. of attended without registration
2021	9083	8901	182
2022	5991	5668	323

Another explanation for the findings in Table 15 can be linked to the type of the event, the circumstances that led to their delivery, the speaker who presented the webinar, the type of activity online which allowed people to join from all the country, and the urgent need to be ready for an imminent life-changing opportunity. Further analysis is needed in the coming years to understand this phenomenon.

Through the thematic analysis I addressed and highlighted the team's concerns related to customers' acquisition, attraction, activation and retention. All the team, including the leadership, recognized the need to focus primarily on the database quality to have big data that will be meaningful and useful. All the team also identified the marketing versus advertisement deficit. The branding has been well done, the Organization's identity is recognized in the national and international industry and is a

symbol of quality and high-standards, and has a highly valued reputation. In some instances, clients verbalized to the leadership that they attended events because their Organization was recognized as the only private healthcare education organization with a high reputation and high quality of healthcare education. The problem is not in preparing events and contents. The problem is in attracting people to these events. The team highlighted the audience may not be in need of the events, or that the database is redundant and reaching the same people who may have already attended the advertised events. The problem in activation and retention that was addressed in the thematic analysis is highly supported by the findings of the quantitative analysis. Tables 16, 17, 18, and 19 on pages 124 and 125 represent the comparison of attraction and loyalty of clients.

Table 16

Percentage Change of Number of Courses and Number of Unique Users

Year	Courses scheduled	Unique users who attended events
2021 & 2022	1035	15074
2021	420	9083
2022	615	5991
% change	46.42%	-34.04%

Note. The Organization scheduled 195 more events in 2022 totaling 46.42% positive change, whereas the number of unique users decreased by 34.04% between the same two years.

Table 17

Customer Loyalty over Two Years and Percentage Change

	Number of Occurrence									Blank emails	Attended 2 and more events	Attended 3 and more events
	1	2	3	4	5	6	7	8	9			
2021 & 2021	10984	1389	247	65	21	6	6	0	1		1735	346
2021	8291	621	93	11	9	4	2	0	0	52	740	119
2022	5324	505	75	15	3	2	0	0	0	67	600	95
% change										28.84%	-18.92%	-20.17%

Note. The percentage of missing emails increased by 28.84% between the two years.

Loyalty decreased as well in 2022 compared to 2021.

Table 18

Count of Events in 2021

2021 events	Count of Events
Cancelled	20
Completed	374
Postponed	26
Grand Total	420

Table 19

Count of Events in 2022

2022 events	Count of Events
Cancelled	21
Completed	543
Postponed	51
Grand Total	615

Tables 18 and Table 19 on page 125 show a 45.18% increase in the activities completed between the two years, which is considered a positive change. However, the Organization must monitor the rise in the number of canceled and postponed events. Table 20 summarizes changes occurring between 2021 and 2022. Leaders at the Organization have the opportunity to address these changes in the gap analysis and the development of the new differentiation by quality strategy.

Table 20

Summary of Changes between 2021 and 2022

Item	Details	Change Interpretation
Number of completed events	169 more events a 45.18% increase	Positive change
Unique attendees	3,092 less than year 2021 accounting for -35.04%	Negative change
Members attending 2 or more events	Decreased by 140 members accounting for -18.91%	Negative change
Member attending 3 or more events	Decreased by 24 members accounting for -20.16%	Negative change
Missing email	Increased by 28.84%	Negative change
Location of events	Increased by 11 locations accounting for 68.75%	Positive change
Activation of Jeddah branch	Activities increased from 3 events on the first year to 133 in the second year accounting for 4333.33%	Positive change

The diversity in locations in two years indicates that the Organization is available to cover the customers' needs in the country; hence, they can expand out of the capital. Noted in Table 20 the 68.75% increase in locations from one year to another is calculated based on the findings from the archival data. This increase reflects active partnerships

and agreements with institutions to conduct courses at their locations or for their teams. However, the events were all related to trauma or life support; no other training was provided to these institutions. The interest in this study is to check the activities at the Organization's two branches; the headquarters in Riyadh and the branch in Jeddah. The Jeddah branch opened at the end of 2021. Table 21 reflects the increased dynamic activity in that branch. Even though the branch has an in-house certified safety officer instructor, events related to this topic are still pending and not offered.

Table 21

Activation of the Two Branches

Location	Count of completed events	Percentage
Jeddah	142	
Cancelled	2	1.41%
Completed	128	90.14%
Postponed	12	8.45%
Riyadh	763	
Cancelled	35	4.58%
Completed	668	87.55%
Postponed	60	7.86%
Grand Total	905	

The event type's count in the Organization is shown in Table 22 on page 128. As discussed before, there is a 45.18% positive change in the number of completed activities. Two conferences were completed in 2021 while only one was done in 2022. This major change can account for the decreased attendance numbers between 2021 and 2022. However, we did not attract or retain those 2.8K attendees from the year before. Table 22 shows the changes of events types between 2021 and 2022.

Table 22

Changes in Event Types between 2021 and 2022

Event Types	2021	2022
Conference	2	1
Course	403	592
Webinar	11	16
Workshop	4	6
Grand Total	420	615

Satisfaction and Loyalty: The events evaluation form was standardized at the start of 2022. The forms are saved in a common drive. The team was trained on its use and how to prepare a form for each event. However, I found in the archival data analysis that the evaluations of the conferences are the only ones filled with an adequate number of more than 80% response rate to have a statistical significance. All other events had no more than 3 respondents, which made it very difficult to analyze the level of satisfaction with the events conducted by the Organization. Moreover, the lack of feedback limits addressing attendees' needs. In the interviews and the focus groups the team mentioned that the needs assessment is based on the evaluations; however, none of the coordinators checked if the evaluation was properly completed. While discussing the process for closing an event and certificate distribution, I found a lot of wasted manpower conducting this exercise and there was no definite process. The team prepared the certificates and distributed them without collecting feedback. When attendees receive their certificates they have no reason to provide any feedback. In addition, the team is wasting time following up with independent individuals to collect their full names for the certificates;

whereas, the problem will not exist if the fields in the registration link are mandatory and limited to the required criteria.

