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Quality Improvement Methods in Health Care for Reducing Patient Wait Times

Karen Denise Brown
Walden University

Walden University

College of Management and Human Potential

This is to certify that the doctoral study by

Karen D. Brown

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Warren Lesser, Committee Chairperson, Doctor of Business Administration Faculty

Dr. Deborah Nattress, Committee Member, Doctor of Business Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

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Abstract

Private sector health care managers who ignore the importance of quality improvement methods may fail to reduce patient wait times and decrease patient satisfaction. Grounded in the conceptual framework of kaizen methodology for quality improvement, the purpose of this qualitative single case study was to explore strategies health care managers use to improve patient wait times and resultant patient experiences. The participants were five health care leaders from one private health care facility who successfully implemented quality improvement strategies in an eastern U.S. state. Data were collected using semistructured interviews and a review of organization patient surveys. Through thematic analysis, three themes were identified: (a) use of patient satisfaction surveys, (b) continual communication between staff and patients, and (c) increase the number of staff members. A key recommendation is for private practice health care leaders to hold weekly meetings among the health care staff to discuss the patient survey responses. The implication for positive social change includes the potential for improved patient wait times and health outcomes.

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Dedication

This dissertation is dedicated to my mother, father, and daughter. My mother and father passed on knowing that their little girl would one day be a doctor. Mommy and Daddy, your little girl kept the faith, remained determined, and completed the task. Thank you both for your love, support, and continued prayers.

To my daughter, Zoe. You are my reason for everything. I hope I have inspired you to never give up, to dream big, and to always be true to yourself. I love you.

Acknowledgments

I would like to acknowledge my committee members Dr. Warren Lesser and Dr. Deborah Nattress. Your support, guidance, and understanding helped me to stay focused and realize I could accomplish my doctoral goal. I wish you both continued success. Thank you.

Table of Contents

List of Tables

List of Figures

Section 1: Foundation of the Study

The importance of quality improvement methods in health care has gained attention by health care providers, especially regarding patient wait times. The increase in patient wait times contributes to overcrowding and inadequate health care (Alowad et al., 2021). The focus on quality improvement methods by health care providers may result in better experiences for patients.

Background of the Problem

The failure of those who manage the United States health care systems to provide consistent positive patient outcomes has prompted quality improvement efforts that are proactive, patient-focused, and data driven within the health care system (Reiter et al., 2014). On average, poor quality can cost a health care system between $500,000 and $850,000 annually, making the case for the need to develop and implement performance standards (Kennedy et al., 2019). The economy devoted to health care as measured by gross domestic product was 17.9% in 2016–2017 and 17.7% in 2018 (Hartman et al., 2020). Given the health care costs, health care leaders are faced with ongoing challenges to produce more effective outcomes (Venkataraman, 2015). Patient experience is the most influential factor in health care among patients and health care leaders (Venkataraman, 2015). Improved experiences result in better outcomes for patients (Hwang et al., 2014).

Health care quality improvement is a primary objective for all health systems (Zaadoud et al., 2020). But to help improve health care quality through effective implementation methods, there must be communication among health care leaders and a

shared understanding of the need for quality improvement measures in health care (Hwang et al., 2014). Most of the problems linking the effect of quality improvement methods (QIM) to patient outcomes result from the many components and complexity of a quality improvement system (Groen et al., 2018). Quality improvement projects within health care can be broken down into steps: (a) defining the problem, (b) measuring the problem, (c) analyzing the problem, (d) improving the problem, and (e) controlling the problem (Harris, 2018). The key to fixing the problem is knowing where to start or how to identify and define potential problems. Additionally, some information does not accurately reflect the patient's health status or accurately reflect the treatments or care that was rendered (Brandrud et al., 2017).

Problem and Purpose

In 2018, U.S. officials spent nearly 18% of the nation's gross domestic product or $3.6 trillion on health care (Crowley et al., 2020). The mean wait time for health care visits is 24.1 minutes, with less than 20,000 annual visits and 48.7 minutes with 50,000 or more annual visits (National Center for Health Statistics, 2019). Waiting 45 minutes or greater results in patient dissatisfaction (Nottingham et al., 2018). The general business problem was that some health care managers do not have effective strategies for implementing process improvements. The specific business problem was that some health care operations managers in physicians' offices lack strategies to improve patient wait times and resultant patient experiences, which can improve repeat business. The purpose of this qualitative single case study was to explore strategies that health care managers in physicians' offices use to improve patient wait times and resultant patient

experiences, which can improve repeat business.

Population and Sampling

The target population included five health care leaders from one health care organization who have successfully implemented quality improvement strategies to reduce patients' wait times and increase patient satisfaction in an eastern U.S state. The implications for positive social change include the potential of improved patient wait time. By improving the quality of patient care, health care leaders can implement quality improvement changes that may enhance the quality of life for patients and families. Improving health care experiences, self-efficacy, self-worth, and dignity through an attitude of respect, acknowledgment, and generosity for citizens can be enhanced by embracing the holistic approach to citizens' care (Salemonsen et al., 2020).

Nature of the Study

Researchers use three methods: qualitative, quantitative, and mixed (Saunders et al., 2017). Qualitative researchers use open-ended questions to encourage interviewees to provide extensive and thorough answers and to reveal experiences related to the problem (Saunders et al., 2017). Quantitative researchers use closed-ended questions to gather statistical information or test hypotheses about variables' characteristics or relationships (Saunders et al., 2017). I did not test the hypotheses for examining variables' characteristics or relationships, so the quantitative method was not appropriate for my study. Mixed-method research includes both the qualitative element and quantitative element (Saunders et al., 2017). I did not be use statistical methods to examine the quality improvement strategies used by operations managers, which was the quantitative aspect

of mixed methods research. I selected the qualitative method as an appropriate choice for my study.

I considered four research designs for my qualitative study: ethnography, narrative inquiry, phenomenology, and case study. Ethnographic researchers study the culture or social phenomena of a group to explore the complexity of everyday life and the wider political, cultural, social, spatial, and temporal dimensions shaping social enterprise (Mauksch et al., 2017). Ethnography design was not the optimal choice because I did not seek to study the culture or social world of a group. Researchers use narrative inquiry to collect data to analyze participants' experiences through their personal stories (Anna-Maija et al., 2018). Narrative inquiry design was not the best choice because I did not seek to explore or analyze personal life stories of participants. The primary objective of a phenomenological study is to explicate the meaning, structure, and essence of participants' lived experiences, beliefs, or attitudes around a specific phenomenon (Heinonen, 2015). A phenomenological design was not the best choice because I did not study the participants' beliefs or attitudes about experiencing an event but rather the quality improvement strategies used to improve patient wait times experiences.

The case study design is used to conduct an in-depth exploration of intricate phenomena within a specific context (Rashid et al., 2019). A multiple case study design is used for a broad review to determine whether findings can be replicated across multiple cases and if similarities and differences exist from each one (Saunders et al., 2017). A single case study is used by researchers to explore a phenomenon in one organization to garner a more comprehensive understanding (Anderson et al., 2018). The single case

study design was the best choice because I used one case to garner a more comprehensive understanding of quality improvement methods used in health care.

Research Question

What strategies do health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?

Interview Questions

1. What strategies do you use to improve patient wait times and patient experiences?
2. What key challenges did you experience in implementing improvement strategies for patient wait time and patient experiences?
3. How did your organization address the key challenges to implementing improvement strategies to improve patient wait time and patient experiences?
4. What principal changes were made within the organization to help sustain improvement strategies?
5. How have you evaluated the effectiveness of the improvement strategies used to improve patient wait times and patient experiences?
6. How will the ongoing monitoring of quality assurance of patient wait time and patient flow occur in the office?
7. What additional information would you like to share related to the improvement strategies used to improve patient wait times and patient experiences?

Conceptual Framework

The theory of kaizen methodology was the conceptual framework of this study. Kaizen methodology is a system for communicating ideas throughout the company hierarchy, encouraging everyone to seek and exploit new opportunities, and dismantling barriers to information flow (Rosak-Szyrocka, 2019). The quality within the framework of an organization's existing processes is that one key element of kaizen methodology enhances the existing processes to achieve incremental improvement (Rosak-Szyrocka, 2019). Leaders can use the kaizen approach as an effective and reliable system that tracks all types of inefficiencies within an organization (Al-Hyani et al., 2019). The use of kaizen methodology is known for challenging and empowering those involved to use their creative ideas to improve their daily work by placing an emphasis on the process rather than the outcome (Rosak-Szyrocka, 2019). Managers use kaizen to help with the continuous improvement in personal, family, social, and work life (Alvarado-Ramirez et al., 2017). Additionally, kaizen success in health care environments occurred because measures addressed and changed management behavior.

Behavior change is required for long-term cultural transformation toward a continuous improvement mindset. Because kaizen is considered continuous improvement processes, the efforts of all people involved in the organization are necessary to attain improvements that contribute to superior results of achievement over time (Alvarado-Ramirez et al., 2017). Nevertheless, managers play a large part in the maintenance and improvement of working standards which should be understood throughout the organization (Alvarado-Ramirez et al., 2017). I therefore expected health care managers

who used kaizen methodology as a conceptual framework for understanding quality improvement strategies to improve patient wait times and resultant patient experiences as well as repeat business.

Operational Definitions

The following operational definitions provide an understanding of terms used for the study.

Kaizen methodology: Continuous improvement that brings a group of people together in a structured way to solve a well-defined problem (Murrell, 2021).

Malcolm Baldrige national performance excellence award model (MBNQA): An award established by the U.S. Congress to raise awareness of quality management. U.S. Congress members use MBNQA to recognize U.S. companies that implemented successful quality management systems (ASQ, n.d.).

Patient flow: The identification of patients in need of care and directing each patient through a streamlined, reliable process (Kreindler et al., 2021).

Quality improvement methods: A systematic approach used by individuals who seek to improve the safety, effectiveness, and experiences of a business. Changes are tested in small cycles that involve planning, doing, studying, and acting (Jones et al., 2019).

Theory of constraints: An organizational change method where profit improvement in an organization should have at least one constraint or factor that limits the organization from reaching set goals (Rattner, 2006).

Assumptions, Limitations, and Delimitations

Assumptions

An assumption occurs when someone takes an action for granted (McDonald, 2017). The assumptions of my case study included that participants were honest and thorough in their responses. Participants allowed sufficient time to provide detailed answers. Sufficient secondary data were available to support the interview data. Participants were willing to share documents that support their statements.

Limitations

Major limitations of qualitative research are time consumption, nongeneralizability, and ethical liabilities (Weil, 2017). The results of this study were limited by the honesty and thoroughness of participants' responses. Additionally, data were limited by secondary documentation availability and the ability to recruit sufficient number of participants to allow for data saturation.

Delimitations

Delimitations indicate boundaries that represent the scope of the research (Alpi & Evans, 2019). The first delimitation of the study was that participants are health care leaders such as operations managers (excluding pharmacists, dentists, and personal caregivers). The second delimitation of the study was the number of health care leaders. Only health care leaders will be asked to participate in this study. The study also included delimitations of the type of health care facilities used for the study and the limited geographic area. The facilities consisted of clinics, private practices, and hospitals, only (excluded facilities such as nursing homes, urgent care centers, and mental health

centers). The fourth delimitation was the geographic focus, which was an eastern U.S. state.

