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Healthcare Leaders' Translation of Patient Feedback to Quality Improvement in Integrated Care

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Walden University

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Michele Adams

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2024

Abstract

Healthcare Leaders' Translation of Patient Feedback to Quality Improvement in
Integrated Care

by

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

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Abstract

Healthcare inequalities impact patient impression of the healthcare quality provided by healthcare institutions. This qualitative phenomenology study examined healthcare leader experiences in using patient input to enhance the quality of care within an integrated healthcare system. The primary research question involved understanding the lived experiences of healthcare leaders on using patient feedback to improve the quality of care in an integrated healthcare system. The conceptual underpinning was the patient feedback response framework. Braun and Clarke's six-step inductive thematic analysis was used to analyze transcripts. The findings from the participants' responses suggest that providing caring, patient-centered care was the factor that most strongly and positively influenced patient satisfaction. Patient satisfaction results identified gaps in quality of care and guided performance improvements, as well as facility cleanliness, orderliness, and privacy. Hindrances to the use of patient satisfaction results included staff limitations, resource constraints, and lack of receptivity to feedback as well as patient satisfaction and healthcare quality. Implications for positive social change include revealing a means through which integrated healthcare systems can use patient satisfaction feedback to enhance care quality and to turn patient perceptions into actionable quality improvement programs. The findings could guide policymakers to develop strategies to integrate patient feedback effectively, thereby promoting advancements in healthcare quality and performance.

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Dedication

I humbly dedicate this work to God the Father, who gave me strength, grace, and wisdom during my academic journey. I could overcome the obstacles I faced only because of His grace and favor.

In addition, I want to dedicate and express my heartfelt appreciation to my dear spouse, Cliff. You have been my unwavering support and strength through every obstacle and triumph. I am deeply grateful for your constant love and encouragement, which words cannot fully express.

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Chapter 1: Introduction to the Study

The issue under study was the need to understand how healthcare leaders employ patient feedback to enhance the quality of care within an integrated healthcare system. The perspectives of insurance companies, care providers, managers, and caregivers play a vital role in determining the quality of patient care. However, it is equally important to consider the attitudes of the patients themselves (Miller-Matero et al., 2019). They are the most reliable source to identify the healthcare services they receive.

Responding to patient feedback is essential to developing programs that improve primary healthcare performance and quality of care for patients in an integrated healthcare system (Chen et al., 2019; Kangovi et al., 2018). Hospital administrators assess the quality of patient care by administering surveys to them upon their discharge. These surveys assess the level of satisfaction that patients have with the care they received (Chen et al., 2019). The incorporation of patient feedback is vital in improving the services offered by medical establishments, particularly when it is implemented. The current inadequacy arises from a limited understanding of how patients self-reported perceptions contribute to the enhancement of healthcare quality. Rai et al. (2019) highlighted the importance of evaluating healthcare quality and stressed the significant role of patient participation in this assessment.

The predominant societal concern revolves around the unequal distribution of healthcare resources, which directly impacts patients' view of the quality of care they receive. Kangovi et al. (2018) found that individuals with a lower socioeconomic status (SES) are more prone to experiencing poorer self-reported health, shorter lifespan, and a

higher prevalence of chronic diseases in comparison to individuals with a higher socioeconomic position. These authors argue that patients face financial restrictions and limited insurance coverage, which leads to reduced use of diagnostic tests and medications for chronic diseases and restricted access to healthcare. Patients from low SES who attend healthcare institutions have diverse perspectives of the services provided to them (Bombard et al., 2018). Many have negative perceptions, which affect their belief about the overall healthcare they receive and may explain why they report poor outcomes related to medical care.

Chen et al. (2019) recognized the absence of research that particularly investigates the correlation between self-reported patient satisfaction and several health outcome measures. Their primary emphasis lies on establishing a correlation between unique patient traits and the subsequent impact on their health outcomes. To enhance the overall satisfaction of patients in healthcare institutions, it is crucial to get a comprehensive understanding of the underlying determinants that contribute to patient happiness. This understanding enables the development of more focused strategies and approaches. The aim of this study was to establish a correlation between patient satisfaction and the extent of treatment administered. The study challenge is in line with the healthcare services program, specifically focusing on the quality of care in the healthcare industry. To ensure high levels of patient satisfaction, healthcare delivery tactics need to be improved and advanced by facilities.

Background

Patients are the most reliable source for identifying the healthcare services they receive. Larson et al. (2015) reported that patient satisfaction measures are significant for identifying specific areas of healthcare service delivery essential to individuals.

Aggregated patient satisfaction is a dependable measure that reflects if healthcare services match the specific needs and expectations of individuals (Larson et al., 2015). Larson et al. suggested that satisfaction measures were significant for identifying specific areas of healthcare service delivery that were essential to individuals. Responding to patient feedback is vital to developing programs to improve primary healthcare performance and quality of care for patients in an integrated healthcare system (Chen et al., 2019; Kangovi et al., 2018). Many healthcare systems have recognized the importance of patient-centered care (PCC) and have consequently transitioned to a person-centered approach (Larson et al., 2015). Larson et al. reported that this model values patient feedback and is associated with improved healthcare services.

According to the 2019 National Healthcare Quality and Disparities Report, the rate of progress in healthcare differed in various areas from 2000 to 2018, including person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability (Agency for Healthcare Research and Quality [AHRQ], 2020). Furthermore, there were ongoing differences in various aspects across different racial and ethnic groupings and also based on where people lived (AHRQ, 2020). Based on the Healthcare Access and Quality (HAQ) index, the United States has the lowest position compared to other nations with similar characteristics, with a score of 88.7 (Kurani et al.,

2020). In a retrospective cross-sectional study conducted by Chen et al. (2019), it was discovered that young males who identified as Black/African American, had Medicaid insurance, and had a poorer financial status were more prone to reporting insufficient levels of pleasure. Furthermore, the study conducted by Chen et al. found that low satisfaction levels were primarily linked to patient characteristics such as sex and race, which are not subject to modification. Arpey et al. (2017) conducted interviews with 80 state Medicaid enrollees and found that these individuals believed their SES influenced their access to healthcare.

Arpey et al. (2017) investigated the perceptions of healthcare practitioners regarding healthcare delivery and clinical decision-making when it comes to patients with low socioeconomic levels. The results revealed that most participants expressed concerns related to their low socioeconomic position, specifically in relation to their experiences and outcomes in the healthcare system. The core issues encompassed the connection between patients and healthcare providers, the availability of healthcare services, and the quality of treatment administered. These writers emphasized the need to comprehend the position of healthcare leaders in tackling bias, as this would enhance the abilities of healthcare practitioners and diminish healthcare inequities (Arpey et al., 2017). The performance of primary healthcare, namely in terms of its focus on society and its emphasis on family-centered therapy, requires enhancement (Chen et al., 2019).

Lloyd et al. (2018) proposed that person-centered coordinated care (P3C) was a major priority for stakeholders in the healthcare system, including providers, policymakers, professionals, and patients. P3C is an acronym that stands for care

coordination and person-centered care, as described by Lloyd et al. in 2017. This complex intervention requires support for changes in the behaviors of both patients and professionals, as well as the organizational structure. Its goal is to meet the preferences and needs of individuals (Lloyd et al., 2017). Lloyd et al. (2018) suggested that it is necessary to identify more suitable metrics for evaluating satisfaction with P3C through a process of iterative validation and adaptation. This is because there is a lack of clear methods available for obtaining individuals' experience with P3C in regular practice.

The quality of healthcare provided within the integrated U.S. healthcare system exhibits substantial variation across different geographical areas. From a demographic standpoint, there are significant disparities and discrepancies in the capabilities of healthcare practices (Barnea et al., 2020; Canedo et al., 2018; Hero et al., 2017; Levine et al., 2018; Potts et al., 2018). It is necessary to analyze the content of patient-reported outcomes (PRO) and their influence on the quality of healthcare services (Eton et al., 2014). Eton et al. (2014) suggested using tactics including clearly defining entities to facilitate the coordination of patient-reported outcome (PRO) initiatives and using information technology assistance to fully integrate PRO information directly into electronic health records (EHR). The authors also proposed the adoption of practical guidelines for assessing patient input and resolving any obstacles that may occur (Eton et al., 2014). Øvretveit et al. (2017) highlighted the importance of PRO metrics in assessing the quality of care with the aim of enhancing it. They suggested that using these measurements assists guarantee that care is directed towards the requirements and encounters of the patients. The authors demonstrated that PRO measures have the

potential to enhance healthcare services. This is pertinent to my study as it emphasizes the significance of patient feedback in improving quality.

Problem Statement

The objective was to comprehend the factors associated with healthcare leaders' use of patient feedback to enhance the quality of care within an integrated healthcare system (Berger et al., 2017; Chen et al., 2019; Griffiths & Leaver, 2018; Lee et al., 2017; McGowan & Reid, 2018). This issue was resolved by examining the firsthand experiences of healthcare leaders regarding the use of patient input to enhance the standard of care within an integrated healthcare system. The quality of healthcare in integrated healthcare systems in the United States exhibits substantial regional variation, with notable disparities and inconsistencies in healthcare practices based on demographic factors (Barnea et al., 2020; Canedo et al., 2018; Hero et al., 2017; Levine et al., 2018; Potts et al., 2018). The National Healthcare Quality and Disparities Report of 2019 found that the rate of improvement in healthcare varied across different domains between 2000 and 2018, including person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability (AHRQ, 2020).

Moreover, disparities persisted by racial and ethnic groups and residence location (AHRQ, 2020). According to the Healthcare Access and Quality (HAQ) index, the United States has the lowest ranking among similar countries with a score of 88.7 (Kurani et al., 2020). It is imperative to acknowledge that patients have a pivotal position in the healthcare system, and their feedback can be used to evaluate if their desires and preferences are being fulfilled (Rai et al., 2019).

Purpose of the Study

This study implemented a qualitative phenomenology approach to investigate the firsthand experiences of healthcare leaders regarding their use of patient feedback to enhance the quality of care within an integrated healthcare system. The key issue addressed in this study was the lack of understanding on how healthcare leaders use patient feedback to enhance the quality of treatment in an integrated healthcare system (Berger et al., 2017; Chen et al., 2019; Griffiths & Leaver, 2018; Lee et al., 2017; McGowan & Reid, 2018). The conceptual framework used in this research study to investigate the research problem was the patient feedback response framework (Sheard et al., 2017).

Research Question

The following overarching research question guided this study:

RQ. What are the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system?

Conceptual Framework for the Study

The Patient Feedback Response Framework (PFRF) guided this study. Sheard et al. (2017) developed the PFRF to explain factors that influence the staff's ability to implement quality improvement related to patient feedback effectively. The assumption was that actions to improve services based on patient feedback are more likely with the appropriate combination of three factors: normative legitimacy (NL), structural legitimacy (SL), and organizational readiness (OR; Sheard et al., 2017).