The feedback from the conferences is shown in Table 23. For confidentiality I refer to the conference by number and the year they were conducted.

Table 23

Level of Satisfaction in the Conferences

Conference	Benefit from event; excellent	Benefit: Good	Overall satisfaction Excellent	Overall satisfaction good
C1-2021	58.02%	36.1%	65.5%	31.9%
C2-2021	68%	29%	73%	26%
C3-2022	64%	32%	71%	28%

Regarding loyalty and retention, 606 members attended events in 2021 and 2022 at least once each year. There were 5,194 new clients that joined the Organization in 2022 and attended at least one event. However, 8,122 clients in 2021 did not attend any event in 2022. The Organization was able to attract new clients in 2022 but could not activate and retain 8,122 from 2021. This finding contradicts the team's perception of data saturation and having the same people receiving the announcements. I was not able at the time I conducted the study to properly analyze the growth hack as the database was not standardized and incomplete in its majority. The missing data were full name of the participant, email address, specialty, sub-specialty, mobile number, and affiliation.

Moreover, there is no unique customer ID per person, the records and even the accounting are linked to the person's email. Some members registered with their

Organization's emails and then joined other events in their personal emails. The inconsistency resulted in the creation of two accounts in the Organization and were counted as two different people. This discrepancy affects the members' loyalty counts and the standardization of their files. I could not extract their history because they do not have a unique identifier.

Operations: Leaders of the Organization are adamant about making the Organization a game changer in the market. Moreover, a new practice started at the start of 2023 with the decision of the leadership to publish academic articles about programs in the Organization. With this decision, the CEO foresees a spike in the status and positioning with the shift of academics and contributing to science, and not only to be labeled as a "Business". Interesting activities and contributions are occurring now, and the team has a higher chance of success with the peer-reviewed publications they are working to complete.

Services: The Support and Consultancy Models are services that need attention and activation. The assessment conducted with the leaders made me understand their sound analysis. The services provided in these models are more advanced than the public would understand. The concepts are new and not yet well accepted. The Business Development leader highlighted that these models are services that need to be appealing and enriched so that he can market them properly. This is an additional action item to include in the gap analysis.

Support activities related to Firm Infrastructure, Human Resource Management, and Technology Development.

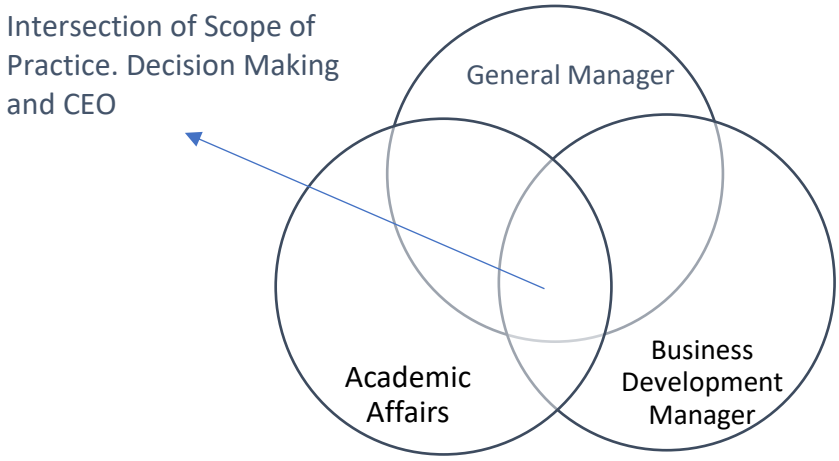
Firm Infrastructure: The Organization employed two part-time employees to cover the business development and marketing campaigns and design the advertising material. The Organization newly hired a full-time employee dedicated to business development. This employee will be crucial in implementing the corrective actions presented in this study. The interviews included the CEO, general manager, business development, and marketing manager. As of the study, the Organization had no employees dedicated to advertising, social media traffic, and trends. The general manager (GM) and the consultant for business and academic affairs (BAA) work in synergy in their distributive leadership role to improve the Organization's efficiency. The GM and the BAA will work closely with the business development team to address the recommendations presented in this study and develop a comprehensive and inclusive differentiation by quality strategy.

Human Resource Management: The leaders of the Organization discussed in the interviews their awareness for the need to expand. The vision is to have at least 5 branches to cover the territory. The foreseen expansion implicates an increase in the staffing, which could not be determined at that moment. The leaders recognized the need to address fundamentals and build a strong structure before proceeding with the expansion. Moreover, they were aware that at that moment, the organizational breakdown structure needed to be flattened, and inclusive of the distributive leadership. There was a

need to hire a chief academic officer who would take over the execution, implementation, activation, and follow-ups of educational projects. At the time, the role of CAO was covered by the consultant for business and academic affairs who is working remotely. The consultant was proactively working for the benefit of the Organization. The remote work limited the completion of the task at certain levels. However, the collaboration with the new in-house business development specialist is helping cover the requirements for the CAO role. The distributive leadership is represented in Figure 7 where the General Manager, Consultant for Academic Affairs, and Business Development Manager work on their specialized expertise and scope of practice, but where the center decision is the intersection of all their work in the Organization. The final collaborative decision will be submitted to the CEO for review and approval.

Figure 7

Organization's Distributive Leadership



Note. This figure illustrates the findings discussed with the leaders about the distributive leadership in the Organization.

Technology Development: The Organization did not have any method of creating unique customer IDs. The emails bank had 34K email. The emailing system had a problem because of the domain and the emails were sent to the junk and spam folders, or they were blocked for many recipients. The team worked on the mass email issue, the problem was solved temporarily and was under evaluation. However, the data in the emailing system was mostly not accurate. I was able to collect 16.5K emails from two years data. The trauma events had been conducted since 30 years (refer to historical context of the Organization), this alone indicated that the database was missing multiple emails.