Significance of the Study

Contribution to Business Practice

The results of this study add value to the practice of business by helping health care leaders improve the patient experience and reduce patient wait times which can improve patient satisfaction. Health care leaders can improve patient experiences and satisfaction by using improvement strategies (Jensen et al., 2016). The results of this study can benefit health care providers by providing information on successful improvement strategies to reduce patient wait times. Patient satisfaction is improved with the use of key quality improvement processes, which results in the reduction in providers' costs and increased patient quality.

Implications for Social Change

This study can effect social change by helping to reduce patient wait times, enabling positive social benefits such as patients' quality of life affecting both patients and patients' families. Disconnected health care leaders who do not address quality of care deficiencies may negatively impact overall organizational performance and may adversely affect patient outcomes (Vaughn et al., 2019). By developing and implementing strategies for improving the quality of patient care, health care leaders can implement effective quality improvement changes for enhancing the quality of patients' and families' lives.

A Review of the Professional and Academic Literature

The objective of this qualitative single case study was to explore strategies that health care managers in physicians' offices use to improve patient wait ties and resultant patient experiences that can improve repeat business. Improving health care quality poses one of the most significant challenges of modern health care leadership (Brandrud et al., 2017). The review of literature includes peer-reviewed articles. The review of literature included relevant theories, patient experiences, patient satisfaction, and patient wait times. The key terms used for researching the qualitative study included *kaizen methodology*, *theory of constraints*, *Malcolm Baldrige national quality award model*, *quality improvement methods, patient satisfaction*, *patient experiences*, and *patient wait times*. The databases used to find information for the qualitative study included Walden University Library, Google Scholar, ProQuest, ABI/INFORM Collection, Emerald Insight. In compliance with Walden University doctoral study requirements, of the 178 references, 157 references 88.2% were published between 2017 and 2022, no more than 5 years before expected graduation (see Table 1).

Table 1

Literature Review Source Content

Literature Review Content	Total #	# Within 5-yr range (2017-2022)	% Total Peer-reviewed within 5-yr range (2017-2022)
Books	5	3	60.0%
Peer-reviewed articles	155	147	94.8%
Online resources	10	7	70.0%
Total	170	157	92.3%

Theory of Kaizen Methodology

The conceptual framework for this case study was the theory of kaizen methodology. Kaizen methodology is considered complex, interrelated, and context-dependent (Marin-Garcia et al., 2018). Historically, leaders in manufacturing fields applied kaizen methodology, but kaizen methodology can be applied to service businesses (Debnath, 2019). Kaizen is a management philosophy that helps leaders generate changes or minor incremental improvements in the working method or work process, making it possible to reduce waste and improve work performance within the organization (Marin-Garcia et al., 2018). Individuals who use kaizen methodology consider the methodology as the essence of continuous improvement (Chiarini et al., 2018; Wittenberg, 1994). Users of kaizen methodology also consider the methodology as a philosophy, mindset, and breakthrough performance, a critical aspect of achieving imperatives and executing value process improvement plans (Chung, 2018). Managers who use kaizen develop a series of governing principles to guide employee behavior in applying techniques and tools to improve daily workflow and productivity (Marin-Garcia et al., 2018).

Imai developed kaizen as a concept used in business management and everyday life as continuous improvement involving everyone, managers, and workers alike (Carnerud et al., 2018). Kaizen is a strategy that includes concepts of lean thinking and a systematic approach to help reduce human activity that absorbs resources but does not create or add value to the organization (Berhe, 2022). Kaizen is also referred to as lean thinking and a systematic approach to help organizations systematically reduce waste,

where waste is any human activity that absorbs resources that creates or adds no value to the process (Berhe, 2022). Imai proposed kaizen as the nucleus of competitive success for businesses regarding quality initiatives with quality control and quality management (Carnerud et al., 2018).

Kaizen methodology is a structured project performed by a multi-disciplinary team to improve a targeted work area or process within a given timeframe (Bortolotti et al., 2018). However, to achieve improvement, different initiatives and methodologies are available under the kaizen umbrella. The different kaizen initiatives and methodologies are (a) customer orientation, (b) total quality control, (c) robotics, (d) quality control circles, (e) suggestion system, (f) automation, (g) discipline in the workplace, (h) total productive maintenance, (i) quality improvement, (j) zero defects, (k) small-group activities, (l) cooperative labor-management relations, (m) productivity improvement, and (n) new-product development (Gonzalez-Aleu et al., 2018). Further, kaizen quality improvement movement has helped develop a specific set of tools and techniques in the continued pursuit of business excellence: cutting, time reduction, and continuous improvement (MacPherson et al., 2018). Kaizen and continuous improvement strategy contributes to effectiveness with the five elements of teamwork, personal discipline, improved morale, quality circles, and suggestions for improvement (Paraschivescu & Cotirlet, 2015). Other kaizen goals are to build employee ownership and establish a culture that encourages improvement with zero errors during the process of improvement (Paraschivescu & Cotirlet, 2015). Kaizen methodology is better suited for a slowly growing economy, whereas innovation is better suited to a fast-growing economy

(Wittenberg, 1994).

Health care practitioners have used QIM to improve patient care. Managers who implement kaizen methods develop stronger teams of people, who demonstrate cohesiveness when confronted with adverse environmental or psychological phenomena (Stelson et al., 2017). Kaizen methodology is a system for communicating ideas throughout the company hierarchy, encouraging individuals within the company to seek new opportunities, and dismantling barriers to information flow (Rosak-Szyrocka, 2019). Health care managers can use kaizen in health care to help with the continuous improvement in personal, family, social, and work-life (Alvarado-Ramirez et al., 2017).

Despite the successes, leaders who use kaizen methodology should be aware of the barriers that may occur within the organization after the application of the methodology. Leaders who use kaizen methodology have identified the five barriers as a lack of involvement from all staff, restriction of resources, lack of formal commitment and support of top management, lack of understanding, and resistance to change (Berhe, 2022). In addition to the identified five barriers, Berhe (2022) also summarized barriers to kaizen philosophy implementation in three groups:

- Managerial barriers: lack of lean culture, awareness, top management attitude, shop-floor employee attitude, poor employee management, unavailable automated systems, and lack of training and communication;
- Operational barriers: unstable customer handling, poor inventory control, longer lead times, operational invisibility, lack of understanding of critical concepts, lack of skilled labor and resistance to change; and

- Financial barriers: resource constraints, implementation cost, and lack of finances (Berhe, 2022).

Because the primary objective of kaizen is to continuously improve the production process by eliminating the non-value-adding factors from the production methods (Debnath, 2019), leaders within the organization need to consider areas of concern when implementing kaizen methodology with the known barriers.

Alternative Theories

Other theories considered for the study related to continuous improvement specific to health care organizations were the theory of constraints and the Malcolm Baldrige national quality award model. The central idea of the theory of constraints is that every system has a minimal number of factors or constraints that limit the system's progress toward a goal (Cox & Boyd, 2020). The idea of the Malcolm Baldrige national quality award model is to help improve the overall performance of an organization and to address and enhance the competitiveness of U.S. businesses (Tettey et al., 2019). Similar to the theory of kaizen methodology, individuals who use the theory of constraints and the Malcolm Baldrige national quality award model focus on quality improvement measures within organizations with incremental change to help improve techniques and process (Kumar, 2019). However, individuals who use the theory of constraints involve certain factors that limit the overall process, and the users of Malcolm Baldrige national quality award model focuse on the business's competitive advantage using continuous improvement.

Theory of Constraints

Developed in 1984 by Goldratt, the theory of constraints (TOC) was developed as a process of ongoing improvement that continuously identifies and leverages a system's constraints to achieve the system's goals. Goldratt and Cox further emphasized the importance of TOC while working on software-based optimization of production systems and TOC use in various organizations (McCleskey, 2020). Goldratt and Cox envisioned TOC as a framework that leaders could use to solve complex problems (Kadhim et al., 2020). The TOC provides approaches to operation decisions that avoid pitfalls of local optimization by reaching across functional boundaries in operations (M. Gupta & Boyd, 2008). The TOC is applied to production planning, production control, project management, supply chain management, accounting, and performance measures, and other areas of business such as not-for-profit facilities like hospitals and military depots (Bauer et al., 2019; Blackstone, 2010).

The TOC is a management methodology based on systems thinking where the main idea of TOC consists of every system having at least one constraint that limits performance, and that constraint then becomes the focal point for improvement (Bahall, 2018; Orue et al., 2021; Upreti et al., 2020). Individuals who use TOC aim to solve unstructured or ill-defined problems and identify cause-and-effect relationships that may generate constraints (Bauer et al., 2019). Individuals who use TOC implement five steps: (a) identify the constraints of the system, (b) decide how to exploit the constraints, (c) subordinate items to the exploitation of the constraints, (d) elevate the constraint in the system, and (e) return to the first step to continue to improve the system (McCleskey,

2020). Individuals who use TOC attempt to determine how leaders make decisions and how to deal with the constraints for the production process (Kadhim et al., 2020). Leaders who use TOC seek to solve potential issues with the production process while ensuring continuous improvement (Kadhim et al., 2020; Pacheco et al., 2019).

In health care, the TOC helps to identify bottlenecks, reduce wastes, decrease lead times, and balance the flow of patients (Bauer et al., 2019). The use of TOC by health care leaders may reduce adverse situations that may impact the patients. The use of TOC may improve decision-making in conflicting situations like matters found in health care service systems (Bauer et al., 2019). Managers and practitioners of health care systems can easily employ and explore the set of TOC tools to manage conflict situations, uncover main problems within their organization to encounter main issues, and quickly propose suitable solutions (Bauer et al., 2019). The TOC presents a new paradigm in operations management that replaces the primary concern of efficiency with the organization's goal as a significant concern for operations management (Al-Fasfus et al., 2020). The TOC use by health care leaders may provide health leaders the option to improve the organization's overall operations.

Even with identified benefits of productivity increases, maintaining continuous improvement of system performance, an increase of flow rates, reduction of the accumulation of inventory between activities, and optimal use of resources that lead to improving the profits and sales within the organization (Kadhim et al., 2020), limitations of the TOC use exist. The TOC focuses steps, tools, and limitations exist where the constraints are subjective and qualitative (Upreti et al., 2020). But the steps are not

suitable in the service context, which comprises interaction among people, customers, and processes at the high content end, whereas the low contact end includes quasi-manufacturing (Upreti et al., 2020). The existing TOC process also lacks three factors: not having any mathematical approach to help identify high-level constraints, the thinking process misses the softer issues like empathy and critical observation, and there are limited scopes to involve employees and people in decision making (Banerjee & Mukhopadhyay, 2016).

TOC is different from kaizen methodology because TOC is an administrative approach used for identifying the limiting factor or constraint that stands in the way of achieving a goal (Banerjee & Mukhopadhyay, 2016). Despite this difference, leaders who use either methodology seek continuous improvement. However, the leaders who use kaizen identify critical success factors of initiating and evaluating changes and employees' ideas, management and employee support, building an adequate evaluation system, developing an internal communication system, and strategic orientation of employees to change (Vesna et al., 2020). In comparison, leaders who use the Malcolm national quality award model seek additional insight in providing continuous improvement.

Malcolm Baldrige National Quality Award Model

The Malcolm Baldrige national quality award (MBNQA) is named after the late Secretary of Commerce Malcolm Baldrige, a proponent of quality management (ASQ, n.d.). Since its inception in 1988, MBNQA has provided a basis for organizational performance excellence (Mai et al., 2018). Individuals who use MBNQA aim to practice

effective quality control of goods and services within American businesses and other organizations (Cook & Zhang, 2019). The MBNQA model is a service excellence standard developed by the National Institute of Standards and Technology (NIST) measured along the lines of leadership, strategic planning, customer and market focus, informational analysis, human resources, process management such as those in education, and health care institutions (S. Fatima & Mahaboob, 2018). Parast and Golmohammadi (2019) also found that when leaders use the MBNQA model, information analysis and knowledge management significantly impact quality results, customer focus, customer satisfaction, quality results, and customer satisfaction for health care organizations. For successful MBNQA implementation, leaders must shape corporate culture by using effective communication to upgrade specific performance standards (Roberts et al., 2020). Leaders can improve the effectiveness of their operational processes by consistently adhering to MBNQA standards.