Normative legitimacy refers to the staff's willingness to acknowledge and respond to patient feedback. NL is the first component of the PFRF needed; without it, change rarely occurs. Structural legitimacy is the second component of the PFRF. The authors propose that SL consists of three interrelated concepts: autonomy, ownership, and resources. The staff must perceive that they have enough autonomy, ownership, and resources to respond to issues. Therefore, staff must believe they are free to respond to patient feedback, it is within their role to respond, and they possess the requirements to make the change based on the feedback received from patients. Alternatively, it is the third component necessary for the staff to enact change, and it refers to how staff believes inter-departmental and high-level system support can facilitate change.

The framework is in line with the suggested research, which aims to comprehend the viewpoints of healthcare leaders on the translation of patient feedback to enhance the quality of care in an integrated healthcare system. The study had the potential to provide information related to the leaders' perspective about (a) the legitimacy of the patient feedback; (b) their autonomy, ownership, and resources to effect change; and (c) having inter-departmental and high-level system support to facilitate change. These perspectives are essential components needed for healthcare leaders to affect change based on patient feedback. The presence or absence of these factors has an impact on the leaders' capacity to use patient feedback to enhance the quality of treatment within an integrated healthcare system.

Nature of the Study

This study used a qualitative phenomenological research methodology. A qualitative methodology allows a researcher to examine events and ask questions about the mechanisms and causes behind them (Aspers & Corte, 2019). Qualitative research methods allow researchers to perform in-depth explorations of phenomena and uncover themes that may not have been anticipated in advance (Aspers & Corte, 2019). Moreover, a qualitative method provides a structure for inductive theorizing, which entails deriving inferences from qualitative information that can be a valuable approach for examining unexplored or under-researched empirical contexts (Bansal et al., 2018). Therefore, the decision to use a qualitative research method was considered appropriate for this study as it allowed for an in-depth analysis of the research phenomena in its specific context, while also considering the viewpoints of the study participants and the contextual factors that influenced them (Yin, 2014).

The study employed a phenomenological methodology to investigate the participants' subjective experiences and perceptions of a specific phenomenon (Leedy & Ormrod, 2018). Phenomenological researchers aim to gather several viewpoints on a particular circumstance to generalize their findings as if they were part of the situation themselves (Leedy & Ormrod, 2018). A qualitative phenomenological approach enabled me to directly gather information from healthcare executives regarding their experiences with the phenomenon (Bradshaw et al., 2017). This study examined the firsthand experiences of healthcare leaders regarding the use of patient feedback to enhance the quality of care within an integrated healthcare system. Therefore, a qualitative

phenomenological design was considered appropriate for the purpose of this study, which was to understand the perspectives of healthcare leaders on feedback and the quality of care within the system.

The research data were collected from healthcare leaders employed in an integrated healthcare system who had the responsibility of enhancing the quality of care provided in the institution. The main method used to collect data was conducting in-depth interviews (Guest et al., 2013) using the Zoom platform. I engaged with the participants using semistructured questions to obtain rich details of the phenomenon. Essentially, in-depth interviews are a technique that allows for engagement with a participant in a manner that encourages detailed information exchanges. I conducted interviews with a total of 10 participants. The interview questions were prepared by referring to the existing literature and focusing on the specific subject being investigated. The ongoing COVID-19 pandemic has posed difficulties for doing in-person interviews. Instead, I engaged with the participants through phone calls or online video conferencing using Zoom. My committee members acted as a valuable resource throughout the study to verify the reliability and credibility of the data that was collected and processed. I used Braun and Clarke's (2006) thematic analysis approach during the data analysis phase.

Definitions

Healthcare leaders: Leaders in healthcare organizations (Lee et al., 2017; McGowan & Reid, 2018). In this study, healthcare leaders refer to department managers in these organizations.

Integrated health care: The systematic coordination of general and behavioral health care (Barnea et al., 2020; Sheard et al., 2017).

Patient-centered care: In health care, patient-centered care is where patients actively participate in their medical treatment in cooperation with health professionals (Lloyd et al., 2018).

Quality of care: The degree to which health care services for patients increase the likelihood of desired health outcomes (Akachi & Kruk, 2017).

Assumptions

Assumptions are ideas that researchers and possible readers of the study consider to be true or reasonable (Wolgemuth et al., 2017). To protect the research from the researcher's biased perspectives that confuse assumptions with infallible truth, it is important to be conscious of these assumptions (Wolgemuth et al., 2017). Therefore, it was crucial to consider assumptions to make well-informed decisions during the investigation. The current research is based on the following assumptions.

The research was carried out with the methodological assumption that a qualitative phenomenological research design was appropriate. The rationale for this assumption was that the qualitative phenomenological research approach is highly suitable for deepening the comprehension of the subject matter by offering a full depiction of its phenomena (Wolgemuth et al., 2017). The underlying premise of this study was that employing Sheard et al.'s (2017) PFRF as a conceptual framework is suitable for establishing the foundation of this investigation. The reason behind this assumption was that the PFRF had been extensively used in studying patient feedback

and its impact on enhancing the quality of treatment within an integrated healthcare system (Baines et al., 2021; Ramsey et al., 2019; Turk et al., 2020).

The underlying premise of this study was that gathering insights and viewpoints from healthcare leaders regarding patient feedback and quality of care would enhance the researcher's understanding of their perspectives. The studies conducted by Lee et al. (2017) and McGowan and Reid (2018) provide evidence that leadership positions in an integrated health care system have a substantial impact on delivering excellent treatment and generating suitable action plans. It was assumed that the leaders gave honest answers to the questions.

Scope and Delimitations

There was limited evidence that identifies how patient feedback is translated to policies and procedures to improve healthcare facilities' quality of care. This research could fill the gap by understanding the perspectives of healthcare leaders on how they interpret patients' self-reported perceptions of the care they receive for quality improvement. Data were gathered from healthcare leaders working in an integrated healthcare system in the United States' Northeast region responsible for improving the quality of care in the facility.

Delimitations refer to the limitations or restrictions that a researcher has control over (Theofanidis & Fountouki, 2019). The researcher intentionally establishes limitations to protect the authenticity of the research (Theofanidis & Fountouki, 2019). The following limitations were identified. The study was constrained by the choice of a qualitative phenomenological design. The data collected for this study were solely

qualitative, relying on texts and narratives as the main sources of information. Due to the particular scope and limitations of the study, no statistical findings were presented. The conclusions were obtained from the themes identified through a thematic analysis of the data. Moreover, this study was limited to healthcare leaders currently engaged in a consolidated system within the United States. The outcome of this delineation was that the potential to transfer and generalize findings was limited to the same sample and geographic categories.

Limitations

Limitations refer to constraints that are placed on study and are beyond the researcher's control (Theofanidis & Fountouki, 2019). An anticipated constraint arose from the difficulties in arranging meetings with the healthcare executives who willingly took part in the research. Another expected constraint was the recruiting of participants, which relied on obtaining consent from the chosen research site and the willingness of healthcare leaders to take part in the study. Furthermore, in relation to the COVID-19 pandemic and the enforcement of social distancing protocols, all interviews were conducted solely via the online platform Zoom.

Significance

In the present study, I sought to enhance the current body of knowledge by investigating how patients' views influence the enhancement of integrated care, a topic that has been neglected in prior studies. My main objective was to comprehend the methodologies employed to enhance the standard of treatment in integrated healthcare systems, as evidenced by patients' self-reported contentment. This study offers an

understanding of how integrated healthcare facilities convert patients' views of treatment quality into programs aimed at improving quality. The project aimed to enhance the performance of healthcare systems by using a person-centered healthcare model (Santana et al., 2018).

The current body of research on the impact of patient feedback on improving healthcare quality in various contexts is limited (Greenhalgh et al., 2018). Greenhalgh et al. (2018) highlighted the need for more proof of the transformation of patient feedback into policies and procedures that can improve the quality of healthcare services offered by medical institutions. Additionally, Ramsey et al. (2019) suggested that upcoming studies should concentrate on how response type, organizational culture, and the practical application of feedback are interconnected.

Moreover, the available research indicates that there have been few efforts to specifically examine the personal experiences of healthcare executives as they strive to use patient feedback to enhance the quality of treatment within an integrated healthcare system. This study examines the perspective of healthcare leaders regarding the possibility of solving gaps in healthcare. The research references the works of Bombard et al. (2018), Greenhalgh et al. (2018), and Ramsey et al. (2019). This study's findings can benefit academics and scholars regarding patient experience and healthcare quality, yield practical consequences, and foster positive social change.

To implement change legitimacy, providers need to exhibit normative legitimacy, develop structural legitimacy, and provide ownership and resources, which requires the hospital to be well-prepared for collaboration amongst departments or to seek support

from higher-level authorities to achieve transformation. Enhancing the level of preparation will enhance the engagement and support of staff members in facilitating the collection and solicitation of feedback from patients (Baines et al., 2021). Therefore, the study's findings have the potential to improve the effectiveness of the healthcare system and provide insightful information to leaders in the field, enabling them to use patient feedback to develop treatment strategies and raise standards for patient care. In turn, this improvement in care quality could benefit the well-being of patients in an integrated health care system and help promote positive social change.

Summary

Chapter 1 introduced the following subject areas: background, problem statement, purpose, research question, and conceptual framework. This study examined the experiences of healthcare leaders in an integrated healthcare system who used patient input to improve the quality of care. A qualitative phenomenological approach was used to investigate the lived experiences of individuals who used feedback to enhance the quality of treatment. The theoretical framework used in this investigation was PFRF, as proposed by Sheard et al. in 2017. Chapter 2 provides an overview of the methodology used to look for relevant literature, the theoretical foundation of the study, and a comprehensive assessment of the major variables related to the research problem.

Chapter 2: Literature Review

This study implemented a qualitative phenomenology approach to investigate the firsthand experiences of healthcare leaders regarding the use of patient feedback for enhancing the quality of care. The quality of healthcare provided in an integrated healthcare system in the United States varies greatly across different regions. Additionally, there are significant differences and inconsistencies in the capabilities of healthcare practices based on demographic factors (Barnea et al., 2020; Canedo et al., 2018; Hero et al., 2017; Levine et al., 2018; Potts et al., 2018). The National Healthcare Quality and Disparities Report of 2019 found that the healthcare improvement rate varied across many domains, such as person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability between 2000 and 2018 (AHRQ, 2020). Furthermore, there were ongoing differences in various aspects between different racial and ethnic groupings and among individuals living in different locations (AHRQ, 2020). Enhancing the standard of care in a unified healthcare system poses a difficult challenge for numerous healthcare practitioners (Sheard et al., 2017). Nevertheless, the effect of using patient feedback to assess care quality in an integrated healthcare system remains uncertain from the standpoint of healthcare leaders (Berger et al., 2017; Chen et al., 2019; Griffiths & Leaver, 2018; Lee et al., 2017; McGowan & Reid, 2018).