The competitive advantage that the Organization in technology development is related to the new innovation in healthcare education using artificial intelligence and virtual reality. This breakthrough shifts the rivalry and hinders the threats from competitors. Moreover, this innovation is a revolution in healthcare education that adds value to the scientific contribution.

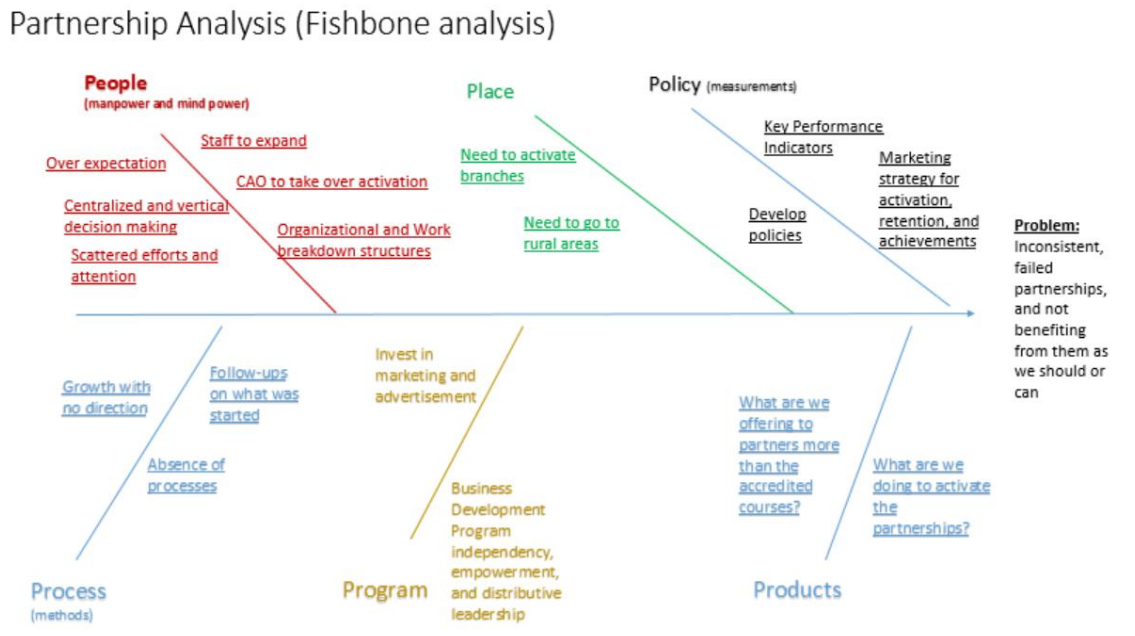
Missing Rivalry Analysis

When I started the study, I found that there are no partnership analysis, GAP analysis, or competitor analysis. During the work on this study, I started preparing the basis for these analyses that will help leaders complete them and include them in their strategy. Figure 8 on page 134 is a fishbone analysis for the problem in sustaining, activating, and benefiting from existing and new partnerships. I collected the reasons based on the thematic analysis from the interviews and the focus groups. Refer to the

recommendation for actions sub-section to find possible solutions to the findings of the partnership analysis under strategic alliances. The items from the fishbone are actionable items to be incorporated in the differentiation by quality strategy. Leaders must work together to revise this draft and update it. One common factor mentioned by all leaders affecting partnerships is that, at this stage of growth, the Organization is more careful and selective in the upcoming partnership requests. They had a learning curve and are more aware now of what they want and what the Organization needs. Simply put, the Organization was looking for strategic partnerships which would elevate its value and add value to its services.

Figure 8

Partnership Analysis Fishbone



Note. This figure is based on the thematic analysis and my discussions with the leaders of the organization under study.

The archival data had in its content agreements with the partners, however, there were no details about the agreements' content, achievements, status, results, and future opportunities. The General Manager and Business Development Manager assisted with the creation of the Partnership Analysis Table 24 to understand these partnerships.

Table 24

Partnership Analysis Table

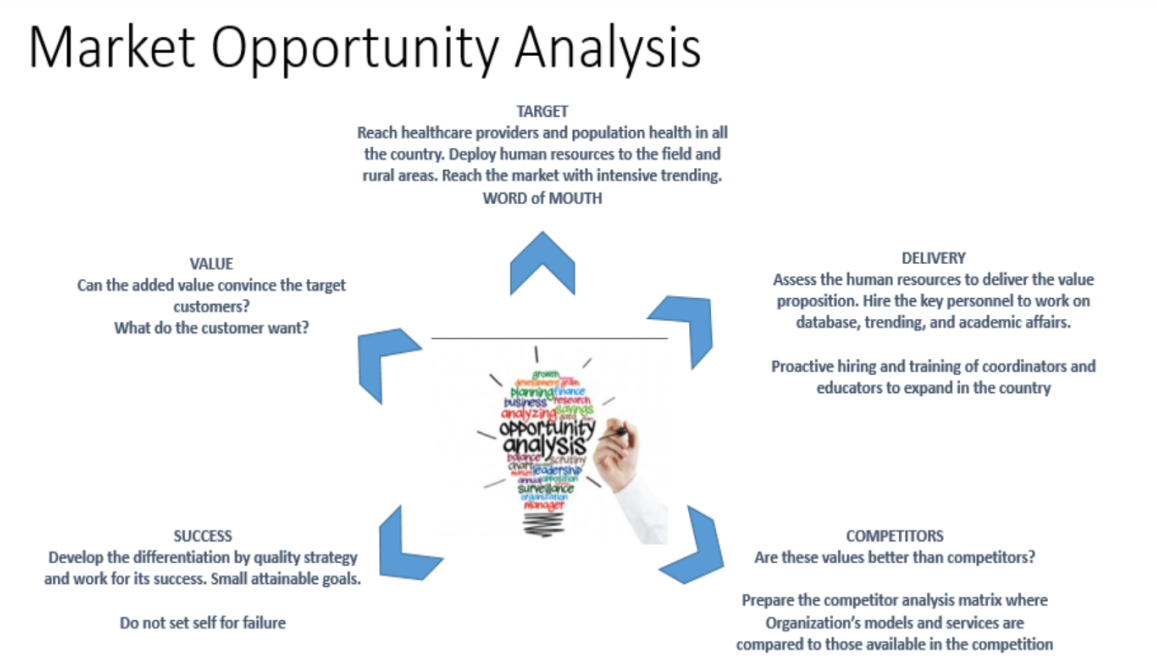
Type	No. signed	No. and Status	Results	Reason
Governmental	7	2 ended	Successful	Accreditation required for their centers & successfully completed
		3 ended	Failed	No support from the requesting entity. No accountability and no interest from the nominees, even though the training was mandatory.
		1 active	Successful	Continuous training of the healthcare providers in life support. Areas for improvement and more activation, but no one to take over the activation
		1 on hold	Failed	Waiting for someone to follow up No one to take over the activation
Private	5	1 active	Good	Not providing them more than trauma and life support training. Not activating the agreement
		1 on hold	Failed	Not benefiting from the agreement No one to take over the activation
		3 inactive	Failed	No one to take over the activation for 2 of the agreements 1 agreement has a limitation from the second party with the proposed course fees; there is no added value to the Organization to activate it or invest in it
International	4	4 active	Successful	International accreditation centers which differentiates it from other HCEOs