The MBNQA methodology focuses on improving the entire organization and instituting and nourishing a culture focused on quality improvement (O'Donnell & Gupta, 2021). The performance criteria of MBNQA are a set of quality standards defining how an organization can establish an excellent quality management system (Aydin & Kahraman, 2019). Leaders in manufacturing, service, and small businesses apply MBNQA criteria for performance excellence (Aydin & Kahraman, 2019). The management principles necessary for effective performance consist of seven criteria of the MBNQA framework (Cook & Zhang, 2019). The criteria and requirements of each criterion are

- Criterion 1: leadership. How does upper management lead the organization, and how the organization leads within the community?
- Criterion 2: strategic planning. How does organization leaders establish and plan to carry out strategic directions?
- Criterion 3: customer focus. How does organization leaders build and maintain strong, lasting relationships with customers?
- Criterion 4: measurement, analysis, and knowledge management. How does organization leaders use data to support key processes and manage performance?
- Criterion 5: workforce focus. How does the organization leaders empower and involve its workforce?
- Criterion 6: process management. How does the organization leaders design, manage, and improve key processes?
- Criterion 7: results. How does organization leaders perform in terms of customer satisfaction, finances, human resources, supplier and partner performance, operations, governance, social responsibility, and how does the organization leaders think their organization compare to its competitors (Aydin & Kahraman, 2019)?

The usefulness of MBNQA has become apparent to qualified experts and other parties interested in the growth of American businesses (Tettey et al., 2019). For example, S. Fatima and Mahaboob (2018) stated health care providers who want to overcome issues with quality measures, the health care provider uses the MBNQA model.

However, with the usefulness of MBNQA among quality experts and other parties, a decline in small business applications have begun with a noted decline in performance relative to the Baldrige criteria within the for-profit sectors, suggesting a lack of sustained improvement or attention to the criteria changes (Cook & Zhang, 2019). Leaders in education and healthcare appear to be making progress in their efforts relative to the Baldrige criteria (Cook & Zhang, 2019). Organizational leaders should acknowledge the decline of MBNQA framework usefulness before implementation.

The reason for the decline of MBNQA use is unidentified, but two plausible explanations exist. Cook and Zhang (2019) stated that the first explanation for the decline is that management and MBNQA have become decreasingly relevant or attractive to organizations in the USA. The second explanation of the fall is rooted in the marketing choice and involves what is known as the substitution effect, whereas other programs for or approaches to quality management have become more desirable when compared to MBNQA (Cook & Zhang, 2019). Similar to kaizen methodology, users of MBNQA seek overall quality improvement in the organization. However, those who use MBNQA strive to achieve performance excellence within the organization (Aydin & Kahraman, 2019). Recognizing how patient experiences and patient satisfaction affect patient wait times, health care operations managers in physicians' offices should acknowledge the necessity of formulating effective, operational strategies to reduce patient wait times with employee involvement. Leaders who choose to use kaizen over the MBNQA model tend to seek employee empowerment, employee development, and improvement of company performance (Vesna et al., 2020). Leaders who embrace kaizen recognize the importance

of improvement, specifically in health care, also acknowledge the need for improvements in the quality of patient care.

Quality of Patient Health Care

Standards of care are vital to the quality of care for patients (Corkin & Kenny, 2017). Corkin and Kenny (2017) stated that quality care has different meanings to different health professionals and other professional groups. D. Johnson et al. (2016) found that health care service quality occurs in three categories administrative, interpersonal, and technical (D. Johnson et al., 2016). O'Hara et al. (2018) argued patients play active roles in ensuring their health care is safe and appropriate. Considering the intricate parts of health care organizations, health care leaders may need to implement a systematic review.

Fischer et al. (2021) stated that safety and quality improvement is about change, in either behavior, process, or both; therefore, accounting for the attributes of how human experiences, accept or resist change is crucial to individual engagement in the change. Additionally, Fischer et al. (2021) emphasized positive leadership improves engagement and quality care. Souza et al. (2021) emphasized health care organizations face challenges to find appropriate management solutions that improve efficiency, productivity, and quality performance; specifically, hospital costs, worker satisfaction, and patient satisfaction. Souza et al. (2021) further stated health care systems are composed of a network of service providers, interconnected between the public and private environments. The management and decision-making precision by health care leaders is essential, so quality of care for patients is not adversely impacted (Souza et al.,

2021). Hibbert et al. (2021) added a key characteristic of health care organizations that deliver high quality and cost performance in a suitable manner is a systematic approach to capacity and capability in building quality improvement. Furthermore, the need to address patient satisfaction can result from increased patient awareness regarding the quality of their care.

Patient Satisfaction

Satisfied patients may ultimately end up with better outcomes; thus, health care providers must have a comprehensive understanding of patient satisfaction. Patient satisfaction is a criterion used for the quality assessment and improvement in health care (Abdulsalam & Khan, 2020). In the health care setting, patients are the essential capital of the hospital. Patient satisfaction is an outcome measure of a patient's experiences of care and health outcomes and confidence in the health care system, reflecting whether the care provided has met the needs and expectations of the patient (Larson et al., 2019). Patient satisfaction is the focal point in the organizing, execution, appraisal of service quality, and quality of health care (T. Fatima et al., 2018). Patient satisfaction is a preferred outcome in health care, as it is directly related to health care faculties' success (Addo et al., 2020). Addo et al. (2020) emphasized that the re-use of health care facilities depends on patient satisfaction since greater satisfaction results in higher patient retention. The importance of patient satisfaction not only impacts the rate of patient consistency with health care providers, but patient satisfaction also upgrades the image of the health care facility, ultimately converting patient satisfaction into expanded services (T. Fatima et al., 2018). Developing health care services prompts the need to emphasize

the importance of patient satisfaction.

After a patient receives a medical service, health care leaders evaluate patient satisfaction (Ling & Chao, 2019). Patient satisfaction is defined as the difference between a patient's expectation before receiving medical care and the patient's perception after receiving medical care (Ling & Chao, 2019). Ling and Chao (2019) stated that patient satisfaction is the evaluation of service quality based on the structure, procedure, and results of the medical service received. Loyalty towards services rendered by the health care provider occurs through adequate patient satisfaction (Worlu et al., 2019). Worlu et al. (2019) further stated that patient satisfaction is the foundation of patient loyalty. If the patient has a higher perception of care received, the patient's satisfaction level will be higher (Ling & Chao, 2019). Therefore, health care leaders need to acknowledge high patient expectations since high patient expectations can improve repeat business.

Ferrand et al. (2016) found that health care providers should manage the health and well-being of their patients in a manner that enhances patient satisfaction. Ferrand et al. (2016) identified two reasons why physicians should focus on enhanced patient satisfaction. First, research reveals a link between patient satisfaction and patient health as patient satisfaction can directly and positively affect a patient's health by increasing the likelihood of the patient complying with discharge instructions (Ferrand et al., 2016). Secondly, physicians should focus on enhanced patient satisfaction because patient satisfaction affects health care providers financially through referrals and reimbursements (Ferrand et al., 2016). Patient satisfaction is directly linked to the degree of completion of the patient's expectation and consists of communally a cognitive evaluation and

emotional reaction to the components of care delivery and services (Abdulsalam & Khan, 2020). Patient referrals are an essential source of business for many health care providers; through numerous government and consumer websites, potential patients now have easy access to comments and evaluations from current or past patients (Ferrand et al., 2016). In addition, the patient who is intuitive about their health care not only seeks patient satisfaction but is an engaged patient who is knowledgeable about their health care.

Patient Engagement

Patient engagement involves patients becoming more knowledgeable and engaged about their quality of care. Clavel et al. (2019) stated that health care organization leaders engage patients as a quality improvement strategy. Health care managers who partner with their patients regarding quality improvement are involved in (a) designing the patient partnership approach so that the partnership makes sense throughout the organization, (b) structuring patient partnership to support its sustainability, (c) managing patient advisor integration in quality improvement to avoid minimal involvement, and (d) evaluating patient advisor integration to support continuous improvement (Clavel et al., 2019). Individuals working in health care systems face challenges in delivering high-quality, effective, and safe care at affordable costs (Saillour-Glenisson et al., 2017). Cheng et al. (2015) identified health care leaders as having one of society's most critical roles and noted that health care requires significant investments and constant improvements. Cheng et al. (2015) also emphasized that current health care systems need fundamental changes for safety and quality problems, specifically concerning the need to improve the quality of health care services, patient safety, and patient satisfaction.

Sharma et al. (2017) defined patient engagement as an active partnership among patients, families, and caregivers to improve health care delivery. Sharma et al. (2018) further stated that patient engagement is the involvement of patients, families, and caregivers in improving health care and health care safety. Patient engagement can be fostered at the individual, clinical, organizational, and policy levels (Sharma et al., 2017), and enhance health care organizations' sustainability (Palumbo et al., 2016). Patient and family engagement appeals to principles of equity by recognizing patients as valued partners in developing safer health care systems (Sharma et al., 2018). Patients engaged in their care include monitoring and self-administration of medications, alerting care teams to concerning symptoms, and reporting adverse events (Sharma et al., 2018). Health care leaders should embrace the engaged patient and look towards continuous quality improvement within the organization.

Quality Improvement Methods

Quality improvement has been increasingly used globally over the past decade to change health care (Shah et al., 2021). Hill et al. (2020) emphasized that quality improvement has received considerable attention within health care to enhance the quality of care and reduce costs for patients. Globally, nearly 5 million lives are lost annually due to suboptimal quality of care where poor quality contributes to more deaths than lack of access to care (Datta & Livesley, 2021). Shah et al. (2021) stated quality improvement in health care requires proportionate measurement to confidently improve systems and outcomes. Ntwiga et al. (2019) affirmed the importance of quality improvement in health care and its impact on those involved. Akmal et al. (2021)

emphasized that a viable quality improvement system requires improvement approaches that are implemented at an organization-wide level, well-resourced and carefully monitored, underpinned by a long-term vision, and supported by quality improvement methods with the necessary power and influence to integrate quality improvement subsystem within the wider health care organization. Quality improvement methods are not just effective for making rapid adaptions in a crisis but properly supported, can also foster change in the longer term (Shah et al., 2021). Quality improvement is defined as securing understanding of the complex health care environment, applying a systematic approach to problem solving, designing, testing, and implementing changes using real time measurement for improvement, and making a difference to patients by improving safety, effectiveness, and experience of care (Hibbert et al., 2021). Modi (2021) added that quality improvement consists of approaches to improve the quality-of-care patients receive by using structured methods applied in repeated cycles of measurements, intervention, and re-measurement. Health care leaders who implement quality improvement and quality improvement methods should reap the benefits of quality care for patients.