Chapter 2 provides an examination of the current body of literature pertaining to the research problem. It encompasses four main sections: (a) an introduction to the topic, (b) the conceptual framework, (c) the many themes or subtopics, and (d) a concise

recapitulation. This literature review contains comprehensive insights from multiple researchers addressing the study's objective. To establish a solid basis for the research and identify any existing gaps in the literature, I conducted a comprehensive evaluation of peer-reviewed dissertations and consulted relevant journal articles. I initially used the resources available in the school library, as well as academic databases such as ScienceDirect and SAGE journals. I searched the literature by applying a variety of alternative search terms, such as *patient experience, feedback, reflective practice, health care disparities, low socioeconomic status, patient perceptions, primary care, patient feedback, online patient feedback, care opinion, level of care, integration, health delivery, health services, patient engagement, patient involvement, quality improvement, quality of care, patient satisfaction, health care outcomes, provider performance, health reform, health care access, use, patient-reported outcome measures, quality of life, patient-centered care, patient-reported outcome measures, patient-reported outcomes, quality improvement, and quality measurement*. One hundred percent of the literature sources are peer-reviewed, and all were published between 2017 and 2021.

Conceptual Framework

The conceptual framework for this study was the patient feedback response framework (PFRF; Sheard et al., 2017). The PFRF was developed by Sheard et al. (2017) to explain the factors that influence the ability of healthcare staff to use patient feedback effectively for quality improvement. In the PFRF, Sheard et al. (2017) assumed actions to improve services based on patient feedback were more likely with the appropriate combination of three factors: (a) normative legitimacy (NL), (b) structural legitimacy

(SL), and (c) organizational readiness (OR). Specifically, NL refers to the willingness of staff to acknowledge and respond to patient feedback (Sheard et al., 2017). The SL consists of three interrelated concepts, namely, autonomy, ownership, and resources, which Sheard et al. (2017) believed staff must have so that they could respond to an issue. Last, OR refers to how staff believes inter-departmental and high-level system support can facilitate the change implemented (Sheard et al., 2017). Sheard et al.'s (2017) PFRF was the appropriate conceptual framework for studying the research problem. Grounded in the PFRF, McGowan and Reid (2018) found that collecting feedback data from older adults presented unique challenges due to chronic conditions involving vision, hearing, speech, and cognitive processing.

McGowan and Reid discovered that nurses struggled to use feedback data for enhancing quality. This challenge was notably linked to inadequate leadership, the lack of clear goals and a defined action plan, and the demands of the clinical changes needed. Through the perspective of the PFRF and digital technology, Ramsey et al. (2019) carried out research aiming to categorize the types of responses from healthcare personnel on Care Opinion, a UK-based non-profit platform for patient feedback online.

Ramsey et al. (2019) discovered that there were differences in patient feedback and staff responses in three areas: (a) the level of specificity and personalization in the responses to the patient's story, (b) the degree to which participants embraced the public online discussion, and (c) whether participants indicated that the feedback had resulted in learning or influenced the delivery of care. Ramsey et al. (2019) discovered that staff

members exhibited diverse reactions to patient comments received online. These responses were influenced by the organization's policies and practices.

Most recently, using the PFRF, Baines et al. (2021) explored how an acute hospital implemented online feedback to support its improvement of quality of care. Employing semistructured interviews, Baines et al. highlighted the difficulties of implementing patient feedback and proposed that staff members be engaged and supported with opportunities to respond and invite patients to give feedback. Therefore, Sheard et al.'s (2017) PFRF was the appropriate conceptual framework for grounding this study because of its high relevancy and wide applications to researching patient feedback, and the role it plays in improving the quality of care in an integrated health care system (Baines et al., 2021; Maxwell, 2020; Ramsey et al., 2019; Sheard et al., 2017). Healthcare leaders improved services based on patient feedback by combining three factors: NL, SL, and OR, as suggested by Sheard et al. (2017). During the NL phase, staff should acknowledge and respond to patient feedback. In the next phase, staff had autonomy, ownership, and resources for them to respond to an issue. Last, in the final phase of OR, staff need to believe inter-departmental and high-level system support can facilitate the change implemented.

Quality of Health Care in the United States

Akachi and Kruk (2017) argue that the performance of health systems plays a crucial role in promoting sustainable development in the field of health and well-being. The success of universal health coverage initiatives is greatly dependent on the caliber of healthcare delivered (Akachi & Kruk, 2017). Citizens who are discontented with the

extent and variety of services offered are unlikely to support the allocation of public expenditures for healthcare (Akachi & Kruk, 2017).

Fatima et al. (2018) investigated the viewpoints of patients regarding private healthcare service providers, specifically emphasizing the standard of patient service in hospitals. The researchers analyzed the relative significance of quality parameters in forecasting patients' satisfaction and loyalty. In addition, the authors also examined how patient satisfaction acts as a mediator between the quality of healthcare services provided by hospitals and the loyalty of patients (Fatima et al., 2018).

Fatima et al. (2018) conducted a questionnaire study on a group of 611 patients from six privately owned hospitals in Islamabad, Pakistan. The data underwent analysis using descriptive statistics, common method variance, reliability, correlation, and regression. The objective was to investigate the impact of customers' perception of service quality on their intentions to remain loyal to private service providers. Fátima and colleagues demonstrated that private healthcare service providers made efforts to give enhanced healthcare services to their customers. Fatima and her colleagues confirmed that providing higher-quality healthcare services increased patient satisfaction and loyalty. They also suggested that specific characteristics of healthcare service quality, such as the physical setting, customer-oriented ambiance, promptness, communication, confidentiality, and safety, are positively correlated with patient loyalty. Patient satisfaction serves as the intermediary in that relationship.

Socioeconomic Status Affects Quality of Care

Health systems and care approaches differ significantly on a global scale due to factors such as local conditions, proximity to medical facilities, cultural practices, available resources, personnel availability, geographical factors, and political considerations (Barnea et al., 2021). Akachi and Kruk (2017) have found increasing evidence that the substandard quality of healthcare hampers the effectiveness of health initiatives in countries with lower incomes. There are substantial disparities in the amount of money spent and the actual results achieved in healthcare. The fragmented nature of the healthcare system, along with insufficient planning and uneven allocation of resources, leads to a failure in delivering critical life-saving treatments (Barnea et al., 2021). The clinical decision-making and healthcare delivery for individuals with low SES have been influenced by the perceptions of clinicians, as noted by Arpey et al. (2017). It is morally imperative to guarantee that every individual, even those in extreme poverty, obtains a minimum standard of care that effectively enhances their health. Nevertheless, the existing techniques for assessing the standard of care in low- and middle-income communities are inadequate for this objective (Akachi & Kruk, 2017).

Using in-depth interviews with 80 state Medicaid program enrollees, Arpey et al. (2017) aimed to identify recurrent themes in how they perceived hospital care. Arpey et al. discovered that most participants acknowledged that their SES had an impact on their access to healthcare. Arpey et al. discovered that the prevailing topics encompassed the provision of treatment, availability of healthcare, and the relationship between patients and healthcare providers. Canedo et al. (2017) examined the extent of racial/ethnic

differences in the quality of diabetes care in the United States. They analyzed data from the 2013 Medical Expenditure Panel Survey, which included information on persons diagnosed with Type 2 diabetes from throughout the country. The authors also analyzed the variations in adherence to five diabetes quality-of-care guidelines based on race/ethnicity, while accounting for three socioeconomic determinants of health and other demographic characteristics.

According to Canedo et al. (2017), the study revealed that in 2013, 74.9% of diabetic adults in the United States had undergone at least two HbA1c tests, 69.0% had received a foot examination, 64.9% had been given an eye examination, 85.4% had undergone a cholesterol screening, and 65.1% had been vaccinated against the flu. Canedo et al. discovered that Hispanics had lower rates than Whites in all areas examined. Blacks had lower rates than Whites in HbA1c tests, eye exams, and flu vaccine. Asians had lower rates than Whites in HbA1c tests, foot exams, and eye exams. The adjusted models revealed that the only residual discrepancies in quality-of-care indicators were observed in HbA1c tests for Hispanics, Blacks, and Asians; foot checks for Hispanics; and flu vaccination for Blacks. Canedo et al. found that the presence of racial/ethnic differences in diabetes quality of care could be partly attributed to the absence of insurance coverage and lower levels of education.

Hero et al. (2017) investigated disparities in income levels between 2011 and 2013 regarding individuals' self-assessments of personal health and healthcare across 32 nations with intermediate and high-income levels. In accordance with Hero et al. (2017), there was a significant disparity between high-income and low-income respondents in

their optimism toward health and health care across different countries. However, this gap was more pronounced in certain countries compared to others. Hero et al. (2017) discovered that the United States exhibited significant income-related disparities in many indicators, including both respondents' prior experiences and their confidence in getting necessary healthcare in the future.

Hero et al. (2017) found that there were comparatively low levels of moral discomfort about income-based healthcare disparities despite people being aware of the unmet needs. This suggests that there is a higher level of public acceptance for healthcare inequities in the United States compared to other countries. Hero et al. demonstrated that a majority of Americans perceived income-based healthcare inequities as unjust. The respondents exhibited a considerably higher likelihood of supporting substantial reform in the health system compared to their fellow citizens. These discrepancies can be attributed to the political divisions present in the United States.

The quality of healthcare provided within an integrated healthcare system in the United States varies greatly across different regions. Additionally, there are significant differences and inconsistencies in the capabilities of healthcare practices based on demographic factors (Barnea et al., 2020; Canedo et al., 2018; Hero et al., 2017; Levine et al., 2018; Potts et al., 2018). Arpey et al. (2017) emphasized the intricate perceptions that patients had on the impact of SES on their healthcare. Arpey et al. argued for a more thorough understanding of how health care disparities impact the relationship between healthcare providers and patients. Arpey et al. suggested implementing interventions aimed at promoting health equity through a comprehensive strategy, focusing on both

healthcare practitioners and the healthcare system. Fatima et al. (2018) provided a comprehensive analysis of patients' behavioral attitudes, contentment, and intentions to remain loyal to healthcare services based on their quality. Fatima et al. additionally presented the perspectives and opinions of patients regarding the quality of healthcare services.

Health Information System in Quality of Care

The adoption of a health information system (HIS) to improve healthcare services and enhance patients' experiences is becoming increasingly popular (Alsharo et al., 2020). Akachi and Kruk (2017) put forward six policy recommendations aimed at enhancing the measurement of quality of care and increasing its influence on policy. These recommendations encompass: (a) intensifying efforts to enhance and establish civil registration and vital statistics systems, (b) revamping facility surveys and reinforcing routine information systems, (c) developing novel quality measures suitable for low-resource settings, (d) incorporating the patient's viewpoint on quality, (e) allocating resources to national quality data, and (f) effectively communicating quality evidence to achieve policy impact.

In their study, Hallas et al. (2019) examined the interprofessional practices that facilitate collaboration between traditional and atypical health care professionals. Their main objective was to provide education to nurse practitioner preceptors and students regarding population health, with a particular focus on using geographic information system (GIS) maps to get insights into the opioid problem. The study entailed examining data from New York State pertaining to the opioid epidemic and juxtaposing it with GIS

map results of opioid usage in two boroughs of New York City. In addition, the team created online modules for evaluating Geographic Information System (GIS) maps that display the use of opioid drugs in relation to the areas of clinical practice. Their investigation revealed that state statistics provided a general understanding of opioid use, whereas GIS maps precisely identified the exact regions within the boroughs of New York City that were significantly affected by the opioid crisis. Hallas et al. concluded that local GIS maps were crucial due to their ability to provide real-time information, enabling the rapid design, evaluation, and modification of interventions to address the immediate needs of the community.