Absence of Strategies to Minimize the Threats of New Entrants and Substitute Products/Services, and Decrease the Buyers' Bargaining Power.

The thematic analysis allowed me to understand the need of a market opportunity analysis. I developed Figure 9 to represent the market opportunity analysis in a concise and comprehensive way that will help the leaders develop the differentiation by quality strategy.

Figure 9

Market Opportunity Analysis



Note. This figure is based on the market opportunity analysis as an output to help the leaders focus on what requires their immediate attention and action. This analysis will help guide them in the development of actions in the strategy. Leaders need to answer these five items in every action they decide to implement.

Recommendations for Stakeholder Action

In this sub-section, I presented my recommendations for the stakeholders as a result of this study. In Section 1 of this study, I conducted an extensive literature review pertinent to differentiation and quality healthcare education. The articles I read gave me ideas for the recommendations for stakeholders' action. I also referred to the findings I presented in Section 3, and to some feedback from the Organization's leaders and employees. The recommendations I presented were aimed to help the leaders achieve the goals outlined in this study. To show the outcome of this study, I decided to present the recommendations under the specific goals to show the status of the goal and what additional actions were required for their completion.

Goals A and B

Goals A and B were (a) increase registrations in educational activities by 25% per year for the next two years, and (b) develop standardized processes that will help increase by 10% per semester the number of events provided for the next two years. These two goals' defined period was for two years, the work invested in this study and the elements that started to be addressed in the Organization will help achieve these goals in two years. The success of these two goals depend on finding solutions to increase the number of clients registering in events and on developing processes in the Organization. These goals are attainable and can be considered KPIs for the overall organizational performance. However, based on the findings, they were long-term, and I expect that the Organization

can start achieving them a year after addressing the opportunities for improvement, differentiation, and increasing the value of the services.

In regards to the cancellation and absenteeism rates, I recommend that the customer services conduct a retrospective analysis on the entries and inquires to gather the reasons for absenteeism and complaints. In parallel, I advised the customer service team to start the log immediately and move forward to have more accurate and informative data for action. I also recommended that the customer service team log all inquiries about educational events. The business development full time employee could also interact with the attendees during the in-house activities, listen to their concerns and suggestions, and inform them about the upcoming activities planned in the Organization.

Goals E and F

Goals E and F included (e) develop by the end of July 2023 policies that will support the differentiation by quality strategy, and (f) develop, by the end of this doctoral study, a differentiation by quality strategy that will help the leaders create a brand, and increase competitive advantage. The CEO of the Organization was aware and supportive of this study. The CEO became aware of the key elements (namely the outputs) needed to develop the differentiation by quality strategy. As of February 2023, the higher management started developing policies, processes, and procedures to support the differentiation by quality strategy. In retrospect, the Organization was a new business shifting to accelerated growth; thus, it has learned from the dynamic changes since its establishment and has a clearer idea about the direction to take. Leaders of the

Organization were more aware of the need for the strategy and were investing in developing it. The brand and reputation of the Organization are set in the market. The leaders need to address the opportunities for improvement to have a differentiation by quality strategy, which will increase competitive advantage.

Based on the lack of feedback from attendees, the process of activity closing and certificate distribution needs to be addressed first. The team needed to find an easy solution to collect clients' feedback in an event before any certificate is distributed. The response rate for all activities needs to be more than 80% to be statistically significant. In this region, having a mandatory evaluation is deemed a hassle and may affect the level of satisfaction; usually, the community in the Gulf Area is not used to the concept of completing the feedback to receive their certificates. If the Organization made the collection of feedback a mandatory process, the clients might be biased in answering the survey and retaliate by providing a negative feedback. For that matter, I recommended they add the option to respond "do not like to provide feedback" and the option "everything was excellent, no need to fill further information". This way, everyone will have an opportunity to complete the evaluation, and they can conduct appropriate analysis of the evaluations knowing that they have more than 80% response rates.

Another issue was identified in the evaluation forms, the area to write the date of the event was left as text. This makes the analysis per event per date very difficult and almost impossible to compile. Especially that most of the attendees will be writing the Hijri date and not the accurate Gregorian calendar. I recommend this field as a built in

Gregorian calendar where the attendees will have to choose the appropriate first day of the event. Another option was to have the event planners add the date themselves. This decision needs to be finalized with the team when the process of closing events is finalized.

The last issue to address in the evaluation forms was the open field for future recommendations. This field needs to be mandatory, and a separate field needs to be added for the question: What educational activity would you like to receive? This question will help the team collect the needs assessment. This question can be added at the start of the form, after which the attendees can decline to answer further questions. A solution for the response rates is to have portable pads with the evaluations open in them, and which can be used by the attendees while waiting for the exams in practice to be done, or while waiting for the last modules of the trainings.