The five main principles of quality improvement include a focus on organizational process and systems rather than on individuals within the system, the use of statistically and methodologically robust structured problem-solving approaches, the use of multi-disciplinary team working, empowerment of employees to help identify problems and action improvement opportunities, and a focus on patients through an emphasis on creating the best possible patient experience and outcomes (Hill et al.,

2020). The use of quality improvement in health care has evolved since the 1990's, using quality control techniques and management theories employed in the industrial and manufacturing sectors (Hill et al., 2020). To make the changes that will lead to better patient outcomes (health), better system performance (care), and provider competency developments, leaders need knowledge and skills beyond the clinical management of patients for efficient quality improvement (Baernholdt et al., 2021). Datta and Livesley (2021) stated quality improvement in health care is a combined and unceasing effort for everyone involved health care professionals, patients and their families, researchers, payers, planners, and educators. Baernholdt et al. (2021) stated the skills beyond the clinical management of patients include system thinking, performance measurement, data management, designing, implementing, and evaluating small tests of change, and human factors engineering. Modi (2021) further identified safety, effectiveness, patient-centered, timeliness, efficiency, and equitability as significant domains of quality health care. Ricciardi (2021) added to what quality in health care involves. Ricciardi (2021) stated health care quality consists of

- The extent to which health care services provided to individuals and patient populations improve desired health outcomes. To achieve the desired improved health outcomes, health care leaders need to ensure the health care environment is safe, effective, timely, efficient, equitable, and people centered.
- The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

- The degree to which the treatment dispensed increases the patient's change of achieving the desired results and diminishes the chances of undesirable results, regarding the current state of the health care leader's knowledge.

O'Donnell and Gupta (2021) stated that before implementing quality improvement initiatives, careful planning and groundwork need to be done. Quality improvement links front-line staff with a fundamental responsibility to improve the team's systems (Comfere et al., 2020). The essence of quality improvement asserts that everyone has two jobs. The first job is to do the job trained to do, and the second job is to improve the system in which individuals do the job (Comfere et al., 2020). O'Donnell and Gupta (2021) further opined that the groundwork may include articulating quality improvement goals, identifying specific clinical outcomes and administrative outcomes for the organization's future state, evaluating current processes to identify what functions and does not function in the organization's current state, understanding how health care information technology use can help the leaders meet their goals, and developing a plan to collect data going forward and compare progress to benchmarks.

QIM is a management style and when used by health care leaders, the health care leaders may see positive results in the quality of health care for their patients. (Ntwiga et al., 2019). Health care policy developers at the national level support QIM as a standard primary health care delivery method (J. Gardner et al., 2018b). Zoutman and Ford (2017) identified impacts and success rates of quality improvement and found quality improvement positively improved numerous health care performance factors 90% of patient safety outcomes, 88% of patient care outcomes, and 81% of patient satisfaction

outcomes by quality improvement. Health care leaders who use QIM seek to improve service quality through ongoing cycles of reflection and refinement (Gadsen et al., 2019). Health care providers can use QIM as a process of ensuring that health care providers deliver the proper care (Ntwiga et al., 2019).

The use of QIM programs helps improve quality in health care worldwide with planning, implementing, and evaluating to improve quality patient care (Buttigieg et al., 2016). Buttigieg et al. (2016) indicated that the use of QIM might eventually enhance the quality of patient care. Modi (2021) suggested health care leaders may want to accept two types of quality improvement activities. The first type of quality improvement a health care leader may want to consider is to identify the quality improvement intervention where evidence of causality is necessary to justify why improvement is needed. The second type of quality improvement a health care leader may want to consider is understanding why causality does not matter (Modi, 2021)). For this type of quality improvement, motivated health care staff are likely to drive improvement, and do whatever is needed to drive change without worrying about capturing balancing and process measures occurs (Modi, 2021). However, health care leaders must assess the holistic and strategic benefits of QIM to analyze the case for each QIM project (Buttigieg et al., 2016). By addressing the holistic and strategic services of QIM, health care leaders can provide better patient treatment.

Providing high quality care requires patient care pathways organized according to the patients' needs (Knudsen et al., 2020). QIM is a systematic continuous approach in health care that when used by health care leaders may improve service provision and

ultimately provide better outcomes for patients (Backhouse & Ogunlayi, 2020). Backhouse and Ogunlayi (2020) defined quality improvement as (a) improvement in patient outcomes, system performance, and professional development that results from a combined, multi-disciplinary approach in how change is delivered, (b) the delivery of health care with improved outcomes and lower costs through continuous designing of work processes and systems, (c) using a systematic change method and strategies to improve patient experiences and outcomes, and (d) to make a difference to patients by improving safety, effectiveness, and experience of care by using an understanding of health care environments, applying a systematic approach, and designing, testing, and implementing change using a real-time measure for improvement. Health care leaders who make a conscious effort to implement QIM in their organizations may positively impact patient care.

QIM programs have been widely used over the last decade by primary health care service providers (K. Gardner et al., 2018a). Health care leaders who use QIM are known to use measurement and problem-solving techniques to identify unwarranted variations in patient care and assess and embed improvements (Sibthorpe et al., 2018). In health care, the balance between efficiency and quality of care affects patient safety, life and death, and long-term health (K. Gardner et al., 2018a). Nambiar et al. (2017) stated that health care quality improvements could contribute to a healthier population. Nambiar et al. proposed an approach focusing on five elements to maximize the potential of quality improvements in health care: (a) system thinking, (b) stakeholders' participation, (c) accountability, (d) evidence-based interventions, and (e) innovative evaluation.

According to the element of system thinking, health care providers may consider the interdependency of the various levels of health facilities and health care systems and the effect that interdependency has on health outcomes (Nambiar et al., 2017). The participation of stakeholders brings an element of improvement interventions from the experience and knowledge of local and national health care systems (Nambiar et al., 2017). According to Nambiar et al. (2017), the purpose of accountability mechanisms is to ensure health care providers get the necessary support from other levels of the health care system. This support helps providers deliver quality care while strengthening accountability mechanisms to promote efficiency and ownership of service delivery by professionals and communities. Leaders in health care use evidence-based interventions to help guide quality improvements and find that innovative evaluations are essential for advancing quality improvement science while assessing specific intervention efforts (Nambiar et al., 2017). Health care leaders who remain accountable regarding QIM and their actions gain the respect of others.

Finkelstein et al. (2015) stated that health care organizations should have a formal and explicit oversight process for quality improvement. Green et al. (2017) found that QIM methods provide a structured approach in bringing together clinicians, researchers, health care managers, and patients to overcome the lack of understanding regarding quality improvements. Along with growing health care occurrences of increased life expectancy, rising costs, and other challenges, health care leaders face the pressure of delivering high-quality patient care (Yazici, 2014). Quality improvement use should include input from quality improvement experts, health service researchers,

administrators, clinicians, patient representatives, and those experienced in the ethics review of health care activities (Finkelstein et al., 2015). Barson et al. (2017) presented health care leaders' views on successful quality improvement initiatives within their contexts and pointed out the need to further understand QIM in health care. Millar (2013) stated with the ongoing emphasis on QIM in health systems health care leaders need to develop, implement, or modify quality improvement tools to distribute within health care settings. Millar (2013) conducted a case study to show how QIM is applied in various health care settings. The structural approach of QIM in health care has resulted in the collaboration of health care leaders, patients, and family members. With the increasing acceptance of QIM, qualitative research on those methods has increased and identified strategies for implementing QIM.

Researchers found the qualitative method valuable and beneficial when studying QIM methods. Bagchi et al. (2012) conducted a qualitative study to explore the cultural differences in the perception of health care quality across various groups. In their study, Bagchi et al. (2012) determined that health care quality depends upon the patient's perception of care received. QIM, with good guidance and focus on measurement for improvement, can help with problems that affect the patient outcome (Brandrud et al., 2017). Melo (2016) stated that health care quality improvement is one of the critical priorities of health care leaders and is a significant concern in the health care sector. Sharma et al. (2017) conducted a qualitative thematic analysis to investigate the impact of interventions involving care outcomes, patient safety, and patient satisfaction using QIM. Gowen et al. (2012) conducted qualitative research to help with process improvement

efforts regarding the enhancement of patient safety outcomes, operational effectiveness, competitiveness, along with the use of QIM.

Melo (2016) identified several initiatives to improve the quality of care: total quality management, plan-do-study-act, collaborative, statistical process control, and Lean Six Sigma. Quality improvement strategy is the gradual improvement of product quality, services, productivity, and competitiveness, with all involved (Paraschivescu & Cotirlet, 2015). Health care managers who conduct research and use strategy improvement methods in their organization with QIM may improve patient satisfaction, flow, and wait times resulting in repeat business. One aspect of the QIM strategy is to have QIM operate horizontally across all departments while ensuring all employees extend QIM to the patients (Ntwiga et al., 2019). Shah et al. (2021) emphasized developing a deep understanding and application of QIM across health care systems will require the continuous use of improvement tools of daily problem solving to include skill building, incentives, and learning mechanisms. O'Donnell and Gupta (2021) further stated a successful QIM initiative is the result of a careful and thoughtful structured planning approach. As the use of QIM in health care increases, health care leaders may need to recognize improvement methods through each aspect of the organization especially with patient flow and patient wait time.

Patient Flow

Patient flow is a significant aspect of health care that ensures patients receive care when and where they need it. Asgari and Asgari (2021) defined patient flow as an effective approach to improving accessibility and quality of care and reducing waste and

cost in health care systems. Patient flow is the movement of patients, information, or equipment between or among departments, staff groups, or organizations that are part of the care pathway (Elamir, 2018). Wall and O'Sullivan (2021) stated patient flow in a health care setting involves minimal delays for patients throughout their journey from the emergency department to the wards, outpatients, and to a suitable discharge destination. Wall and O'Sullivan further stated good patient flow requires effective processes, staff buy-in, and staff education. Kreindler et al. (2021) emphasized that stagnant patient flow has myriad destructive consequences such as delayed care and protracted suffering. Kreindler et al., (2021) also emphasized patient flow is a system problem that demands a system response; however, leaders may have existing evidence that is inadequate to guide decisions through the difficult, complex, and potentially risky undertaking. The issue of patient flow is vast, intersecting with multiple dimensions within health care quality, and is a theme of myriad improvement efforts in diverse areas (Kreindler et al., 2021). Olsson et al. (2017) discussed how a hospital is typically a complex configuration of highly specialized clinical departments that must manage patient flow. Patient flow at the administrative or clinical levels has different functional speeds, and a department must guide and manage each patient according to the health care needs of the patient.

Olsson et al. (2017) stated patient flow is based on individual patient needs where the roles of middle management are still considered crucial for smooth patient flow in health care organizations. Patient flow or the uninterrupted movement of patients, represents both the progression of a patient's health status and the transferring of the patient through multiple health care units (Abdulsalam & Khan, 2020). For the smooth

transition of patients, health care leaders should acknowledge the importance of patient flow. Patient flow is considered one of the most critical points in outpatient health care services and helps to reduce patient wait time (Lot et al., 2018). Patient flow is also a crucial factor affecting multiple key health care performance measures, including accident and emergency waiting time, patient experience, and patient outcome (Bean et al., 2019). Bean et al. highlighted that patient flow has multiple interacting factors, which are time-varying resulting in a significant challenge to health care research and management. Lewis et al. (2018) stated that improving patient flow through health care systems to maximize patient capacity and efficiency has received attention from health care leaders. Specifically, efforts to improve patient flow need to include all parts of the health care system.