Alsharo et al. (2020) expanded the technology acceptance model by incorporating the concept of habit as an external factor that influences users' perception of the ease of use and utility of a healthcare information system (HIS). Their study specifically examined users' attitudes toward maintaining the usage of an HIS after its first adoption. Alsharo et al. investigated the views of experienced healthcare workers on the continued usage of an HIS. Alsharo et al. conducted a study in a developing country where a statewide HIS called Hakeem was established. The study demonstrated that in the healthcare sector, attitude had the most significant role in determining the continued usage of HISs. Alsharo et al. also showed that habit substantially impacted healthcare workers' perception of the usefulness and simplicity of use of HISs, leading to enhanced attitudes towards their adoption.

The use of an HIS to augment the standard of care and enhance the patient's experience has been a progressively growing trend (Alsharo et al., 2020). Nevertheless,

HISs offer insufficient and frequently untrustworthy data, whereas facility surveys gather numerous indicators with dubious usefulness, concentrate on a restricted range of services, and become outdated rapidly (Akachi & Kruk, 2017). Akachi and Kruk (2017) contended that current measurements inadequately captured the intricacies of the care process and the subjective experience of patients. Healthcare practices, which are a crucial aspect of quality assessment in high-income nations, were hardly documented despite their impact on patient outcomes.

Patient Feedback

An essential element of excellent healthcare and health systems is the focus on the individual, a feature that is both inherently and practically significant (Larson et al., 2019), which implies that every person should have the entitlement to be treated with dignity and respect. Furthermore, there is a correlation between person-centered care and enhanced use of healthcare services as well as improved health outcomes (Larson et al., 2019). Patient feedback in healthcare has been recognized as a valuable source of information for identifying areas for improvement and implementing successful strategies to enhance the quality of care (McGowan & Reid, 2018). As part of routine therapy, patients must fill out standardized and validated questionnaires, known as patient-reported outcomes, which assess their symptoms, functioning, and well-being (Snyder et al., 2019). Initially, patient-reported measure instruments were employed in research to assess the results of intervention studies. Over time, these instruments have expanded into a wide variety of tools that measure various concepts, such as quality of life and experiences of care (Lloyd et al., 2018).

Lloyd et al. defined PC3 as the delivery of care and assistance that is effectively structured and tailored to meet individuals' requirements and preferences.

Numerous international bodies, including the World Health Organization (WHO), are increasingly using this term. Lloyd et al. (2018) documented the PC3 methodology's successful adaptation and implementation at renowned universities worldwide.

PCC, or Patient-Centered Care, is a method that emphasizes an individual's right to make decisions for themselves and recognizes their equal involvement in the exchange of care (NCBI, 2016). Contemporary health and social care policy is progressively endorsing the use of patient-reported measure surveys to incorporate the perspective of patients into the process of redesigning services, which is particularly evident in the implementation of new care models like P3C (Lloyd et al., 2018). When selected with caution and used effectively, these tools can enhance care delivery in innovative ways, such as providing system-level feedback for health care administration and commissioning (Lloyd et al., 2018).

Using person-centered care metrics enables the evaluation of efforts to enhance quality. It ensures that health systems are responsible for patients and users (Larson et al., 2019). Nevertheless, the effectiveness of these measures is constrained in real-world scenarios due to the need for clear and precise guidelines for developing and implementing measures that capture various dimensions of person-centeredness (Larson et al., 2019). Hence, it is crucial to provide assistance and direction regarding the use of patient-reported measure surveys to enhance the quality of life and care encounters (Lloyd et al., 2018). In their study, Lloyd et al. (2018) found patient-reported measures

that could improve the development of P3C. They compared these measures to an existing model of P3C domains and organized the information in a user-friendly Web-based database. The authors employed a practical method to identify potential P3C-PRMs comprehensively. They used resources such as current compendiums, peer-reviewed and gray literature, and engaged with stakeholders.

Lloyd et al. (2018) subsequently correlated a portion of those potential measures with a theoretical model of P3C, enabling the identification of the specific construct being assessed and the subsequent creation of shortlists for general P3C measures, particular aspects of P3C and condition-specific measures in priority areas, as indicated by stakeholders. Lloyd et al. discovered 328 patient-reported measurements for P3C, which were then used to create a publicly accessible online database. Lloyd et al. discovered that 63 patient-reported measures for P3C satisfied the criteria for consideration, were categorized based on their measurement components, and aligned with the theoretical P3C model. The findings also revealed that all the necessary information was accessible through a user-friendly web-based portal. This portal included comprehensive details about each measure, including the specific constructs being addressed and links to relevant research and shortlists based on those characteristics.

Santana et al. (2018) concentrated on developing a person-centered care model through a collaborative effort with a patient partner, constructing a universal conceptual framework informed by a narrative review of literature on person-centered care. They incorporated facts, recommendations, and exemplary methods from established frameworks and case studies. Using the Donabedian model for healthcare improvement,

the elements of person-centered care were categorized into structural, process, and result groups to improve healthcare quality. They specifically identified critical structural components that are essential for person-centered care. These include fostering a culture of person-centered care across all stages, collaborating with patients to develop educational and health promotion initiatives, creating a supportive and flexible environment, implementing structures integrating health information technology, and evaluating the effectiveness of person-centered care.

Lloyd et al. (2018) created an extensive collection of patient-reported measurements for P3C using a practical and organized method involving stakeholders' input. Lloyd et al. determined the instruments with the highest coverage of P3C, demonstrating their content validity as outcome measures for new care models. Lloyd et al. also proposed that existing metrics should have addressed transitions and medication. In contrast, Santana et al. (2018) focused on the structural domain of the healthcare system or context in which treatment was provided. Their framework laid the groundwork for person-centered care and impacted the processes and results of care. Santana et al. proposed that this conceptual framework offers a systematic plan to assist healthcare systems and organizations in delivering person-centered care across different healthcare sectors.

Current health and social care policy progressively promotes patient-reported measure surveys to incorporate patients' perspectives into redesigning services, which is particularly evident in implementing new care models like P3C (Lloyd et al., 2018). If selected judiciously and used effectively, these instruments can enhance care

provision innovatively, such as providing system-level feedback for healthcare administration and commissioning (Lloyd et al., 2018). In theory, using person-centered care metrics enables the evaluation of efforts to enhance quality and ensures that health systems are held responsible to patients and consumers (Larson et al., 2019).

Nevertheless, the effectiveness of these measures is constrained in real-world scenarios due to the need for clear and precise guidelines for developing and implementing measures that capture various dimensions of person-centeredness (Larson et al., 2019). Therefore, support and guidance on using patient-reported measure questionnaires are critical to improving the quality of life and care experiences (Lloyd et al., 2018).

Santana et al. (2018) emphasized the significance of fostering effective communication and providing care that is both courteous and compassionate. They also stressed the importance of involving patients in the management of their own treatment and integrating different aspects of care. Lloyd et al. (2018) asserted that their accessible collection of tools was specifically created to serve as a gateway to the realm of patient-reported measurements for P3C. These tools are intended for use by healthcare commissioners, managers, and researchers. According to McGowan and Reid (2018), it is crucial to have adaptable and reactive feedback systems in place due to the varying health care experiences among different patient groups.

Patient Satisfaction Measures

Jerant et al. (2018) examined the correlation between patient satisfaction with the physician and the doctor's rejection of various types of patient requests, taking into account patient characteristics. They conducted a cross-sectional observational analysis

using a sample of 1,319 outpatient visits to 56 family physicians by 1,141 adults at a Northern California academic health institution. The researchers used six components of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Adult Visit Survey to evaluate patient satisfaction with the physician they had consulted. After collecting the data, the authors calculated the satisfaction score by averaging the standardized items. They then translated the score into percentiles.

An essential element of exceptional healthcare and health systems is the focus on the individual, which is vital in theory and practice (Larson et al., 2019). Therefore, every person must be given the entitlement to receive medical care that is marked by decency and respect. Moreover, an association exists between person-centered care and increased consumption of healthcare services, along with improved health outcomes (Larson et al., 2019).

Older persons with more complex health issues have a lower level of satisfaction with their general practitioner, according to a study by Poot et al. (2019). Poot et al. (2019) examined the potential correlation between improvements in integrated care received from their general practitioner and the reported health state of older individuals. The researchers specifically focused on changes in satisfaction levels among this population, while also considering their perceived health state at the beginning of the study. Poot et al. evaluated the degree of contentment with the general practitioner by using a 5-point Likert scale. At the start of the trial, the researchers assessed the participants' perceived health state using the Older Persons and Informal Caregivers

Survey-Composite End Point (TOPICS-CEP). The individuals were then grouped depending on their percentile rating.

Poot et al. (2019) subsequently demonstrated the variations in satisfaction improvement between the intervention and care/control groups, expressed as percentages of participants who reported being “very satisfied” and those who experienced an increase or decrease of one or more points on the Likert scale. The authors disclosed that both the intervention and control groups consisted predominantly of females who were living alone at the beginning of the study. Additionally, the average age of the participants was 83 years. The findings revealed that the percentage of participants in the intervention group who reported being “very satisfied” decreased from 44.4% at the beginning of the study to 37.1% at the end. Poot et al. discovered that the percentage of individuals who reported being “very satisfied” in the control group was 32% at the beginning of the study and 29.2% at the follow-up. When the data was analyzed based on TOPICS-CEP, the results remained unchanged.

Chen et al. (2018) suggested that poor satisfaction was associated with specific unmodifiable patient-level characteristics and mental health scores. Jerant et al. (2018) suggested that clinician denial of some types of requests was associated with worse patient satisfaction with the clinician but not for others when compared with the fulfillment of the recommendations. Poot et al. (2019) suggested that in older persons with a high level of complexity of health problems, person-centered integrated healthcare did not influence their satisfaction with the general practitioner and not among those with the highest or lowest perceived health state. Patient feedback instruments are generally

patient experience measures and patient satisfaction measures (Chaitoff et al., 2017; Chen et al., 2018; Larson et al., 2019). Chen et al. (2018) argued that patient satisfaction was a complex metric that could affect provider performance more than provider performance. Jerant et al. (2018) highlighted the need to train clinicians to deal effectively with requests, potentially enhancing patient and clinician experiences.