For the operations, I recommend that the GM requests a log of refunds with reasons from the accounting team. Also to have a log with registration, percentage of discounts, reasons for discounts, and other factors that he deems necessary for analysis in the future. I also discussed with the CEO and the GM the list of policies that were urgently needed to be developed in the Organization. I will be working with them to have them developed as output from the study. One of the requirements is to address the technological problem that hinders the development of an accurate database. Firstly, I recommend to create customer IDs, and in the process, have a dedicated person validate the information. For the future new registries, the validation must be done automatically

by the system. Secondly, I recommend to have the names limited to first, middle and last, and in English, with the option to have the Arabic spelling optional.

To monitor the progress, and meet deadlines, the whole team must meet once a month, and conduct a quarterly strategy follow up meeting. Moreover, the academic affairs and GM must meet every other week to take pertinent decisions, review the policies and process development before submitting to the CEO. I also recommended they retrain the team on the newly standardized database, and on how they can generate immediate reports. Moreover, I recommended they train the program leaders on monthly report generation and analysis.

Goals C and D

Goals C and D were to (c) conduct a gap analysis to identify opportunities for improvement and differentiation, (d) increase the value of the services provided by continuously delivering high-quality healthcare education activities that respond to clients' educational needs. My work in this study served as the gap analysis to identify the opportunities for improvement and differentiation. However, a proper gap analysis must be completed by the leaders while developing the strategy. I prepared Table 25 on page 142 as a Gap Analysis template for the leaders to use in their analysis.

Table 25

Gap Analysis for the Organization under Study

Current business state		Accelerated Growth with no road map, growth direction, or growth plan
Ideal state T0 (summary of what decision makers described in the interviews that success will look like)		Become a leading healthcare education institution know by the world international as well as contributing to the science of healthcare education. have multiple highly active branches Expand our scope. Example have professional certifications Hire highly competent experts in the right positions and fill the academic affairs leadership position Become a game player and changer in the market
Fishbone Analysis		Conduct a fishbone analysis in each department and identify the actionable items
Gap Remedies (how to achieve T0)		
Actionable item no.	Action plan/Reach Key performance Indicator (KPI)	Responsibility
Item 1		
Item xx		

The recommendations and the findings of this study served as an input for the gap analysis. High level leaders need to start the analysis, prepare the Organizational and Work Breakdown Structures, and then have each program's leader develop actionable items with the respective action plan and KPI, and assign responsibilities for the actionable item. The improvement areas within the Organization are related to the primary activities (Marketing and Sales, Operations, and Services) and the supporting activities (Firm Infrastructure, Human Resource Management, and Technology Development).

I used the program logic model (refer to Table 1 on page 12) throughout this study to help me focus on the long-term outcome: developing a differentiation by quality strategy. Hence, I first advised the Organization's leaders to keep the program logic model posted in their Organization where all the staff can see it. They can update it on the go and discuss it in the staff meetings. This way, everyone will be engaged and aware of the firm's direction. The logic model is a road map. I recommended that the leaders meet with the team and explain this tool. Then, each department's leader can be assigned to develop their logic model and identify the inputs they need and the outputs they want to work on to achieve the Organization's goal of developing a differentiation by quality strategy. In other words, I advised that the middle management get involved in developing the strategy. The higher management identified the mission and vision of the Organization (see Organizational Context in Section 1, p 4). The employees must be aware of this mission and vision, and middle management will then be able to prepare their plan for their respective departments to achieve the Organization's strategy. Using the logic model will help the middle management plan, execute, evaluate, and implement the needed to differentiate their departments and increase the value and quality of the services offered in their departments. They will also be able to present their suggestions for differentiation and expansion.

Regarding the quality of the faculty, I recommended that the academic affairs conduct a thorough analysis of the contracted faculty, the frequency of their participation, and what events they can create or develop to be added to the pipeline of events. The

analysis must also include if they are active, on-hold, instructor potential, level (educator, instructor, lecturer), and their background. A sheet for the Faculty Database was added in the new database format, faculty information will be updated on the go in one place, and in a standardized manner. In addition, I recommend that the background check include collecting the updated CVs and creating a folder with a tracker about their biographies. Having these documents at hand would help the team determine the internal title for the faculty to calculate remuneration as per the newly developed policy, and it would also help in the easy application for educational credits in the government online system to fill the faculty's credentials and support the variety of their backgrounds.

Recommendations for Marketing and Sales

The first finding in the study was related to the database. The database was not standardized to capture all entries, preventing the marketing team from having a growth hack strategy. Standardizing the form for data collection was necessary, and ensuring the team had input on what information was needed during registration and follow-ups for the events. I met with the customer service officer, and they led the revision of the database with the team. We then standardized the form and presented it to the general manager and the CEO for approval, who approved the database standardization process recommendation, and the team is working now to compile all entries, starting to input data from January 2023 in the newly approved form. This form will allow the marketing team to check the loyal clients and offer them something as an incentive for their loyalty,

encouraging others to participate more in the events offered in the Organization, thus, increasing sales.

The interviews and focus groups highlighted the need for an active advertisement. The team suggested taking pictures of the daily activities and posting them on social media to show the successes and achievements. At the time of the study, the Organization performs with high standards and is always busy with ongoing activities; however, these activities are not shared with the public. Advertising active and successful events will attract more clients to the Organization and increase its position in the market. The participants highlighted an urgent need for a dedicated staff to activate the Organization's social media. This staff will also be responsible for activating social media platforms that are not currently used but are active in the community, like TikTok. Trending in all its forms is needed for the Organization to have better visibility.