Lewis et al. (2018) found a wide range of initiatives to improve patient flow and reduce waiting times in health care settings. Lewis et al. (2018) identified initiatives such as lean or continuous improvement approaches, triage, and prioritization, Specific and Timely Assessment for Triage, Advanced Access, and rationing to improve patient flow. The efforts and resources required to manage and improve patient flow for health care services should be acknowledged (Lewis et al., 2018). Souza et al. (2021) stated patient flow goes through the following steps registration, screening, first medical care, exams, medication administration and/or observation room, hospitalization and/or medical discharge. Souza et al. (2021) further explained the process of the common steps of patient flow:

- Screening: performed by a nursing professional, brief assessment of patient

clinical conditions regarding severity to define care priority,

- Medical care: physical examination and interview to understand the main complaint,
- Initial diagnosis: actions based on the primary complaint, oral medication or other modality, and auxiliary services (as needed),
- Intermediate diagnosis: additional service result evaluation and/or medication administration, and
- Final diagnosis: hospitalization or medical discharge.

Additionally, due to physicians' and nursing teams' complexity, patients' service limitation includes lack of beds, inflexible paper-based systems, precautionary isolation, delays in cleaning, excessive bed dependence for patients under observation or hospitalization, and unsatisfactory diagnosis or discharge instructions (Souza et al., 2021). The continuous flow of patients is an aspect of health care, health care leaders should address as an important health care step.

Elamir (2018) identified an ideal continuous patient flow as one that involves the immediate movement of patients from one care step to the following care step. Four elements of successful patient flow process include (a) improved forecasting and predictability of reduced variation, (b) flow within health care sub-systems, (c) empowered staff to adapt the service, thereby meeting the patient's needs and exceeding the patients' expectations, and (d) well-managed demand and capacity (Elamir, 2018). Bittencourt et al. (2018) discussed the need for techniques that help create health care systems that are safe, effective, patient-centered, timely, efficient, and equitable.

Bittencourt et al. (2018) recognized convenient access to health care as a critical component of high-quality health care. The importance of improving the flow of patients is a business process of quality improvement (Elamir, 2018). Furthermore, health care leaders who improve patient flow systems will reduce patient wait times.

Patient Wait Time

Waiting times are important issues that reflect on the performance of the staff and good management practice within the health care organization (Shalihin & Rifin, 2021). Long wait time is perceived by the patients in different ways and generates different reactions and consequences (Abdulsalam & Khan, 2020). Rathnayake and Clarke (2021) further emphasized that waiting times are key performance indicator for many health care systems, used to encourage improved performance in health care institutions, with the aim of delivering high-quality care without necessary delay. Patients who wait a long time for their health care procedure are more likely to report problems such as prolonged pain, discomfort, anxiety, and disability, which are associated with reduced quality of life (Rathnayake & Clarke, 2021). Health care leaders consider wait time as the time a patient waits before being seen by one of the medical staff and acknowledge the length of time may differ from one health care organization to another (Shalihin & Rifin, 2021). Extended wait time in health care negatively affects a patient's perception, increases the feeling of illness, and is the significant cause of dissatisfaction in health care (Lot et al., 2018). Elkholi et al. (2021) added long wait times in health care organizations are associated with decreased patient satisfaction and increased morbidity and mortality. Abdulsalam and Khan (2020) proclaimed that prolonged waiting time by the patient as a

result of overcrowding in health care facilities is a well-known recurring phenomenon that adversely impacts the patient's health care outcome. The recurring phenomenon of patient wait time occurs when there is an absence of medical personnel, unavailability of examination rooms, and contemporaneous registering of patients (Abdulsalam & Khan, 2020).

Lot et al. (2018) stated that the perception about the wait time and patient dissatisfaction had gained attention due to increase demand, limited resources, and the necessity to invest efforts to prevent errors. Abdulsalam and Khan (2020) emphasized wait time is perceived to be longer than usual time as a consequence of either physical or emotional stress to the patient. The management of information, efficiency in data use, acceptable use and distribution of resources, and process execution time are critical for optimizing a patient's journey and reducing the discomfort associated with waiting for health care (Lot et al., 2018). Specifically, Alowad et al. (2021) identified six areas of concern that directly impact patient wait. The six areas of concern identified by Alowad et at. (2021) are (a) miscommunication between health care staff and patients, (b) lack of teamwork, (c) overcrowding, (d) inefficient health care environment layout, (e) inadequate bed capacity, and (f) unavailability of resources. The known areas of concern that contribute to patient wait times should be acknowledged by health care leaders to help with the flow of patients.

Elkholi et al., (2021) stated prolonged waiting times in health care organizations is a well-recognized global problem. Long waiting times before triage carries a negative impact on patient safety, especially for time-sensitive diseases such as acute myocardial

infarction and acute surgical conditions (Elkholi et al., 2021). Kagedan et al. (2021) added when longer wait times occur, health care leaders and staff are led to adjust scheduling disruptions for health care staff, patients, and family members. Kagedan et al. (2021) identified several factors that contribute to the increase of patient wait times: (a) inadequate trainee involvement during appointments, (b) late arrival of patients, and (c) higher daily volumes of scheduled appointment along with fewer experienced health care staff (Kagedan et al., 2021). Chu et al. (2019) revealed ways health care leaders can curtail the frustrations that occur as a result of long wait times for patients. To ease the frustrations of the patients, health care leaders should proactively inform patients of delays, apologize for the delays, and provide opportunities for diversion (Chu et al., 2019). The acknowledgement of the interconnectedness of health care plays a major part in the improvement of health care and quality care.

The interconnectedness of health care involves communication among health care leaders and staff, patients and staff, and different departments. Quality health care is a multidimensional service confirming the technical quality and functional quality that satisfies patient expectations consistently (Kokatnur & Pilli, 2018). Kokatnur and Pilli (2018) analyzed the technical and operational quality aspects of patient expectations in health care. For patients, these aspects include the average length of stay, readmission rates, infection rates, and outcome measures (Kokatnur & Pilli, 2018). Kokatnur and Pilli (2018) classified functional qualities for patients as health care service delivery cleanliness of facilities, and availability of infrastructure and equipment. Kokatnur and Pilli (2018) emphasized that patients cannot assess the technical quality of a health care

facility, which makes the available quality of health care the primary determinant of patients' quality care perceptions. Improving the quality of health care involves assessing process and outcome measures of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity, as well as strengthening the capacity of health systems and clinical practices to create and sustain an organizational culture of quality and safety (Ricciardi, 2021). Ricciardi (2021) further emphasized quality improvement programs are well positioned to identify gaps in quality and safety, and to generate ideas for implementation studies in healthcare. Furthermore, health care leaders should keep in mind the perceived value of quality improvement for the patient, in terms of the health care leader's time and effort spent on the quality improvement activity used to enhance the patient's experience, and outcomes beyond current practices and beside care (Fischer et al., 2021). To influence willingness to engage in safety and quality improvement, the health care provider must see the project as genuinely worth their time and effort for themselves and their patients (Fischer et al., 2021).

Recognizing the quality improvement methodologies initially used in industry include frameworks such as the Plan-Do-Study-Act (PDSA), the Malcolm Baldridge model, Lean, and Six-Sigma (Comfere et al., 2020). All quality improvement frameworks require adhering to an iterative, methodical process where the underlying system systematically examines the onset of quality improvement (Comfere et al., 2020). Regardless, identifying the determinants of quality care for patients is an essential focus of health care leaders in quality improvement. The qualitative study regarding the quality improvement methods in health care organizations, specifically private health care

practices, filled a literature gap regarding private health care providers who use quality improvement methods. The authors of the articles used for the qualitative study presented information on quality improvement methods used in public health care facilities. The qualitative study presented quality improvement methods private practice health care providers used to improve patient wait times.

Transition

The purpose of this qualitative single case study was to explore strategies that health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business. In this section, I began by presenting the benefits of QIM methods in health care. A review of professional and academic literature was then included to explain why the use of QIM methods is important in health care. Section 2 of the study included an explanation of the research procedures, including information related to participants, research method and design, and population and sampling. Section 2 also included information related to ethical considerations and data collection. Section 3 of the study consisted of a presentation of the findings, applications for professional practice, implications for social change, recommendations for both action and future research, and reflections.

Section 2: The Project

The project section of the qualitative study includes information regarding the purpose of the study, the role of the researcher, study participants, research techniques, and data analysis. Section 2 gives detailed information on how the study's reliability, validity, and ethical standards address the research question: What strategies do health care managers in physician's offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?

Purpose Statement

The purpose of this qualitative single case study was to explore strategies that health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business. The target population included five health care leaders from one private health care organizations who have successfully implemented quality improvement strategies to reduce patients' wait times and increase patient satisfaction in an eastern U.S. state. The implications for positive social change include the potential of improved patient wait time thereby improving patient experiences. Improving health care experiences, self-efficacy, self-worth, and dignity through an attitude of respect, acknowledgment, and generosity for citizens can be enhanced by embracing the holistic approach to citizens' care (Salemonsen et al., 2020).

Role of the Researcher

In qualitative research, the researcher is the primary instrument used to study the phenomena. The researcher actively develops and communicates a strategy about

managing the relationship (Venselaar & Wamelink, 2017). In this study, I was the primary data collection instrument, and qualitative interviews were conducted with the interview protocol (see Appendix C). A protocol builds quality and consistency by providing data essential for the research study (Braaten et al., 2020). After the collection of the data, I developed a coding scheme to analyze interview transcripts and identify themes.

A researcher who interviews participants and analyzes collected data can be guilty of subjectivity and bias (Hadi & Closs, 2016; Peterson, 2019). To reduce the possibility of subjectivity and bias, I documented any of my own feelings of subjectivity or prospective inference insertions. My relationship with the participants was also professional, which did not interfere with my objectivity or pose a risk of bias.

Further, a clear distinction should be drawn between ethical commitments to individual research participants and the organizations of the participants by following ethics guidelines (Summers, 2020). For this qualitative study, I adhered to the *Belmont Report* protocol (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). I also completed the Protecting Human Research Participants training by the Collaborative Institutional Training Initiative.

Participants

Participants met the eligibility requirement within the scope of the population in order to participate in the study. The criteria for study participants included 10 or more years of leadership experience in health care, direct contact with patients, and successfully implemented quality improvement strategies to reduce patients' wait times

and increase patient satisfaction in an eastern state in the U.S. The criteria for selecting the participants aligned with the overarching research question to help answer what kinds of quality improvement strategies have proven effective for health care leaders and their patients. I informed the participants about the study by sending e-mails, making phone calls, and making personal visits. I established a working relationship with all participants by providing the participants with correspondence regarding the study consent form and interview protocol (see Appendix C). I recruited participants through purposeful sampling and interviewed participants using semistrctured interviews. Similar research on QIM with health care leaders supported this recruitment process and choice of participant criteria (Barson et al., 2017; Farokhzadian et al., 2018; Gadolin & Anderson, 2017)

Research Method and Design

Research Method

Qualitative researchers uncover multiple perspectives of a single organization, situation, event, or process at a point in time or over time (Cooper & Schindler, 2008). Qualitative researchers want to understand real-world situations and make assumptions that such understanding is likely to involve important contextual conditions pertinent to the study (Yin, 2018). In comparison, quantitative researchers attempt to provide valuable insight to the ordering of reality while mitigating personal bias (Savela, 2018). Researchers who use mixed methods aim to combine qualitative and quantitative methods specifically to analyze data for empirical studies (Timans et al., 2019). Qualitative researchers may explore, in an in-depth manner, matters that are unique to the experiences of the interviewees. The in-depth insight from the interviewees gives

information on their experiences and perceptions regarding the phenomena (McGrath et al., 2019). I did not select quantitative or mixed methods research methods because I did not use numerical criteria or instruments to record and/or analyze data collected from study subjects. I selected qualitative research to gain a better understanding and analyze the use of quality improvement strategies by health care managers.