Patient Experience Measures

Keshtgar and D’Cruz (2017) examined whether patient feedback and questionnaires had a positive impact on the quality of care. The proposition suggests that using patient experience measurements is a more dependable approach for evaluating quality compared to patient satisfaction questionnaires. The authors contended that using patient satisfaction surveys as a foundation for dentists’ compensation inside the NHS was unsuitable. Chaitoff et al. (2017) conducted a study to determine the parameters linked to physician empathy and to investigate how physician empathy relates to standardized patient experience metrics. Chaitoff et al. gathered information about the demographics, professional, and empathy levels of physicians in the Cleveland Clinic Health System from 2013-2015. These data were collected before the physicians underwent mandatory communication skills training. To measure empathy, the researchers used the Jefferson Scale of Empathy. The authors specifically gathered data from seven measures, including six items related to provider communication and an overall rating of the provider. This data was acquired from both the visit-specific and 12-month Consumer Assessment of Healthcare Providers and Systems Clinician and Group (CG-CAHPS) surveys.

Chaitoff et al. (2017) used linear regression and ANOVA to examine the connections between empathy and provider attributes. Chaitoff et al. incorporated important factors into a multivariable linear regression model and assessed the associations between empathy and CG-CAHPS scores using Spearman rank correlation coefficients. The bivariable analysis conducted by Chaitoff et al. shown that several factors, including female sex, specialization, outpatient practice environment, and DO degree, were positively correlated with higher empathy scores among the 847 physicians included in the study. Chaitoff et al. discovered in their multivariable study that being female and having one of four specialties – obstetrics-gynecology, pediatrics, psychiatry, or thoracic surgery – were strongly linked to greater empathy scores. In addition, the findings revealed that out of the seven CG-CAHPS measures, the scores on five measures for the 583 physicians who had data unique to their visits, and on three measures for the 277 physicians who had data for a 12-month period, showed a positive correlation with empathy.

Understanding the patients' perspective in emergency departments (EDs) helps in the development and enhancement of services to meet the specific needs of patients (Male et al., 2017). In their study, Male et al. (2017) aimed to find patient-reported experience measures specifically for emergency departments (EDs). Male et al. also assessed the rigor and psychometric qualities of the developments, comparing them to conventional criteria. Male et al. conducted a systematic search of research evidence from several databases including Medline, Scopus, CINAHL, PsycINFO, PubMed, and Web of Science. They used particular search terms and inclusion criteria to identify relevant

articles. The search covered the period from the inception of these databases up until May 2015. The authors collected data on the development and performance of four patient-reported experience metrics from eight articles. The measures were evaluated based on quality standards. Male et al. discovered substantial variability in the caliber of creation and documentation of psychometric features.

Keshtgar and D’Cruz (2017) proposed that Patient-Reported Outcome Measures (PROMs) effectively assessed patient experience in the field of medicine. Hence, the implementation of PROMs in the field of dentistry should be taken into account (Keshtgar & D’Cruz, 2017). Chaitoff et al. (2017) proposed that there is a separate and distinct relationship between physician empathy and both specialty and sex. Chaitoff et al. also established a correlation between empathy and greater scores on many CG-CAHPS items. The findings revealed that the initial creation process for all four patient-reported experience measures involved gathering patient experiences through qualitative interviews. However, the evaluation of the instruments’ performance was inadequate. While certain research assessed the validity and reliability, they failed to quantify responsiveness, a crucial component of survey construction (Male et al., 2017).

Larson et al. (2019) examined the differentiation between two overarching classifications of metrics for patient-centered care: patient experience and patient satisfaction. Larson et al. provided guidance to policymakers, academics, and implementers on the process of measuring person-centered care. The authors specifically investigated (a) the potential applications of the measure’s findings, (b) the consideration of patient subjectivity, and (c) the validation or testing of the measure. Researchers can

enhance the usefulness of their measures by tackling these challenges throughout the design phase.

Male et al. (2017) argued that there was no standardized instrument to measure patient experience. Male et al. provided evidence that patient-reported experience measures were available in the EDs, but they had uncertain validity, reliability, and responsiveness. Male et al. suggested additional validation studies to evaluate the acceptability of patient-reported experience measures among patients and their practicality in clinical settings. Keshtgar and D’Cruz (2017) emphasized the significance of patient experience measurements. Their findings show that patient experience metrics are a more dependable method for enhancing the quality of clinical care compared to patient satisfaction surveys.

Online Patient Feedback

Patients are increasingly sharing their healthcare experiences publicly on the internet, as Ramsey et al. (2019) reported. As a result, the occurrence of online patient feedback has become more widespread on a global scale (Baines et al., 2021). Responding to online patient feedback is vital to improving patient safety and quality (Baines et al., 2018). The study conducted by Baines et al. (2018) aimed to identify factors that could improve the quality of responses, establish a framework for optimal response strategies, and assess the quality of current responses. Baines et al. used a systematic four-stage mixed methodology to conduct a search for tales that were published on Care Opinion on adult mental health care in the Southwest of England. The

authors used collaborative theme analysis to examine the responses and found characteristics that could improve the quality of the responses.

According to Ramsey et al. (2019), patients progressively disclose their healthcare experiences on the internet. In turn, the prevalence of online patient feedback has increased globally (Baines et al., 2021). Addressing online user feedback is crucial for enhancing patient safety and ensuring high-quality care (Baines et al., 2018). In the study undertaken by Baines et al. (2018), the researchers sought to identify variables that could enhance the quality of responses, provide a framework for the most effective response tactics, and evaluate the quality of existing responses. Baines et al. employed a systematic four-stage hybrid technique to search for narratives published on Care Opinion regarding adult mental health care in the Southwest of England. The authors employed collaborative theme analysis to scrutinize the responses and identified traits that could enhance the quality of the responses.

Ramsey et al. (2019) sought to categorize the various types of comments provided by healthcare workers on Care Opinion. On this non-profit internet platform, patients in the UK could express their personal experiences and opinions regarding health and social care services. Ramsey et al. qualitatively analyzed 486 stories about hospital care and 475 corresponding responses. They identified five distinct categories of responses: (a) no response, (b) standard responses, (c) responses expressing gratitude, (d) responses directing discussions offline while maintaining transparency, and (e) responses that engaged in a dialogue. Ramsey et al. identified the crucial factors that differed among these response types. These factors include the level of specificity and personalization in

the responses to the patient story, the degree to which responders embraced the transparent nature of the public online discussion, and whether responders indicated that the feedback had resulted in learning or influenced subsequent care delivery.

Boylan et al. (2020) conducted a scoping assessment and consulted with stakeholders in England and the UK to compile the existing evidence on online patient feedback. Boylan et al. conducted a comprehensive search for research evidence from various databases, including MEDLINE, EMBASE, PsycINFO, CINAHL, and the Social Science Citation Index. They also manually searched for relevant studies up until January 2018. The primary focus of their research was to include internet-based reviews and other online feedback, such as social media posts and blogs, from patients, caregivers, or the public regarding healthcare providers, individuals, services, or organizations. The authors identified significant findings and organized them into a table for further analysis, led by the themes that emerged from stakeholder consultation.

Boylan et al. (2020) found that the review process showed an increase in both awareness and usage of online comments. Boylan et al. discovered that the majority of comments received pertained to physicians and was generally positive in nature. The findings also demonstrated that certain service customers used online reviews and ratings to guide their selection of provider or therapy. Providers expressed apprehension regarding the accuracy and inclusiveness of the comments. Additionally, the researchers also discovered that those who provided comments were typically not a true reflection of the overall population and tended to be younger and more well educated.

Baines et al. (2021) investigated the use of online feedback to improve an acute hospital that had recently been placed under special measures by a regulatory agency. They conducted semistructured interviews with 11 key stakeholders involved in installing or using online patient feedback. The researchers used deductive thematic analysis, drawing upon the Normalization Process Theory. Afterward, they transformed the research findings into the Engage, Support, and Promote (ESP) paradigm, a model specifically created to expedite the acceptance of feedback. Baines et al. discovered that participants perceived the introduction of online feedback as a chance to acquire knowledge, make alterations, and enhance their performance. Baines et al. discovered that the characteristics that could aid in the implementation process were frequently associated with involvement, support, and promotion. In addition, Baines et al. identified obstacles to implementation that included staff concerns regarding time constraints, moderation procedures, and response obligations, although these were mentioned less frequently. Baines et al. further found that activities, including providing evidence-based responder training, often addressed such anxieties.

Baines et al. (2018) advanced existing understanding by providing previously unavailable guidance. Ramsey et al. (2019) proposed that staff members exhibited diverse reactions to patient criticism on the internet, and these responses were likely influenced by the organization they belonged to. Baines et al. (2021) reported that the workforce's perception of online feedback was predominantly positive, with 24 effects observed at both individual and organizational levels. These effects included enhancing worker morale, resilience, and pride.

In a society that has become increasingly digitalized, Boylan et al. (2020) emphasized that online patient feedback is a readily available, cost-effective, and widely used approach for collecting healthcare experiences. The study conducted by Baines et al. (2018) provided practical and theoretical insights that can be applied to enhance healthcare services, ensure patient safety, and increase the quality of care. Ramsey et al. (2019) suggested that fostering meaningful dialogues between patients and staff could provide valuable insights for enhancing healthcare. Ramsey et al. suggested that future study should concentrate on exploring the correlation between response style, corporate culture, and the practical use of feedback.

Boylan et al. (2020) also established a correlation between online feedback and healthcare quality metrics. Boylan et al. emphasized the significance of practicing mindfulness in preventing problems related to digital exclusion. Baines et al. (2021) stressed that the prompt adoption of online patient feedback can be accomplished in an organization under particular procedures. Baines et al. noted that the challenges associated with adopting such input should be noticed. Baines et al. suggested that staff members must be actively involved and receive enough assistance. They emphasized the importance of regularly encouraging patients and staff to provide, respond to, and seek patient feedback.

Patient Feedback for Effectively Improving Quality of Care

The COVID-19 pandemic showcases the practicality of swiftly organizing resources to deliver efficient and sophisticated medical treatment (Barnea et al., 2021). The implementation of new metrics that allow patients to report treatment outcomes can

now be used in quality improvement and reporting efforts, with the aim of enhancing the patient-centeredness of care (Øvretveit et al., 2017). Øvretveit et al. (2017) conducted a study to demonstrate the utility and significance of patient-reported outcome measures (PROMs) in quality improvement efforts. The paper also provides practical advice and tools for effectively using PROMs. Øvretveit et al. conducted a study of guideline materials on the use of patient-reported outcome measures for quality improvement. They drew on their own experiences with these measures in research and improvement, as well as their workshop at the 2016 Tokyo ISQUA conference.

The study conducted by Lee et al. (2017) investigated the use of patient feedback by hospital boards of directors in the development of strategies and the enhancement of care quality. Lee et al. conducted a comprehensive qualitative study in two acute hospitals, specifically chosen as contrasting models of gathering patient input, inside National Health Service foundation trusts in England. The researchers collected and analyzed data acquired through interviews with directors and managers, as well as observations from board meetings, scrutiny of board documents, and other pertinent information. Lee et al. used comprehensive qualitative and quantitative feedback from surveys to inform the development of strategies, establish quality improvement targets, and plan particular activities for enhancing quality. Lee et al. additionally discovered that both boards exhibited reduced use of feedback to monitor their strategies or expressly ensure the quality of services.