Recommendations for Sales

Key Performance Indicators: Sales mark the profitability of an organization, but sales are not the only indicators of profitability, and profitability is not the only indicator of success. I provided a study with the aim to increase registrations and the number of events. As I explained, goals A and B are long-term goals that can be achieved after a strong baseline is set in the Organization. The success of this Organization is described in the findings from the standpoint of its leaders. The first important step these leaders need to do is to determine and define the KPIs for profitability and success, including the lost opportunities. All employees should know these KPIs, which should be posted so that all

employees can see them frequently and constantly. Moreover, each program manager and director need to have a set of KPIs to be measured, which will indicate their performance, progress, areas for improvement, and evaluation towards the execution of the overall Organizational differentiation by quality strategy.

Curricula Development: The second and most important action to increase sales and differentiation by quality is to prepare a pipeline of events and develop curricula. Based on the literature review I presented in this study, and my personal experience and ideas, the following are topics that leaders of the Organization can develop as differentiation from other competitors. In developing high-quality curricula based on the below topics, the Organization will need to develop:

- A strong differentiation by quality while maintaining high-quality content, retaining a pool of highly qualified faculty, delivering the activities using technology and available resources, and maintaining a higher level of customer service and customer experience.
- A differentiation through diversity, equity, and inclusion: the activities that will be developed will cover all healthcare education disciplines at all levels. Moreover, the Organization can educate the community in healthcare education and other domains.
- Competitive advantage through the inclusion of diverse programs in one Organization: no other institution will have all these activities and training in one place. This competitive advantage will decrease the buyers' power of bargaining,

minimize the threat of new entrants, and limit the choices in the market, thus, limiting the threat of substitutes of products and services. More importantly, the Organization will become a game changer in the Saudi market.

Some topics that can be developed include the following:

- Awareness of patient safety standards
- Patient safety standards in practice, preventable harm recognition, and reporting
- Measurements in healthcare systems: how to create key performance indicators, benchmarks, quality assurance, quality control, audits on performance and patient outcomes
- Reporting patient events, root cause analysis, risk assessment, and action plans
- Community outreach programs on diseases, first aid, what to expect when hospitalized, how to be prepared for a doctor's visit, and patient and family education on disability or management of patients returning home with a changed condition
- Business acumen for healthcare leaders: Microsoft Office use, preparing a presentation, reports, business plans, basic accounting, feasibility studies, projections, calculations of opportunity lost, justifications for employment or equipment purchasing, strategic planning, reimbursements, DRGs (diagnosis-

related groups), and many other leadership and managerial skills needed for healthcare leaders

- Soft skills: critical thinking, communication skills, effective communication, crucial conversations, disciplinary actions and how to address these disciplinary actions with the employees, how to document disciplinary actions, promoting team collaboration, interdisciplinary training and application, multidisciplinary meetings, family conferences
- Academic writing skills: APA, articles, research papers
- Business writing and preparedness: CV writing workshop, bibliography, cover letters, business proposals.
- Value-based Agenda in healthcare education
- Sustainability in healthcare
- Wellbeing: self-care, work-life balance, managing burnout, and mindfulness
- Healthcare leaders: how to evaluate sick time versus overtime and include them in the justification of new FTEs
- Team diversity management, team collaboration and teamwork, integrated practice units
- Evaluation of clinical errors factoring the burnout of the staff
- Talent acquisition, onboarding, and practical, fast productivity
- Succession planning, continuing training, recruitment pipelines, developing, mentoring, and coaching

- Training programs for undergraduates to prepare them in interprofessional skills before they move to senior levels in the workplace
- Identify the needs for clinical leaders and develop accredited educational programs for allied health and physicians, to incorporate the advanced practitioner roles, and train healthcare providers, from the undergraduate levels, on the career paths in healthcare, combining clinical practices and leadership roles
- Train healthcare professionals at all levels on how to use EBP, look for current peer-reviewed articles, critically read these articles, and provide access to research databases
- C-level training on the leadership triad and distributive leadership in healthcare

Recommendations for Operations

Operations cannot be addressed in one paragraph, they are related to multiple areas outside of the scope of this study. To mean the purpose of this study, I will address only one recommendation in operations related to strategic alliances.

The Organization under study already has partnerships with governmental and private organizations. As discussed in the findings, the work was done toward creating leads and Memorandums of Understanding (MOU). However, these partnerships' activation, gain, and sustainability are always problematic. The primary cause for this problem is the absence of a full-time chief academic officer with the appropriate

healthcare and business acumen who will take over the implementation, execution, auditing, and improvement of these partnerships. The second reason is the number of partnerships that did not add value to the Organization.

Strategic alliances go beyond having memorandums with other entities to provide healthcare education. Strategic alliances can be powerful and change the balance in the market. The following are examples of strong strategic alliances that will secure the differentiation and competitive advantage of the Organization:

- Become the first healthcare education organization to conduct research, shifting its image from a business and money-making entity to an academic entity interested in the field's scientific and academic contributions. The alliance in this situation is with the researchers who will conduct in-house research and with the journals publishing the Organization's research.
- Initiate strategic alliances with multiple university hospitals to monitor the performance of the healthcare providers before and after receiving specific training. These alliances will increase research opportunities. Moreover, they will show the investment of the Organization in improving population health and ensuring that the optimal outcome is improved patient care and quality of care.
- Strategic alliances through activating existing branches, expanding with new branches, and creating alliances through franchises. This type of alliance is related to market selection. There are currently two branches of the Organization, the headquarters in Riyadh and another in Jeddah. The market in the capital is

saturated; the majority of the competitors are located there. The Organization already has two advantages; having a branch in Jeddah and having 45 trauma education centers nationwide reporting to it. The first recommendation is to have weekly staff meetings to share the HQ's activities in Jeddah and disseminate them to the area. The second recommendation is to activate the second branch by involving the academic affairs and business development in person in that region to conduct the needs assessment and identify business opportunities. The franchise model is started in trauma education centers reporting to the headquarters. This model has been successful for over a decade, and the reason for the success is the leadership, the set processes, and the continuous quality control. The third recommendation is based on the trauma education program franchise; it is advised to prepare a clear franchise policy and procedure and provide the franchisee with a manual to set the guidelines and maintain the standards of the Organization. Moreover, the academic affairs have to conduct periodic quality control on the franchisee as part of a KPI of quality assurance.