Research Design

Case studies are one qualitative design that researchers can choose to address *how* and *why* research questions (Yin, 2018). Field research may also evolve and need adjusting during the study (Cooper & Schindler, 2008; Saunders et al., 2017; Yin, 2018). Positive and interpretive researchers' case studies may be single-case design or multiple-case design (Cooper & Schindler, 2008; Saunders et al., 2017; Yin, 2018). Furthermore, a case study is an analysis of systems that are studied with a comprehensive view by either one or several methods (Gustafsson, 2017). Specifically, a multiple case study involves the researcher studying multiple cases to understand the similarities and differences between the cases (Gustafsson, 2017).

Researchers may also use ethnography, narrative inquiry, and phenomenology for qualitative research design. Ethnographic researchers observe, inquire, and attempt to understand the experiences, interpretations, interactions, and relationships surrounding a topic in a real-life context (Marghalara et al., 2019). Researchers who use narrative inquiry attempt to obtain information regarding the life story of participants (James, 2018). Last, researchers who use phenomenological design attempt to study a phenomenon experienced or lived by a human being and how events appear in their

experiences (Sundler et al., 2019). I did not select ethnographic design because I was not attempting to understand the experiences in real-life context. I did not select narrative inquiry design because I did not study the real-life story of the participants. I did not select phenomenological design because I did not study a phenomenon experienced by the participants of the study. I selected to use a single case study for the research design to garner a comprehensive understanding regarding the use of QIM in health care.

Population and Sampling

The target population included five health care leaders from one private health care organization who successfully implemented quality improvement strategies to reduce patients' wait times and increase patient satisfaction in an eastern state in the U.S. According to Farrag and Harris (2019), achieving a high-quality health system is a complicated journey. I decided to explore QIM within private health care systems to discuss what health care leaders need or what has been done to achieve high-quality health care systems where patient wait times are improved. Clinicians often evaluate the quality of health care interventions using robust, evidence-based, outcome criteria because of the systematic focus on quality, safety, and productivity (Smith et al., 2020). Considering the expertise of the health care leaders, the outcome of QIM within private health care systems showed a high level of quality, safety, and productivity resulting in improved health care systems. Participants of this study met the following selection criteria: (a) 10 or more years of leadership experience in health care; (b) direct contact with patients; and (c) five private health care leaders from one health care organization who successfully implemented quality improvement strategies to reduce patient wait

times.

Purposeful sampling is used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas et al., 2015). Ames et al. (2019) stated purposive sampling of primary studies for inclusion in the synthesis is one way of achieving a manageable amount of data. Mackie et al. (2018) strengthened the use of purposeful sampling during a health care qualitative study. Mackie et al. (2018) utilized semistructured interviews and the triangulation of data for a sample size of 33 participants. The selected participants were significant contributors to the study because of their years of experience, knowledge about health care, and understanding of the need to improve patient care quality. The criteria used to identify participants meant the participants were eligible to describe the field of health care by providing information about QIM methods and patient quality care. The use of single case, interviews, two recording devices, and relevant corporate documents added to the validity of the study. For the qualitative study, I utilized purposeful sampling to ensure rich data from the selected participants and their knowledge of QIM was obtained.

Ethical Research

Saunders et al. (2017) stated informed consent involves ensuring the interviewer gives individuals involved in the research sufficient information about the research being conducted, providing interviewees opportunities to ask questions, and giving the interviewees time to consider their answers without any pressure or coercion to participate. The Research Ethics Review Process of Walden University requires each student to comply with the university's ethical standards. Students and faculty must

complete the Institutional Review Board (IRB) application before the collection or analysis of data begins. I completed the IRB application, submitted the application for approval, and continued with the IRB process. Each participant completed the IRB consent form before data collection and analysis began [Appendix A].

After I received consent from the study participants, I began scheduling interviews with my participants. If the participant declined to participate after receiving the IRB consent form, I sought another private practice health care leader to participate in the study. To ensure ethical protection and anonymity of participants, I stored the data in a safe place for 5 years. I protected the recorded information with the use of security codes, and any paper notes were protected under lock and key. The document did not include names or any other identifiable information of the participants or the organizations. I protected the confidentiality of the participants since I know each participant.

I gave each participant in the study written consent to take part in the data collection phase of the work. I ensured that the participants had a full understanding of the parts of the study by answering their questions and/or concerns. I ensured the participants understood that they may withdraw from the study at any time without penalty and know how to do so. If a participant decided to withdraw, I attempted to find out why and have the participant draft a statement of withdrawal. However, if a participant did not want to disclose a reason for the withdrawal, I respected the wishes of the participant. The participants who took part in the research study received a $25 Visa gift.

Data Collection Instruments

There are six primary sources of evidence for qualitative studies. Pannone (2017) identified six sources of evidence for case studies documents, archival records, interviews, direct observation, participant-observation, and physical artifacts. For this purposeful single case study, I served as the primary data collection instrument. I clarified how I used data collection. I provided interview questions to the selected participants who met the criteria of the study. The data collection of the study occurred through the recording of interviews with the use of an Apple iPhone recording app and a second voice recorder specifically Sony-BX series digital voice recorder. The secondary data source I used to triangulate included documentation from the health care facility such as policies and procedures that address patient waiting time, how to reduce patient wait times, and how to handle patients who become irritable during long wait times. The secondary data documents helped to substantiate, explicate, or contradict the data received from the participants.

Data Collection Technique

After completing the IRB form and receiving IRB approval from Walden University, I started the data collection process. I contacted each health care leader from the identified health care facility via direct contact, phone, or e-mail to set up a meeting day and time for the interview. Once a date and time was established, I was punctual to conduct the interview. I upheld the timeframe of each interview, respecting the participant's time. Participants were asked interview questions with the goal of addressing the study research question: What strategies do health care managers in

physician's offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?

Data Organization Technique

Data collected after each interview was organized and stored appropriately. Participants' responses were organized on a dedicated thumb drive. The identity of each participant remained anonymous, and each interview was labeled O1P1, O1P2, O1P3, etc. for participants from the health care organization. The secondary data collected from the organization was labeled accordingly. The thumb drive has a designated access code and stored under lock and key for 5-years. After the 5-year time frame, the data will be destroyed by resetting the thumb drive and shredding hard copies of data.

Data Analysis

The data analysis for this qualitative single case study was a compilation of semistructured interviews and related documentation from participants in health care operations management from a private health care facility. Noble and Heale (2019) identified triangulation as a method used to increase the credibility and validity of research findings to help explain the results of the study. By using the four types of triangulation, researchers can use data triangulation, which includes matters such as periods of time, space, and people. Investigator triangulation includes the use of several researchers in a study. Theory triangulation, which encourages several theoretical schemes to enable interpretation of a phenomenon. Methodological triangulation, which promotes the use of several data collection methods such as interviews and observations (Noble & Heale, 2019).

For the qualitative study, I used the methodological triangulation process for data analysis. Good qualitative research is robust, well informed, and thoroughly documented (Nassaji, 2020). The secondary data source of the study for methodological triangulation included documentation from the health care facility such as policies and procedures that address patient waiting time, how to reduce patient wait times, and how to handle patients who become irritable during long wait times. The secondary data documents helped to substantiate, explicate, or contradict the data received from the participants.

Qualitative research is also systematic, involving a careful process of identifying the problem, collecting, analyzing, explaining, evaluating, and interpreting the data (Nassaji, 2020). After collecting responses from the interview questions via the use of an Apple iPhone recording app and a second voice recorder specifically Sony-BX series digital voice recorder, I utilized NVivo software for coding and thematically analyzed the data. Parameswaran et al. (2019) stated coding is an integral part of qualitative research for qualitative researchers who use interviews for data collection. After coding and developing themes, I correlated the themes to the conceptual framework of the qualitative study as well as recent literature on the research topic.

Reliability and Validity

Reliability

Abushaikha (2018) stated case studies enrich the understanding of real-world phenomena where the results of the qualitative research analysis are limited to content experts to increase the reliability of the study. Riege (2003) stated that reliability refers to the demonstration that the operations and procedures of the research can be repeated

by other researchers, which can achieve similar findings as long as the interviewing techniques and procedures remain consistent. The reliability of a qualitative study is to determine the dependability and credibility of the study. (Haven & Grootel, 2019). To ensure the reliability of my study, I used member checking.

Member checking, which is having the data explored by respondents to ensure the respondents share what is intended to be shared, is the single most important method to ensure a study's credibility (Hadi & Closs, 2016). Member checking is an integral part of creating trustworthiness in qualitative research (Candela, 2019). Candela (2019) stated that member checking provides a way for the researcher to ensure the accurate portrayal of participant voices by allowing participants the opportunity to confirm or deny the accuracy and interpretations of data, thus adding credibility to the qualitative study. J. Johnson et al. (2020) stated the research questions of a qualitative study must be clear, focused, and supported by a strong conceptual framework where the researcher's insight into their own biases and rationale for decision-making is critical to rigor. The contribution to the selection of appropriate research methods enhances trustworthiness and minimize researcher bias inherent in qualitative methodologies (J. Johnson et al., 2020). I remained unbiased and rationale during the transcription summary of the data collection. I conducted member checking by involving the participants to contribute valuable information regarding their expertise and insight in using QIM. I performed member checking to confirm the accuracy of the data collected and to assist in the correct analysis of the data. Participants were allowed to clarify or add meaning to their responses. The additional data shared by the participants enriched my study as

participants were allowed to share more in-depth information about quality improvement method use. The contribution from the participants added to the reliability of the study.

Validity

Validity in qualitative research determines whether the research truly measures what was intended to measure or how truthful the research results are (Golafshani, 2003). The principle of credibility in qualitative research concerns the extent to which the research findings and conclusions can be viewed to be believable or concerns the truthfulness of the findings and the extent to which the findings reflect the reality of the phenomenon investigated (Nassaji, 2020). To achieve credibility, the researcher needs to ensure the understanding of the research participants, context, and processes are as accurate and complete as possible and the interpretations are inclusive (Nassaji, 2020). Specifically, triangulation helps to achieve a more accurate and complete understanding of the issue under investigation, therefore increasing the validity and credibility of the findings (Nassaji, 2020). Triangulation is best known for the consistency of the interrelationship between information obtained from the data collected from different sources to increase the understanding of the study in question (Hayashi et al., 2019). I enhanced credibility by incorporating methodological triangulation during the interview process.

Transferability concerns the extent to which the researchers' interpretation or conclusions are transferable to other similar contexts, which requires thorough and rich description of research activities and assumptions (Nassaji, 2020). Amin et al. (2020) stated transferability is the product of rigorous qualitative studies that contain thick

description and thick interpretation. Qualitative researchers should account for the reflections of their writings to frame limitations and strengths and transferability of findings (Amin et al., 2020). I reinforced transferability by identifying the limitations and strengths of the qualitative study to assist with further research.

Confirmability of qualitative research concerns the extent to which others confirm to the researcher's interpretations and conclusions since qualitative research emphasizes the researcher's active role and engagement in the research (Nassaji, 2020). Nassaji (2020) also stated confirmability can be established by describing the data and the findings in a way that the accuracy can be confirmed by others. J. Johnson et al. (2020) emphasized the confirmability of the results is influenced by reducing or at a minimum explaining research influence on the result by applying and meeting standards or rigor such as member checking, triangulation, and peer review. I addressed confirmability by meeting the rigorous standards of triangulation.