Greenhalgh et al. (2018) conducted a study to examine the factors that enhance patient care by using aggregated patient-reported outcome measures data. The study

aimed to identify the causes and circumstances in which this improvement takes place. Greenhalgh et al. discovered three primary program theories that serve as a quality improvement technique for patient-reported outcome measurements. These theories were expressed as nine “if-then” propositions. Greenhalgh et al. conducted a study where they used electronic databases and citation-tracking searches to find worldwide evidence that could be used to test these hypotheses. In addition, the authors enhanced the synthesis by incorporating information from comparable types of performance data. The researchers aggregated this knowledge by analyzing the mechanisms and impacts of patient-reported outcome measures and other performance data on quality improvement. Greenhalgh et al. identified three program theories based on their findings: (a) promoting patient autonomy, (b) enhancing transparency and responsibility, and (c) facilitating performance benchmarking for healthcare professionals.

Griffiths and Leaver (2018) aimed to determine whether the quick and automated collection and integration of different types of patient input could produce a comprehensive evaluation that precisely identified possible risks to healthcare quality. This evaluation could then be employed to aid in prioritizing inspections. Griffiths and Leaver employed a Patient Voice Tracking System to amalgamate patient input from various platforms such as NHS Choices, Patient Opinion, Facebook, and Twitter. This methodology generated a consolidated evaluation rating for acute hospitals and trusts, providing nearly instantaneous data on any specific day. The authors assessed the predictive effectiveness of the combined judgment score by logistic regression analysis. This study examined the relationship between the initial overall assessment score of 456

hospitals and the subsequent inspection outcomes conducted at the trust level. Griffiths and Leaver showed that gathering patient feedback led to a rise in both the amount and diversity of patient-centered viewpoints on the quality of care. Griffiths and Leaver established a definitive and unambiguous correlation between the group judgment score and the subsequent inspection outcomes.

Rai et al. (2019) performed a study to collect patient feedback to evaluate their perception of the quality of care offered at the Heroes clinic. Rai et al. performed a cross-sectional study to gather patient comments regarding empathy and the standard of treatment. For this objective, they employed the Service Quality Measures (SERVQUAL) and Dental Satisfaction Questionnaire (DSQ) frameworks. The authors calculated the mean scores to determine the average positive or negative responses. Rai et al. used Fisher's exact test to investigate discrepancies between patients' perception of care quality at the Heroes clinic and SERVQUAL and DSQ independent variables.

Rai et al. (2019) showed that 177 persons out of the total number of veterans polled responded, yielding a response rate of 35%. Out of the participants, over 50% fell within the age range of 20 to 35, and 63% of them self-identified as students. The estimated mean scores exhibited elevated levels for all factors. In their study using SERVQUAL data, Rai et al. discovered that veterans expressed agreement with the circumstances established by four empathy scales and all responsiveness scales throughout the bivariate analysis. Rai et al. employed DSQ bivariate analysis to illustrate that veterans exhibited concurrence with conditions assessed by four quality of care scores, two pain management scales, one accessibility scale, and their overall satisfaction

with the dental care they were provided. Rai et al. documented that Heroes Clinic provided veterans with exceptional dental care, as verified by the patients.

Berger et al. (2020) conducted qualitative exploratory multiple-case research to investigate the impact of hospital patient input on improving quality. Berger et al. obtained the data through nine interviews from March to June 2019. The study was conducted at three Brazilian hospitals that were chosen for their effective patient feedback processes. In addition, Berger et al. conducted a thorough review of documents and secondary data. According to Berger et al., including managers from various departments such as customer service, quality, nursing, operations, projects, and patient experience in three hospitals showed that the organizational goals related to patient feedback needed to be better defined. Berger et al. expressed managerial apprehensions regarding promoting a dynamic environment that can adapt based on patient feedback. The findings also indicated the presence of several patient feedback mechanisms, such as volunteer events, patient questionnaires, and informal feedback.

According to Greenhalgh et al. (2018), significant contextual aspects include the level of public openness, the use of financial incentives, the perceived credibility of the data, and the feasibility of the results. According to Greenhalgh et al., patients or their representatives seldom used available performance statistics when choosing a healthcare provider. In contrast, Griffiths and Leaver (2018) argued that a collective judgment score could effectively identify a high-risk group of businesses for inspection. This score is accessible almost immediately and provides more detailed information than most existing data sets. Berger et al. (2020) proposed implementing organizational procedures that

prioritize patients' input and ensure effective communication with the staff while fostering a culture that does not involve punishment. Berger et al. reported that the net promoter score served as the primary strategic measure of patient input to evaluate the effectiveness of improvement initiatives.

Research by Berger et al. (2020), Chaitoff et al. (2017), Greenhalgh et al. (2018), and Lee et al. (2017) has shown that patient feedback is a valuable tool for enhancing the quality of healthcare. In their study, Lee et al. (2017) discovered limitations in hospital boards' use of patient feedback. The findings indicate that boards should reassess their existing approach to ensure they properly use the various types of patient feedback to enhance, monitor, and guarantee the quality of care. Chaitoff et al. (2017) presented evidence supporting the idea that enhancing physician empathy could improve the overall experience for patients.

According to Greenhalgh et al. (2018), the perceived reason behind public reporting played a crucial role in influencing how providers reacted. According to Greenhalgh et al., doctors engaged in gaming or data manipulation when they were paid to collect performance metrics that they considered as not reliable. Greenhalgh et al. emphasized that the lack of promptness in data regarding the performance of providers limited their effectiveness. Consequently, Greenhalgh et al. suggested that healthcare practitioners should combine and analyze patient-reported outcome measures and other outcome data alongside other data, as the outcome data alone does not reveal the underlying reasons for inadequate care. Alternatively, Griffiths and Leaver (2018) suggested using the collective judgment score to prioritize inspections. In their study,

Berger et al. (2020) proposed that management should tackle the challenges associated with developing tools for measuring patient feedback, with a particular emphasis on targeted areas within the healthcare sector. Berger et al. emphasized that enhancing the healthcare team, providing various feedback channels, and using quality tools are valid foundations for patient feedback to facilitate quality improvement.

Implementing Patient Feedback: Challenges and Patient Engagement

Healthcare providers are now seeking more input from patients on their experiences. However, healthcare workers often face difficulties in properly using this feedback to improve services (Sheard et al., 2017). In addition, patient engagement can also have an impact on the results of integrating patient feedback (Bombard et al., 2018). McGowan and Reid (2018) conducted a study that specifically aimed to gather feedback data from older people who have distinct difficulties due to chronic diseases and comorbidities related to vision, hearing, speech, and cognitive processing. McGowan and Reid also discovered that nurses frequently acknowledged the difficulty of using feedback data to enhance quality. The challenge stems from inadequate leadership, the lack of specific objectives and a well-defined action plan, and the complexity of the necessary clinical transformation (McGowan & Reid, 2018).

In their study, Bombard et al. (2018) aimed to uncover the specific tactics and contextual aspects that facilitated the most effective involvement of patients in the process of designing, delivering, and evaluating health services. The authors conducted a comprehensive search of various databases including MEDLINE, EMBASE, CINAHL, Cochrane, Scopus, PsychINFO, Social Science Abstracts, EBSCO, and ISI Web of

Science. The search covered the period from 1990 to 2016 and focused on empirical studies that examined the involvement of patients, caregivers, or families in the design, delivery, and evaluation of health services with the aim of enhancing the quality of care. Using theme analysis, Bombard et al. discovered (a) the tactics and contextual elements that facilitated the most effective involvement of patients, (b) the results of patient engagement, and (c) the experiences of patients who were engaged.

Bombard et al. (2018) demonstrated that strategies and contextual elements that facilitated patient participation were categorized thematically and linked to methods for improving the design, recruitment, involvement, and leadership action, as well as establishing a receptive setting. Bombard et al. discovered that the reported outcomes varied in nature, ranging from the development of teaching materials or tools to the creation of policy or planning papers. These outcomes were aimed at improving care processes, service delivery, and governance.

Patient-reported outcomes can provide valuable information for patient care and management, a concept referred to as PRO-cision Medicine by Snyder et al. (2019). Snyder et al. sought to resolve the concerns using PRO-cision and incorporated fourteen research papers to enhance the analysis. Snyder et al. suggested that PRO-cision Medicine may assist clinicians and researchers in incorporating PRO reporting into clinical practice. This would be achieved by offering methodological principles and practical illustrations to support individualized patient treatment.

McGowan and Reid (2018) emphasized an approach for enhancement known as the Plan, Do, Study, Act cycle. This model offers a systematic learning strategy to

support the process of planning, testing, evaluating, and refining the feedback system. Bombard et al. (2018) proposed that the participation level influences service redesign outcomes. Specifically, they found that low-level engagement primarily leads to the development of discrete goods. On the other hand, the care process or structural outcomes mainly originated from extensive involvement at a higher level. Bombard et al. emphasized that involving patients in decision-making could provide valuable insights for improving patient and provider education, policy, service delivery, and governance.

Bombard et al. (2018) advocated for additional studies to grasp how patients perceive the engagement process and to determine if such interactions lead to enhanced care quality, a concept that ties into the current study's phenomenological qualitative method. Phenomenological research enables investigators to concentrate on the viewpoints and actual experiences of study subjects (Leedy & Ormrod, 2018). This research method is suited for the present study as it involves gathering diverse perspectives within the same scenario, aiming to generalize the results from an insider's perspective.

Summary

To provide a basis for the research and identify any gaps in current knowledge, I conducted a thorough search of peer-reviewed dissertations, consulted journal articles, and used resources available in the school library and academic databases such as ScienceDirect and SAGE journals. I acquired the available literature by finding articles that are pertinent to the stated themes, topics, and subtopics using several alternative search phrases. After conducting an extensive analysis of the available literature, four

major themes about the research problem were identified: The topics covered in this text are: (a) the standard of healthcare in the United States, (b) feedback from patients, (c) the use of patient feedback to enhance the quality of care, and (d) the difficulties and involvement of patients in implementing patient feedback.

During my investigation on the quality of healthcare in the United States, I discovered two key factors: the influence of socioeconomic status on the quality of care, and the impact of installing HISs on enhancing care quality. During the investigation and comprehension of patient feedback, three specific areas or tools were identified: (a) assessments of patient satisfaction, (b) assessments of patient experience, and (c) online patient feedback. All of the sources included in the study were peer-reviewed, and they were all published between 2017 and 2021.

The quality of healthcare provided in an integrated healthcare system in the United States varies greatly across different regions. Additionally, there are significant differences and inconsistencies in the capabilities of healthcare practices based on demographic factors (Barnea et al., 2020; Canedo et al., 2018; Levine et al., 2018; Potts et al., 2018). Hero et al. (2017) emphasized that if the Affordable Care Act is replaced, it is crucial to address inequalities to avoid regressing in an area where the United States urgently needs improvement. The Affordable Care Act has numerous features aimed at reducing disparities, and any replacement should similarly prioritize this issue. Arpey et al. (2017) emphasized the intricate perceptions that patients held on the impact of SES on their healthcare.