- Strategic alliances go beyond having partnerships with entities that support the vision of the Organization. The added value to Organization may be secured by its competitors. This is called venture in a coalition, aiming to partner to serve the same market share covering a broader spectrum of demand. Instead of investing 100% to create something successfully used by the competitors, leaders of both organizations need to assess where their scopes meet and where they have

strengths and build a synergic model to increase sales and market share for both parties involved. This model is called innovative competition. Such an alliance will position the Organization very high in the market and make it very high for new entrants.

- Strategic alliances can also be the integration of complementary products and services provided by other companies. For example complimentary package with a bookstore, or percentage discount for health insurance, or transportation fees discounts in taxis to the Organization based on an agreement with a company, if the client purchased the members

Recommendations for Services

Leaders who develop a differentiation strategy must understand the benefits of product, service, and mixed differentiation for products and services. I discussed in length the differentiation strategies in the review of the literature in Section 1. Leaders in the Organization under study must understand the elements for differentiation to be able to develop their own. I recommended that the CEO, general manager, and business development manager meet, read this study together, and discuss it with me to set the roadmap and identify the areas to include in the differentiation by quality strategy for the Organization.

Patient activation and community involvement are other key elements for differentiation by quality. I also addressed patient activation and community involvement

in the literature review in Section 1. I recommend that the Organization develop two main programs to activate patients and involve the community:

- Outreach program to train key members of the community who will be the first responders to their area and who will be able to guide patients on the actions to take. This program will also include patient education training and pamphlets.
- Corporate social responsibility programs where the community benefits from the sales of services. For example, advertise a cause that is a concern in the community and mention that the profit from this xx course will go to securing medication to the community Y. Another example is that percentage of the benefit will be invested in providing suburban nurses with nursing shoes or investment towards a global matter.

In regards to customer services, the Organization has to include strategies to improve customers' experience in the Organization and throughout the process of registration till the completion of the event. The main recommendation in this area is to have the business development officer, or any personnel, sit with the attendees during the courses and breaks, listen to their concerns and experience, document the findings and interact with them to show them what other opportunities and events are present in the Organization. During these interactions, staff can collect 3-5 referrals from these members and promise discounts or membership packages if the referred people attend an event in the Organization.

Recommendations for Firm Infrastructure and Human Resources

The first area for improvement in the Organization is the absence of a well-defined Organizational Breakdown Structure (OBS) and a Work Breakdown Structure (WBS). The available OBS is rudimentary and was developed for the governing body accreditation; it is vertical and flat. The dynamic in a healthcare education organization prevents it from being flat. Strong distributive leadership is required with a power triad between the CEO, GM, and CAO. Currently, even if the decision-making process is shared with members, the determination of roles and responsibilities is missing.

The WBS is crucial to show the Organization's communication and decision channels. The recommendation was to develop a WBS that included the OBS—having confidence in distributed leadership and exercising it properly. Leaders must start with the job descriptions (JDs) documentation, where they clarify roles and responsibilities and chains of command. Parts of the WBS will be included in each JD so the employee understands their position in the Organization and the escalation channel they need to follow. Once all JDs are completed, the leaders can complete the WBS with the buy-in and involvement of all parties.

Recommendations for Technology Development

The Organization started a milestone by developing the country's first healthcare education Virtual Reality Module. This invention is exceptionally outstanding and is taking the Organization towards brilliant success. However, leaders must be aware of the risks, balancing the short-term profit with the long-term loss. This innovation is in the

start-up phase, and with the rate of its progress, I found that it will skip the turnaround phase and start with the accelerated growth phase. I urged the leaders to watch out for the inclination to stretch all the employees in this project. This innovation is one project, and it needs to have its team. Everyone was being pulled into this project. The team was enthusiastic and motivated; however, they were stretching their bandwidth very thin and may face hassles in completing other projects. The GM must define the percentage of involvement for each member in the areas where job descriptions intersect, maintaining team collaboration and teamwork, and securing the best environment for the staff to complete their other responsibilities.

The Big Data concept is trending in healthcare (refer to Review of the Literature). The Organization has an opportunity to invest in new technology to benefit from this big data.

Recommendations for Future Studies

My work on this study, the interaction I had with the Organization's team and leaders, and the readings I completed inspired me to suggest some recommendations for future studies that could be conducted in the same Organization or other similar ones:

- Replicate this mixed method formative study in another healthcare education organization regionally or internationally
- Conduct a summative program evaluation to this Organization after the development and implementation of the business development program's differentiation by quality strategy.

- Conduct a correlative study between the specialty of the attendees and their attendance to events.
- Conduct a formative program evaluation on a strategic alliance with the Organization
- Conduct a summative program evaluation on the performance of healthcare providers in their place of work after receiving the training.
- Develop a value-based healthcare agenda for healthcare education organizations.

Communication Plan

The results of this formative program evaluation will be emailed to the CEO. I will schedule a conference call with the CEO first to go over the details of the study, the findings, and the recommendations. I will answer all his questions and discuss with him the appropriate course of action to disseminate the results to his team. I will be available to organize a subsequent conference call with the general manager, the business development and marketing manager, and all mid-level managers, educators, and contracted faculty, to provide a presentation of the results and recommendations with the feedback of the CEO. I will answer questions and address any concerns they may have about the study. In addition, I will ask the team for potential future related research topics that align with this research. Lastly, I will request a permission from the CEO to submit a redacted copy of this study for publication in the ProQuest database and distribute at the relevant national conferences to provide other researchers with the results. If possible, I

will ask for permission to publish a paper about this study in collaboration with the Chair and CEO in renowned journals.