Data saturation is used to describe the achievement of sufficient sample size (J. Johnson et al., 2020). Braun and Clarke (2019) identified the concept of data saturation as information redundancy or the point at which no new themes or codes emerge from data. J. Johnson et al. stated the idea of fully achieving data saturation may be unrealistic when applied to some populations particularly smaller populations. However, to overcome the possibility of not meeting saturation, the qualitative researcher has to be transparent in the process and reporting of the results so the resulting data may still contribute to the field and to further inquiry (J. Johnson et al., 2020). I ensured data saturation by asking the participants the interview questions and follow-up questions based on the participants'

responses.

Transition and Summary

In section 1, I presented the purpose statement, the role of the researcher, the participants involved in the study, the research method and design, population and sampling, the ethical research found, data collection instruments used, data collection technique, data analysis, reliability, and validity were presented. In section 2, I presented a thorough description of the process using qualitative research. I explored the strategies health care operations managers use to discover the need to address administrative processes that negatively affect patient experiences. In Section 3 of the study, I presented study findings, the implications for social change, and applications to physician practices. Additional research findings and the recommendation for action is provided in Section 3. Section 3 of the document also includes personal reflection regarding the experience of the DBA Doctoral Study process and a conclusion statement.

Section 3: Application to Professional Practice and Implications for Change

The purpose of this qualitative single case study was to explore strategies used by health care managers in physicians' offices to improve patient wait times and resultant patient experiences, which can improve repeat business. The five participants of the single case qualitative study were health care leaders who met the criteria for inclusion of the study. Each participant answered seven research questions related to strategies used to improve patient wait times and resultant patient experiences. The questions included topics about how the organization address challenges regarding the implementation of improvement strategies, evaluation of the effectiveness of improvement strategies, and ongoing monitoring of quality assurance of patient wait time.

Based on the research findings from the study participants, health care managers used quality improvement strategies to help reduce patient wait times. The barriers health managers faced were managerial, operational, and financial barriers that influenced the effectiveness of quality improvement methods. The major themes identified from the qualitative semistructured interviews were (a) use of patient satisfaction surveys, (b) continual use of communication between staff and patients, and (c) the need to increase the number of staff members. The major themes of the study validated the importance of the need of QIMs in health care by ensuring patients are satisfied.

Presentation of the Findings

The overarching research question for the single case qualitative study was "What strategies do health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?" The target

population included five health care leaders from one private health care organization who successfully implemented quality improvement strategies to reduce patient wait times and increase patient satisfaction in an eastern state in the United States. I asked the participants seven open-ended interview questions, conducted follow-up interviews, and reviewed secondary documents, which added value to the findings of the semistructured interviews.

I transcribed the participants' responses verbatim and conducted theme analysis resulting in three major themes. The themes identified in the single case qualitative study included the use of patient satisfaction surveys, continual communication between staff and patients about quality improvement methods, and increase number of staff members. The use and importance of patient satisfaction surveys was addressed by each participant (Figure 1). Effective communication between the health care staff and patients was another factor addressed by each participant. The participants expressed the need to be able to effectively communicate between patients and each other to have sufficient health care practices. However, each participant expressed the need for additional staff to assist with decreasing patient wait time. The participants acknowledged that without additional staff a significant change in patient wait time may not occur in a timely manner (Table 2).

Figure 1

Zocdoc Patient Satisfaction Survey

Zocdoc
[ ]

How was your visit?

Provider first and last name: _____

Patient first name: _____ Patient last initial: _____

Written reviews require your first name and last initial to appear next to this review on the Zocdoc website.

What did you think about your visit?

Would you recommend this professional?

Highly recommended | Probably | Maybe | Probably not | Never

How would you rate this professional's bedside manner?

Excellent | Good | Satisfactory | Unsatisfactory | Awful

How long was the wait time in the office before you were seen?

Right away | Less than 30 min. | Between 30–60 min. | Over 1 hour | Over 2 hours

By signing this form you acknowledge that your provider gave you an authorization form explaining how this information would be used and processed (including outside of the United States), and that you have signed and returned that authorization.

Signature: _____ Date: _____

Thank you! Your responses will be visible on Zocdoc until Zocdoc elects to remove them or you revoke your authorization. To leave another review, please book your next appointment online at **www.zocdoc.com**.

Table 2

Major Themes and Identified Strategies

Major theme	Identified strategies
Use of patient satisfaction surveys	Zocdoc survey Collect survey responses and implement patient suggestions
Continual communication between staff and patients	Weekly meetings between management and staff members Communicate with patients via face-to-face conversations and/or telephone check-ins Communicate with patients the importance of quality improvement methods
Increased number of staff members	Increase recruitment efforts for staff members Recruit and retain staff members

Major Theme 1: Use of Patient Satisfaction Surveys

The use of patient satisfaction surveys was the first major theme of the study. A satisfied patient may end up with better outcomes; thus, health care providers must have a comprehensive understanding of patient satisfaction. The feedback received from patients was an important way for health care providers to understand patient experience and improve the quality of care effectively and facilitate patient centered care. The participants of the study used patient satisfaction surveys to help identify areas of needed improvement. The participants also used the results of the patient satisfaction surveys to measure the progress of quality improvement methods used in the health care facility. Specifically, P4 explained that by evaluating the effectiveness of quality improvement methods through patient satisfaction surveys, health care managers can achieve the goal of reduced patient wait times.

Patient Satisfaction Surveys and Quality Assessment

Based on literature, patient satisfaction is a criterion used for the quality assessment and improvement in health care (Abdulsalam & Khan, 2020). In the health care setting, patients are the essential capital of the hospital. Patient satisfaction is an outcome measure of a patient's experiences of care, health care outcomes, confidence in the health care system by reflecting whether the care provided has met the needs and expectations of the patient (Larson et al., 2019). According to P05, the continual use of patient satisfaction surveys can help health care management identify the areas of weakness within the organization that adversely impact the patients and the quality of

care.

Understanding Patient Experiences

Understanding patient experience represents an opportunity to elicit patients' expectations and their perceived treatment's effect, which could act as an indicator for evaluating and improving the quality of care (Wong et al., 2023). Patient satisfaction is the focal point in the organizing, execution, appraisal of service quality, and quality of health care (T. Fatima et al., 2018). In the health care setting, health care managers who utilize patient satisfactory surveys can obtain information vital to the patients' desire of their health care needs. The importance of collecting data regarding patient experiences could be treated as a kind of patient measure to improve the quality of care effectively and facilitate patient-centered care in the health care system (Wong et al., 2023). Each participant of the study used patient satisfactory surveys with each patient, reviewed the patients' responses, and incorporated the desires of the patients in the daily functions of the organization.

Major Theme 2: Continual Communication Between Staff and Patients

Continual communication between the staff and patients was the second theme of the study. Communication in health care is vital for human health and development (D. Gupta et al., 2021). The interconnectedness of health care involves communication among health care leaders and staff, patients and staff, and different departments. Hwang et al. (2014) stated that to help with quality improvement in health care and to help improve health care quality through effective implementation methods, there must be communication among health care leaders and a shared understanding of the need for

quality improvement measures in health care. Gehlert et al. (2019) stated that good communication is central to the provision of effective health care. If patient and provider can communicate in a way that leads to the accurate exchange of information, health outcomes are enhanced (Gehlert et al., 2019). P04 emphasized that continual communication should include regular meetings between management and staff members to discuss the effectiveness or ineffectiveness of quality improvement methods implemented within the organization. P04 also stated the positive outcomes of the quality improvement strategies should be publicized among health care employees and patients.

Communication in Medical Relations

Communication in medical relations is based on two fundamental types of behavior. The first fundamental behavior is connected with the instrumental aspect of curing the patient and reducing ailments and improving the quality of life (Kulinska et al., 2022). The second fundamental behavior is connected to the emotional and social aspects of communication as the relationship between a patient's sense of security and communication is based on kindness, trust, and empathy (Kulinska et al., 2022). D. Gupta et al. (2021) stated that effective communication is integral to, and forms the basis of, social and preventative medicine and health promotion. Effective communication involves the provision of critical information on health hazards, enabling individuals to take actions or change behaviors accordingly thus reducing societal levels of harm (D. Gupta et al., 2021). P03 discussed the importance of explaining to the patients what their experience will include while a patient in the health care organization. P03 shared that patients who were informed of what their experience would include were comfortable in

discussing their health care issues with the staff, regularly made their appointments, and were consistent in taking their medication.

Trust in Effective Communication and Patient Satisfaction

Kulinska et al. (2022) stated that trust is the most valuable product of effective communication and a source of patient satisfaction. From the patient's perspective, effective communication can be considered in terms of trust in the competence, honesty, and kindness of the doctors (Kulinska et al., 2022). A relationship based on partnership, trust, and effective communication between the patient and the medical staff positively influences the patient's perception of the illness and strengthens the sense of security for the patients (Kulinska et al., 2022). According to P2 and P3, communication with staff and patients regarding quality improvement operations and improvement strategies is imperative to the success of the organization.

Major Theme 3: Increased Number 0f Health Care Staff Members

The need of additional health care staff members is the third major theme of the study. With a growing and aging population across industrialized countries, the increase in disease burden, and a parallel aging physician workforce nearing the traditional retirement age, it is projected that there will be a shortage of up to 124,000 physicians in the U.S. by 2034, and a shortage of almost 4.3 million health care professionals worldwide (Kaplan et al., 2022). The quality of the U.S. health care system depends on improvements in effectively managed, highly education health care personnel, both quantitatively and qualitatively (Park & Yu, 2019). Park and Yu (2019) identified qualitative factors such as the proper placement of health care staff, improved job

satisfaction, the education level of the staff, and career length staff, affect the patient's health outcomes. A major challenge health care leaders face is securing a skilled workforce and avoiding the negative consequences of staff shortages (Winter et al., 2020). P01 stated that to serve more patients in a timely manner, additional staff is needed. P03 identified that the retaining of staff as a challenge. P03 further stated that because of not having enough staff, patients were becoming impatient regarding their assigned appointment time and stressed regarding obtaining the medical help needed for their ailment.

Adverse Effect on the Health Care System

Winter et al. (2020) identified several factors that adversely affect the health care system regarding staff shortages. Factors adversely affecting health care systems include staffing requirements based on changes in patient characteristics, changes in reimbursement of service provisions, aging staff, suboptimal planning of professional training, career pathways, exacerbating working conditions, and shifts in employee work values (Winter et al., 2020). Health care managers need to acknowledge that poor employee management and lack of skilled workers can result in resistance to change thus affecting the quality of patient care (Berhe, 2022). If managers do not acknowledge the unfortunate impact of not increasing health care staff, managers may have to address the negative effect on patient satisfaction (Winter et al., 2020). The lack of adequate health care staff members may result in managerial and operational barriers that health care managers need to address to prevent a drop in patient satisfaction and quality of patient care. P05 indicated that the lack of staff adversely effects the productivity of existing

staff since time between each patient is minimized resulting in the possibility of incomplete information in the patient's chart. P01 expressed the understanding of the adverse effects of being short staffed and attempts to schedule the patients far enough apart, but with not enough staff members scheduling the patients with time between them does not matter. P02 acknowledged that some appointment times take longer or shorter than other times resulting in lag time between patients. P02 further explained that recognizing lag time even with staff shortages, patients still deserve expected care.

Obligation to Embrace the Need to Attract and Retain Health Care Professionals

Kaplan et al. (2022) emphasized that health care professionals have an obligation to embrace the need to attract and retain the very best health care staff to serve patients and the communities. However, to attract and retain quality health care staff, leadership, collaboration, and a clear vision among the staff are needed (Kaplan et al., 2022). The staff shortage in health care presents a key vulnerability in the health care ecosystem resulting in severe access waits, delays, and forgone care (Kaplan et al., 2022). P4 and P5 stated that improving the overall staffing levels, acknowledging staff resistance to change, and increasing salary to retain staff are factors needed to help improve quality improvement and reduce patient wait times.