The adoption of HIS to enhance the quality of care and improve the patient experience has been increasing. Regrettably, HISs frequently offer inadequate and untrustworthy data, leading to several indications of dubious usefulness and a restricted range of services that become obsolete rapidly (Akachi & Kruk, 2017; Alsharo et al., 2020). Akachi and Kruk (2017) contended that current measurements inadequately reflected the medical process and the patient experience. Healthcare practices, which are crucial for assessing the quality of healthcare in wealthy nations, were seldom gathered to evaluate patient outcomes.

Current health and social care policies are progressively promoting the use of patient-reported measure surveys to incorporate patients' perspectives into redesigning services (Lloyd et al., 2018). In theory, using person-centered care metrics enables the evaluation of efforts to enhance quality and ensures that health systems are held responsible to patients and consumers (Larson et al., 2019). Nevertheless, the effectiveness of these measures is constrained in real-world scenarios due to the need for clear and precise guidelines for developing and employing measures that assess various dimensions of person-centeredness (Larson et al., 2019). Lloyd et al. (2018) said that aiding and direction on using patient-reported measure questionnaires was essential for enhancing the standard of healthcare. According to McGowan and Reid (2018), it is crucial to have adaptable and reactive feedback systems in healthcare due to the varying experiences of different patient groups.

Patient feedback instruments typically consist of measures that assess patient experience and patient satisfaction (Chaitoff et al., 2017; Chen et al., 2018; Larson et al.,

2019). According to Chen et al. (2018), patient satisfaction is a multifaceted measure that can have a greater impact on provider performance compared to provider performance alone. Male et al. (2017) presented evidence indicating that patient-reported experience measures were accessible in the emergency departments (EDs), but their validity, reliability, and responsiveness were unknown. Similar to the findings of Male et al. (2017), Keshtgar and D’Cruz (2017) emphasized the significance of using patient experience metrics. They presented research demonstrating that patient experience metrics are a more dependable method for enhancing the quality of clinical care compared to patient satisfaction surveys.

Research by Berger et al. (2020), Chaitoff et al. (2017), Greenhalgh et al. (2018), and Lee et al. (2017) has shown that patient feedback is a valuable tool for enhancing the quality of healthcare. Online patient feedback is a practical, cost-effective, and easily accessible method for collecting healthcare experiences (Boylan et al., 2020). Boylan et al. (2020) presented findings demonstrating a correlation between online feedback and some indicators of healthcare quality. Boylan et al. emphasized the significance of practicing mindfulness to prevent problems related to digital exclusion. Baines et al. (2021) emphasized that a specific organization might quickly incorporate online patient feedback.

Challenges arise in integrating patient feedback to enhance the quality of care from the viewpoints of patients’ engagement and healthcare professionals (Bombard et al., 2018; Sheard et al., 2017). Healthcare personnel frequently encounter challenges implementing this input to enhance services (Sheard et al., 2017). Active

involvement of patients can also impact the results of incorporating patient feedback (Bombard et al., 2018). The challenges of implementing such input should be considered (Baines et al., 2021). Chaitoff et al. (2017) presented findings suggesting that enhancing physician empathy could improve the overall experience for patients. According to Greenhalgh et al. (2018), the perceived motivation for public reporting was crucial in influencing providers' responses. Simultaneously, Greenhalgh et al. contended that the absence of promptness in performance data limited their effectiveness. Bombard et al. (2018) emphasized that involving patients in decision-making could provide valuable insights for improving patient and provider education, policy, service delivery, and governance.

Researchers studying the use of patient input to enhance the quality of care in the United States have identified practical implications. Arpey et al. (2017) proposed measures that sought to improve health equity by implementing a holistic strategy that targeted both healthcare professionals and the entire system. Lee et al. (2017) proposed that boards should evaluate their current procedures to ensure that they use various forms of patient input more efficiently to enhance, monitor, and guarantee the quality of care.

Santana et al. (2018) emphasized the significance of fostering effective communication and providing care that is both courteous and compassionate. They also stressed the importance of involving patients in the management of their own treatment and integrating different aspects of care. Jerant et al. (2018) emphasized the need of providing training to doctors to successfully handle requests, which could improve the experiences of both patients and clinicians. Greenhalgh et al. (2018) suggested that to

understand the reasons behind poor care, healthcare professionals should combine and analyze patient-reported outcome measures and other outcome data alongside additional data. Griffiths and Leaver (2018) proposed using the collective judgment score to help prioritize inspections. McGowan and Reid (2018) highlighted a model for improvement in the form of the Plan, Do, Study, Act cycle, which provided a structured learning approach to facilitate the planning, testing, analyzing, and refining of the feedback system.

In a recent study, Ramsey et al. (2019) suggested that meaningful talks between patients and staff could be beneficial in identifying areas for development. In their 2020 study, Berger et al. put up a management strategy aimed at tackling the issues surrounding the measurement of patient feedback. The proposed approach emphasizes the need to concentrate on particular components of healthcare. Berger et al. emphasized that enhancing the healthcare team, providing various feedback channels, and using quality tools are valid foundations for using patient input to promote quality enhancement. Baines et al. (2021) suggested that it is crucial for staff members to be actively involved and receive assistance, while also being given regular opportunity to provide, receive, and solicit feedback from both patients and fellow staff members.

Previous research on care quality in the United States and the impact of patient feedback on improving care quality have identified significant gaps in knowledge and recommended specific topics for further study. Arpey et al. (2017) highlighted the necessity for a more profound understanding of how inequalities in healthcare impact the connection between individual patients and healthcare providers. Male et al. (2017)

suggested doing more validation studies to evaluate the acceptability of patient-reported experience measures among patients and their practicality in clinical settings. Bombard et al. (2018) suggested conducting additional study to gain a deeper understanding of patients' experiences during the engagement process and to determine whether these experiences ultimately resulted in enhanced quality of care. Ramsey et al. (2019) proposed that further research should investigate the correlations among response types, organizational culture, and the practical implementation of feedback.

In addition, a thorough examination of existing literature indicates that there have been few efforts to investigate the firsthand experiences of healthcare leaders in their endeavors to use patient feedback for enhancing the quality of treatment within an integrated healthcare system. This study aims to address the research gap indicated by Male et al. (2017), Bombard et al. (2018), and Ramsey et al. (2019) by investigating a specific phenomenon. The investigation will be conducted within the theoretical framework of the PFRF model (Sheard et al., 2017) to extend the existing research trajectory. Therefore, this research aims to enhance the progression of knowledge by filling the identified research gap. The results of this study could be advantageous for academics and scholars working in the areas of patient experience and healthcare quality.

Chapter 3: Research Method

In this study, I used a qualitative phenomenology approach to investigate the firsthand experiences of healthcare leaders within an integrated healthcare system as they used patient feedback to enhance the quality of care. This chapter will thoroughly examine the research strategy and rationalization, the researcher's role, the methodology used, and the different elements of trustworthiness.

Research Design and Rationale

The research methodology uses a qualitative approach, enabling researchers to investigate a phenomenon and inquire about its causes and mechanisms (Yin, 2014). Typically, a qualitative research approach allows for in-depth investigations into phenomena and helps a researcher discover themes not initially expected in the study (Viswambharan & Priya, 2016). Additionally, qualitative research methods were considered suitable for this study because they require the researcher to carefully consider the environment of the research phenomenon being studied and the participants' perspectives, considering their specific contextual influences (Rahman, 2017). In this study, I aimed to investigate the firsthand experiences of healthcare leaders in using patient feedback to enhance the quality of care within an integrated healthcare system. As a result, a qualitative approach was used to assess qualitative data and engage in inductive theorizing to investigate the nature of this phenomenon.

According to Leedy and Ormrod (2018), a phenomenology study focuses on investigating the personal experiences and perspectives of participants on a certain topic. Phenomenological researchers hold the belief that by considering multiple perspectives

on a particular phenomenon, they can draw general conclusions. This strategy allows them to have a privileged understanding, similar to insiders, of information that is not readily available to others (Leedy & Ormrod, 2018). Therefore, employing a qualitative phenomenology design study would allow the researcher to gather firsthand information about a phenomenon through the participants' experiences. In this study, I examined the firsthand experiences of healthcare leaders. Therefore, a qualitative phenomenological approach was considered appropriate for obtaining a deep understanding of health executives' perspectives on how they use patient input to enhance the quality of treatment in an integrated healthcare system.

Role of the Researcher

To achieve the best possible results, it is crucial for the researcher to have a clear understanding of their position in the research process (Harvey, 2017). In this study, I assumed the role of both observer and participant, employing a qualitative phenomenological approach. Thus, following the recommendation of Zhong (2018), I undertook the tasks of selecting participants, conducting interviews, gathering data, and analyzing the collected data. I have found themes that accurately depict the real-life experiences of executives as they endeavor to convert patient input into actionable steps for enhancing the quality of treatment within an integrated healthcare system. Through the process of conducting interviews and gathering data, I created a secure and inclusive atmosphere that encouraged participants to openly express their personal thoughts and complex emotions (see to Harvey, 2017).

Given the significance of ethics, it is imperative for the researcher conducting a qualitative study to be aware of the potential harm they can inflict upon the participants and make efforts to mitigate these risks. Therefore, if participants displayed symptoms of anxiety or demonstrated indicators of discomfort throughout the interview, I ended the session and resumed it only if the participants expressed a desire to continue. The study participants were recruited from the facility where I worked. The inclusion criteria consisted of persons occupying senior roles inside the facility.

It is essential to emphasize that I did not hold a leadership role in this establishment, nor did I possess any influence over the leaders. I had no power dynamic or hierarchical interaction with the recruited people. Given my position within the facility, I had a natural inclination to comprehend the feedback given by patients before gathering data, which may have influenced my opinion that the hospital needs to use patient satisfaction scores when making decisions effectively. To mitigate this bias, I used bracketing and reflective journaling techniques to recognize, discern, and record my emotions and thoughts during data collection and analysis (Burkholder et al., 2016). Bracketing is a technique used to minimize the negative impacts of preconceived notions about the research to improve the project's rigor (Drew, 2004).

Bracketing in qualitative research serves to shield the researcher from the cumulative impact of analyzing potentially emotionally demanding content, hence safeguarding the researcher's well-being. To prevent the possibility of the results being adversely affected, I adopted the reflexive bracketing method that takes place even before formulating the research question, wherein I contemplated and defined some

preconceptions throughout the research process (Ahern, 1999). I was also aware that missing data or the involvement of poorly motivated participants would lead to research bias (Zhong, 2018). Thus, I ensured that such extraneous variables were minimized and avoided as much as possible. In addition, I continued to interview participants until saturation was achieved.

Methodology

This section explains the specific approach used to carry out this research. The rationale for participant selection, instrumentation, processes for recruiting, participation, and data collection are described comprehensively. Finally, the data analysis plan is addressed.