Implications for Positive Social Change

The Organization has an opportunity to increase clients' trust in the services provided and their loyalty and satisfaction with the Organization. Implementing the differentiation by quality strategy that will be completed based on this study will allow the leaders of this Organization to involve and activate the community, tend to the population's health needs, and improve the quality of care of the healthcare providers by improving their knowledge and skills. When the leaders include strategic alliances in their business model, specifically those related to hospitals, to follow up on the performance of the healthcare providers (HCPs), the Organization will have a positive involvement in the healthcare system in the Nation. It will identify best practices that positively affect healthcare management.

Skills and Competencies

Through my formal education, training in a Bachelor's of Science in Nursing from the University of Balamand, Lebanon. My 19 years of work in clinical settings in many senior positions including healthcare management and education, and through my formal education in a Master's Degree in Business administration with emphasis in management, and completing the course requirements for the Doctor of Business Administration with a cumulative 4 GPA, I have obtained the formal training to successfully complete a doctoral study and program evaluation at this level. I have

completed a representation of the literature and exhausted the resources that are related to leadership and management of healthcare education and healthcare education organizations, and I was able to present a comprehensive review on the topics on healthcare education and differentiation in the respective section.

While completing my doctoral study I have worked as a Chief Executive Officer of a management consultancy company, Business and Academic consultant, and Leader of healthcare management and healthcare education projects. Moreover, I have assumed the role of reviewer in a renowned international journals which addresses healthcare education and management for nurses. I have direct experience advising mid-level and senior level managers and executives in healthcare management and healthcare education, and I have been an active member in research studies in healthcare education. My training in the DBA, the years of study, along with my current positions, and the hands-on clinical and leadership experiences in healthcare management and education validate my knowledge to initiate and complete this program evaluation and allows me to pursue my career as a certified Program Evaluator and Business Research Analyst. In addition, my DBA portfolio can be found at https://skillsfirst.com/organizations/walden-university/people/diana-skaff.

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Appendix A: Search Log Template

Database	Search Terms	Results	Notes
Thoreau	Workplace smoking	1175	Search too broad; Narrow by using multiple terms
Thoreau	Smoking cessation programs	130	Much better; Several relevant articles found
Google Scholar	Etc.		

This search log template is retrieved from the Walden University Prospectus template available for use from the Academic Writing Center for the doctoral students.

Appendix B: Literature Review Matrix

Author(s) last name, first initial	Publication date	Title of article or chapter	Book title	Journal title	Database	Library	URL	DOI	Keyword search

Theorists	Method	Design	Population	Sample	Problem	Purpose	Research ?s	Summary (what is it about?)	Analysis (strengths and weaknesses compared to other studies)	Reference list entry (APA 7th ed.)

Appendix C: Interview Protocol

Interview Protocol

Before conducting the interviews, the interview protocol was prepared and is detailed in the table below. It serves as a valuable guide to follow and allows me to practice the interview to fill 45 minutes. I added all the questions prepared in the interview guide. However, the questioning flow depends on who the participant is and their role in the organization. The targeted questions and targeted follow-up questions will be asked according to the flow of the conversation.

What I plan to do	**What I plan to say**
Introduce myself, the reason for the interview, explain the confidentiality of the information, and set the stage.	Good day Mr. /Dr. XYZ. Thank you for agreeing to meet with me. This interview is part of my doctoral study. As you know, the study is being conducted at your organization For this interview, we need 45 mins. The purpose of this interview is to understand your perception of the key success components of the organization's current strategies and identify improvement opportunities for increasing the organization's performance. As a reminder, this interview is confidential; your name, your organization's name, and any other personal identifying information will not be used anywhere in my study, and I will not share the transcripts if the interview with anyone. I will use an identifier L1, L2… when referring to you and the organization being referred to as "The Organization." In addition, please remember that this participation is voluntary, and you may decline to answer or stop the questioning at any time. As discussed and agreed upon, I will be recording the interview for authentic transcription. When I finish transcribing the interview, we will have a follow up meeting where I will share the transcript and address any missing information. Do you have any questions for me before we start?

• Begin interview • Observe non-verbal communication • Paraphrase as needed • Ask follow-up probing questions as per the flow of the interview	**Probing questions** 1. How has your organization's strategy evolve over the past five years? 2. What roles do leaders responsible for the business development program have in developing a differentiation by quality strategy? 3. What have you done so far to develop a differentiation by quality strategy? 4. What barriers do you envision in developing a differentiation by quality strategy? 5. What aspects of the business require a differentiation by quality strategy? 6. Why did you decide to develop a differentiation by quality strategy? 7. What are the major advantages that you have identified existing in your competition that hinder your success and advancement? 8. What strategies have competitors used that create opportunities for you? 9. How could a differentiation by quality strategy increase competitive advantage, profit, and diversification? 10. What does a successful outcome look like? **Targeted Interview and Follow-up Questions** Additional questions may be asked during the interviews depending on the flow of the conversation, the background of the interviewees, their role in the institution, and their levels of influence. **Targeted Wrap-up Questions** 11. What else can you share with me about your organization's strategies for increasing the quality of the services?
Wrap up the interview and thank the participant.	That was the last question. Thank you once again for your participation and your time. Do you have any more information you want to add or any questions for me? I will email you the summary of the answers to the questions before we schedule our 15-min follow up interview.

Appendix D: Focus Group Protocol

If I am able to have the focus group in person, I will prepare the round in a semi-circle shape and have treats in the rooms. If I have to do it in video conference, I will first get the consent of the participants and then I will make sure we have all cameras on and have their active participation during the discussion, and that everyone takes their turn.

I. Introduce self to the participant
II. Welcome the participants and thank them for their participation
III. Distribute the focus groups consent forms and read it together with them while explaining the details
IV. Answer participants' questions and concerns
V. Collect the consent forms
VI. Give the participants a copy of the consent forms
VII. Start the recording of the discussion
VIII. Begin with the first question through the last and modify on the go based on the discussions and ideas
IX. Document notes on a white board
X. Open the room for additional comments, ideas, or questions
XI. End the sequence on the timer set
XII. Thank the participants and inform them that the summary of the discussion will be shared with them for their verification
XIII. End protocol