Methodology Interconnection

The findings of the single case qualitative study extended knowledge in the discipline by providing information on how private sector health care managers can reduce patient wait times. However, the findings presented in the peer-reviewed articles in the literature review did not present information regarding quality improvement

methods in the private health care sector. The peer-reviewed articles in the literature review also did not discuss in detail the use and importance of patient satisfaction surveys. Health care administrators should recognize that quality improvement initiatives that have the greatest impact on health care outcomes, safety, patient experience, and cost saving can be prioritized to achieve the health care agency's strategic goals (Priore & Beauvais, 2022).

Conceptual Framework Connection

The conceptual framework for the study was kaizen methodology. Health care managers can use kaizen methodology to identify the inefficiencies within the organization (Al-Hyani et al., 2019). Alvarado-Ramirez et al. (2017) discussed how health care managers utilize kaizen methodology in a health care environment to help with the continuous improvement in different aspects of health care. The acceptance of kaizen methodology and quality improvement in the health care environment by leaders can change the actions of staff and patients. The additional theory used in the study was the theory of constraints (TOC). TOC was identified by Goldratt as quality improvement theory that continuously identifies and leverages system constraints to achieve goals set by manager (Goldratt, 2981). Health care leaders who use TOC can improve decision-making in conflicting situations found in health care environments (Bauer et al., 2019). Kaizen methodology and TOC are appropriate for the intricacies of the health care system and the major themes identified.

The findings of this qualitative single case study presented by me presented information correlated to five barriers of kaizen methodology. Berhe (2022) identified

five barriers leaders who use kaizen methodology may face. The barriers are a lack of involvement from all staff, restriction of resources, lack of formal commitment and support of top management, lack of understanding, and resistance to change. The data presented by the participants of the study and the five barriers with kaizen methodology are intertwined. The data and the barriers are intertwined as the resistance to change may result in the ineffective implementation of quality improvement methods. The data presented by the participants of the study further added to the correlation to kaizen methodology. Recognized as a continuous improvement process, when health care managers use kaizen methodology and quality improvement methods, positive resultant outcomes occurred regarding the reduction in patient wait times.

Applications to Professional Practice

Health care managers use improvement methods to enhance the efficiencies of the health care environment and patient experiences. The applicability of the findings of the single case qualitative study acknowledged the impact of QIM in health care organizations. The health care organization's investment in substantial and sustainable quality improvement efforts results in the effective implementation of quality improvement (Priore & Beauvais, 2022). Bottle and Browne (2022) stated that the role of the private sector health care agency remains a part of the ever-present debate about the quality and safety of patients by private sector providers. Conversely, Bottle and Browne (2022) stated that subsequent studies presented information suggesting that outcomes at private health care facilities were superior for some patient groups. The authors further found that patients treated in private sector health care facilities had consistently shorter

stays and fewer hospital readmissions, lower rates of recidivism, and less requisite follow-up care (Bottle & Browne, 2022).

I identified three major themes to aid in the improvement of the experience of the patient in wait time reduction: (a) use patient satisfaction surveys, (b) continual communication between staff and patients, and (c) increased number of staff members. Zoutman and Ford (2017) identified impacts and success rates of quality improvement. Zoutman and Ford (2017) found that quality improvement positively improved numerous health care outcomes such as patient safety, patient care, and patient satisfaction. Health care leaders should consider incorporating quality improvement methods with the themes identified in this study. The use of satisfaction surveys, continual communication with staff and patients, and increased staff members can have a positive impact on patient satisfaction, reduction in wait time, and the overall efficiencies of the organization.

Implications for Social Change

Health care managers' lack of utilizing quality improvement methods is an issue facing health care managers and can adversely affect patient satisfaction. Disconnected health care leaders who do not address quality of care deficiencies may negatively impact overall organizational performance and may adversely affect patient outcomes (Vaughn et al., 2019). Private sector health care managers who utilize quality improvement methods can play an essential part in the positive social change of the health care system. By developing and implementing strategies for improving the quality of patient care, health care leaders can implement effective quality improvement changes for enhancing the quality of patients' and families' lives. The implication for potential positive social

change includes the potential of improved patient wait times thereby improving patient experiences, the overall wellness of citizens in the community, and enhancing the holistic care of the patient.

Recommendations for Action

I identified three strategies health care managers can use to help with patient satisfaction and reduce patient wait times, including (a) use of patient satisfaction surveys, (b) continual communication between health care staff members and patients, and (c) increase the number of staff members within the health care organization. The actions of private sector health care professionals who use quality improvement methods to help with patient satisfaction and reduction in patient wait may result in positive patient outcomes. Not all of the themes identified in the study are suitable for all aspects of health care. However, for private health care leaders who are facing challenges in reducing patient wait time and need to improve patient quality methods, those leaders should incorporate quality improvement methods to reduce patient wait times and improve patient satisfaction.

The results of the study can be significant to health care leaders in the private sector. Implementing quality improvement strategies to reduce patient wait time is a collaborative effort among the health care leaders, staff, and patients. To enhance awareness, I plan to share ~~the~~ findings with health care leaders via emails, publication in at least one scholarly journal, and during relevant meetings and conferences. Furthermore, I will share the findings via scholarly journals, meetings, and conferences.

Recommendations for Further Research

Other researchers may be able to enhance the findings of my study by sharing the positive outcomes of quality improvement use with additional private practice health care managers. A recommendation for further research would be to increase the geographic region and sample size of participants. Another recommendation is to have private sector health care managers continue to communicate with their staff and patients regarding the use of quality improvement methods. Private sector health care managers should also continue the use of patient satisfactory surveys to help incorporate what the patients want to see their health care managers implement. Health care managers should remain consistent with quality improvement methods to reduce patient wait times. However, for this qualitative single case study, I was able to recruit a sufficient number of honest and forthcoming participants who explicated their successful quality improvement methods.

Reflections

Throughout my matriculation in the DBA Doctoral Study process, I was encouraged to keep pressing on until the completion of the program. Every professor I had while in the DBA program was knowledgeable, concerned, and demonstrated a passion for the subject content. After overcoming life's unexpected events, changes in my professional career, and family dynamics, I stayed focused and determined to complete a goal I set for myself several years ago. Reflecting on the encouraging words of my mother and father, who both passed during my matriculation in DBA program gave me the courage to continue with the program. Reflecting on the notes left throughout the house by my daughter giving words of encouragement gave me the strength to continue

with the program. I am beyond grateful to everyone who has played a part in my doctoral journey.

I believe my research could help private sector health care leaders who are competing against the larger public sector health care organizations. The participants of this study provided valuable information regarding quality improvement strategies used in the private health care environment. Their expertise and extensive knowledge of quality improvement and what is needed for quality patient care resulted in rich data resulting in understanding of the importance of quality improvement to reduce patient wait times.

Conclusion

The participants of the qualitative single case study provided information regarding quality improvement methods in health care for reducing patient wait times in private sector health care environments. The private health care participants of the qualitative single case study specified information on how private practice agencies effectively utilize quality improvement methods. The managers of the private health care sector were able to incorporate patient satisfaction surveys and adjust practice methods to accommodate what mattered the most to their patients. Although the private health care sector is small compared to the public health care sector, lessons can be learned from the private health care administrators regarding quality improvement, reduction in patient wait times, and patient satisfaction.

The themes identified in the study were (a) use of patient satisfaction surveys, (b) continual communication between staff and patients, and (c) increased number of staff

members resulted in strategies used by the participants. The participants incorporated strategies of collecting survey responses and implementing patient suggestions. The participants conducted weekly meetings between management and staff members as well as communicating with patients regarding quality improvement methods and how their health care is impacted. The participants also used recruitment tactics to help recruit and retain staff members. Based upon the unique combination of study findings and the possible fulfillment of a research gap, all health care leaders – both public and private – should consider implementing the continual use of quality improvement methods detailed in this study, to reduce patient wait times and improve patient satisfaction.

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Appendix A: Interview Questions

Research Question

What strategies do health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?

Interview Questions

1. What strategies do you use to improve patient wait times and patient experiences?
2. What key challenges did you experience in implementing improvement strategies for patient wait time and patient experiences?
3. How did your organization address the key challenges to implementing improvement strategies to improve patient wait time and patient experiences?
4. What principal changes were made within the organization to help sustain improvement strategies?
5. How have you evaluated the effectiveness of the improvement strategies used to improve patient wait times and patient experiences?
6. How will the ongoing monitoring of quality assurance of patient wait time and patient flow occur in the office?
7. What additional information would you like to share related to the improvement strategies used to improve patient wait times and patient experiences?

Appendix B: Interview Protocol

What you will do	What you will say—script
Introduce the interview and set the stage—often over a meal or coffee	Thank you for agreeing to participate in the qualitative research study about the quality improvement methods used in health care for reducing patient wait times. As discussed in my email will meet for 30-40 minutes via face-to-face. You will be asked open-ended interview questions. Your answers will be recorded and transcribed. If needed, a follow-up meeting will occur if additional information is needed. The overarching research question of the qualitative research study is What strategies do health care managers in physicians' offices use to improve patient wait times and resultant patient experiences, which can improve repeat business?
• Watch for nonverbal queues • Paraphrase as needed • Ask follow-up probing questions to get more in-depth	1. What strategies do you use to improve patient wait times and patient experiences?
	2. What key challenges did you experience in implementing improvement strategies for patient wait time and patient experiences?
	3. How did your organization address the key challenges to implementing improvement strategies to improve patient wait time and patient experiences?
	4. What principal changes were made within the organization to help sustain improvement strategies?
	5. How have you evaluated the effectiveness of the improvement strategies used to improve patient wait times and patient experiences?
	6. How will the ongoing monitoring of quality assurance of patient wait time and patient flow occur in the office?
	7. What additional information would you like to share related to the improvement strategies used to improve patient wait times and patient experiences
Wrap up interview thanking participant	Thank you for answering the interview questions. The information shared during the interview will help in the identification of quality improvement strategies best used to help reduce patient wait times.
Schedule follow-up member checking interview	Script XXXXXXXXXXXXXXXXXXXX Follow-up member checking interview was scheduled with participants.

Follow–up Member Checking Interview	
Introduce follow-up interview and set the stage	Script XXXXXXXXXXXXXXXXXXXX Thank you for agreeing to the follow-up interview. Additional information and clarity is needed regarding the answers shared during the initial interview.
Share a copy of the succinct synthesis for each individual question Bring in probing questions related to other information that you may have found—note the information must be related so that you are probing and adhering to the IRB approval. Walk through each question, read the interpretation and ask: Did I miss anything? Or, What would you like to add?	Thank you for answering the interview questions. The information shared during the interview will help in the identification of quality improvement strategies best used to help reduce patient wait times.
	1. What strategies do you use to improve patient wait times and patient experience?
	2. What key challenges did you experience in implementing improvement strategies for patient wait time and patient experiences?
	3. How did your organization address the key challenges to implementing improvement strategies to improve patient wait time and patient experiences?
	4. What principal changes were made within the organization to help sustain improvement strategies?
	5. How have you evaluated the effectiveness of the improvement strategies used to improve patient wait times and patient experiences?
	6. How will the ongoing monitoring of quality assurance of patient wait time and patient flow occur in the office.
	7. What additional information would you like to share related to the improvement strategies used to improve patient wait times and patient experiences?