Participant Selection Logic

The population of interest for this study consisted of healthcare leaders within an integrated healthcare system in the United States. Leaders are typically responsible for overseeing departments, ensuring that care delivery outcomes are supervised, implementing changes within healthcare systems to enhance department efficiency, and establishing effective communication channels between staff and patients. The study focused on healthcare leaders from a specific hospital in the northeastern region of the United States. I enlisted 10 healthcare leaders who satisfied the criteria to investigate their encounters using patient feedback to enhance the standard of care in an integrated healthcare system. Participants were enlisted by sending flyers to the hospital leaders' email addresses. The flyer described the study's objective, criteria for participant participation, and my contact details. The flyer provided contact information for

individuals interested in obtaining further information about the study through telephone or email.

Sampling Strategy

In this study, I used a purposive nonprobability sampling strategy to enlist healthcare leaders from a hospital in the northeastern United States. The individuals who met the specific criteria were chosen using the purposive sample technique. This nonrandom method is not guided by theories or determined by a predefined number of participants. Instead, the researcher sets the necessary parameters and criteria for selection and recruits individuals who have the requisite knowledge or experience related to the study subject and are prepared to provide information (Etikan et al., 2016). The purposive sampling technique, also known as judgment sampling, is commonly used in qualitative research to efficiently find and select information-rich instances using the available resources (Etikan et al., 2016).

Participant Selection Criteria

Researchers need to consider specific groups of relatively homogeneous populations while focusing on a particular phenomenon with which the population is broadly associated.

Inclusion Criteria. The inclusion criteria identified the study population consistently in a reliable, uniform, and objective manner. The selection of participants for a study must be carried out in compliance with the requisite inclusion criteria (Rahman, 2017) to ensure the relevance of the sample to the study. The inclusion criteria for selecting the 10 study participants comprised (a) holding a leadership position within the

selected hospital for a minimum of 3 years, (b) supervising a minimum of three subordinates, and (c) holding experience with patient satisfaction measures or patient experience measures in an integrated healthcare system.

Exclusion Criteria. Exclusion criteria are specific characteristics of potential study participants who meet the inclusion requirements but have extra traits that could impede the effectiveness of the study or increase the chances of negative outcomes (Rahman, 2017). These characteristics could potentially influence the outcome variable as confounding factors. To eliminate the potential for prejudice, persons who hold the position of my direct superior or have a personal connection with me were not included in the study.

Sample Size. I recruited 10 participants from a pool of three directors of nursing, nine assistant directors of nursing, 10 senior leadership administrators, and 20 charge nurses. A sample of this size was deemed sufficient for a study of this nature because I presumed theoretical saturation to occur upon completing data collection and analysis from these 10 participants. Boddy (2016) stated the rationale for sample sizes in qualitative research is provided based on the specialized area of the study. In the context of this particular study, drawing participants from a pool of individuals tasked with different responsibilities under the overarching role of healthcare leadership would ensure a significant amount of homogeneity within the sample and diversity in the information gathered. This strategy was an advantage that the strategy of purposive non-probability sampling offers qualitative research. Thus, in line with the research objectives and with

consideration for theoretical saturation, 10 participants were sufficient for the size of the study sample.

Instrumentation

This study collected data via audio interviews using a semistructured questionnaire (Appendix D). The interviews took place using the Zoom video conferencing app. In such research interviews, I had the opportunity to probe into the facts, thoughts, perceptions, and opinions that participants hold concerning specific phenomena or behaviors (Leedy & Ormrod, 2015). Drawing from the literature review, I employed a set of questions aligned with the qualitative phenomenological approach to elicit in-depth responses pertinent to the research question. Responses from these semistructured interviews were recorded for subsequent analysis. Additionally, I used an interview protocol (Appendix C) for interviewing each participant.

Procedures for Recruitment, Participation, and Data Collection

I discussed the purpose of the study and my proposed plan for implementation with the chief administrator and the vice administrator; I received their support and encouragement to conduct the study. I met with an Associate IRB administrator representing the IRB at the facility. I was then informed that I would need to submit an application to the hospital's IRB for approval following the approval from the Walden University IRB. In addition, I needed to complete HIPAA training before applying to the facility's IRB.

After receiving approval from the IRB (#12-15-22-0316749), the following procedures took place for the recruitment, participation, and data collection in the qualitative study:

Recruitment

I sent recruitment emails to the leaders' work e-mail addresses so that they might respond online with much more convenience. Then, I determined an individual's eligibility to participate in the study. Upon determining that they were eligible to participate, I discussed the purpose of the study, what they were required to do, and whether their participation was voluntary. I assured them that their participation would be confidential. I informed the individuals there were no cash benefits.

I emailed the consent form to individuals who agreed to participate. The informed consent form explained the purpose of the study, expectations from the individual, and commitment in terms of time. Additionally, the participants were informed that the participation was voluntary, and that confidentiality would be maintained throughout the study.

Participation and Data Collection

Upon getting the signed consent (Appendix B), I scheduled a meeting to interview the participants within 2 weeks at a time and location of their preference; I emphasized that they should choose a discreet location where their conversation could not be overheard. I recruited until I could interview 10 study participants or achieve data saturation. Each interview lasted between 30 and 45 minutes and was audio-recorded on

Zoom. I imported the transcript into NVivo 14, a computer-assisted qualitative data analysis software.

Interview Questions

The following questions were selected for interviews with the participants.

1. What is your role as a manager?
2. What characteristics of the healthcare settings may influence patient satisfaction with the care they receive?
 - a. The physical environment
 - b. Practitioners (nurses, physicians, others)
3. What is your experience with how patient satisfaction results identify gaps in the quality of care to patients on your unit(s)?
4. What is your experience using patient satisfaction reports to develop quality improvement plans and initiatives?
 - a. What factors facilitated your use of the patient satisfaction results to effect change in your unit(s)?
 - b. What factors hindered your use of the patient satisfaction results to effect change on your unit(s)?
 - c. What is your experience implementing environmental changes based on the patient's evaluation?
5. What else would you like to add that we might not have covered?

Data Analysis Plan

During the process of data analysis, a researcher gains a deep understanding of a phenomenon by identifying patterns and themes related to the experiences of the participants (Zhong, 2018). The data analysis process has three main stages: data preparation, analysis and triangulation, and data and findings presentation. As a neophyte researcher, I received guidance from my committee members throughout this procedure. First, I organized the interview data by confirming that each participant has responded to all the interview questions. Then, I processed the data using the integrated transcribing capability provided in the cloud recording option on the recording page in Zoom. Subsequently, I furnished the participants with the transcript, soliciting their confirmation about the precision of the information they provided (Yin, 2014). Subsequently, I uploaded the transcripts into NVivo 14, a software designed to assist in the analysis of qualitative data.

A thematic procedure improves the reliability of research results by identifying common themes among the responses of all or most participants, which helps to reduce the impact of individual participants' biases or inaccuracies on the findings (Braun & Clarke, 2006). I conducted data analysis and employed triangulation using Braun and Clarke's (2006) six-step inductive thematic analysis:

1. Familiarizing myself with the data would involve reading and rereading it completely to gain familiarity with it.
2. I coded the data by grouping statements with similar ideas, perceptions, or experiences.

3. Following coding, I themed the data by grouping codes into a smaller number of more comprehensive themes. Data triangulation was conducted by running an NVivo matrix query wherein all codes and themes were cross tabulated with the data source to indicate commonalities or discrepancies among the themes and codes the data sources contributed.
4. After data triangulation, I reviewed and refined all themes by comparing them to the original data to represent the data patterns accurately.
5. The themes were named and defined in clear terms. Each theme was identified with distinct characteristics or jargon that represented it best, and these features informed its definitions, which I outlined clearly for the study.
6. Finally, the analysis of the data took place. Each theme was analyzed individually and then compared. In this study, I generated NVivo outputs, such as the codebook and export matrix query results, to facilitate the comparison of data across the data sources. Findings from these comparisons were outlined in the final write-up of the results.

Issues of Trustworthiness

To assure the accuracy and credibility of research findings, a researcher must establish the reliability and validity of a study, as outlined by Yin (2014). This methodology is implemented to minimize any potential biases. The trustworthiness of a study pertains to the level of confidence in the data, interpretation, and procedures employed by the researcher to assure the study's quality (Connelly, 2016). Ensuring the credibility and dependability of qualitative research is of utmost importance for its quality

(Ang et al., 2016). The four quality standards for all qualitative research projects are credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018). To assure the methodological rigor of my study, I used multiple criteria to evaluate the quality of the qualitative research methodologies deployed, as well as particular standards for each approach. The following discussion provides further details on the strategies and techniques employed to increase the credibility of the study.

Credibility

Credibility involves the believability of the study's findings. In empirical research, credibility is paramount (Connelly, 2016). To uphold the study's credibility, I employed a robust data collection strategy, conducted the study in the natural environments of the participating healthcare leaders who were directly connected to the phenomenon being investigated, devoted ample time for thorough data collection and to reach data saturation, and practiced researcher reflexivity. Such reflexivity ensured that I maintained awareness of the methods used to get the research findings and how the emergent patterns were documented (see Korstjens & Moser, 2018; Palaganas et al., 2017). In addition, I employed triangulation to compare and validate the findings obtained from various sources and approaches.

Transferability

Transferability refers to the degree to which a study's conclusions may be generalized and applied to different situations or settings (Korstjens & Moser, 2018). To enhance the evaluation of transferability, I furnished comprehensive explanations of the healthcare leaders included in the study and the methodology employed in the

research. This detail allows readers to assess the potential relevance of the findings to their circumstances. Additionally, to further support the study's transferability, I ensured the sample size was both sufficient and appropriate, comprising 10 healthcare leaders who satisfied the predefined eligibility criteria, thereby allowing for a comprehensive exploration of the research topic.

Dependability

Dependability refers to the extent to which research techniques are well-documented and consistently reliable (Korstjens & Moser, 2018). To improve the reliability of this study, I evaluated if the analysis adhered to the established criteria for the chosen research design. Following the recommendation of Korstjens and Moser (2018), I implemented an audit trail approach and recorded the investigation process. I furnished a comprehensive compilation of notes encompassing the decisions made throughout the study process, introspective reflections, sampling techniques, research instrumentation, the emergence of the findings, and specifics about data administration. Thus, implementing an audit trail facilitated the visibility of the research process.

Confirmability

The neutrality of the study is commonly known as confirmability (Korstjens & Moser, 2018). Regarding this element of the study, I ensured that the data's intersubjectivity was maintained, and that the interpretation was based solely on the data, without any influence from my personal preferences, values, or opinions. Similar to the procedure for ensuring reliability, the audit trail employed would uphold the study's confirmability. Alongside the audit trail, I considered researcher reflexivity to provide

knowledge of the overall process used to obtain the data and record developing trends (Korstjens & Moser, 2018; Palaganas et al., 2017).

Ethical Procedures

Prior to commencing the recruitment endeavors, IRB approval was secured to assure the implementation of sufficient measures for safeguarding human subjects. The selected hospital got site permission under the advice of the IRB. Participation was completely optional, following the ethical principle of Respect for Persons as outlined in the Belmont Report (National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, 1978). Each subject's autonomy was maintained by acquiring informed consent from all participants. The informed consent form delineated the study's objective, eligibility requirements, prescribed actions, voluntary nature of participation, and the guarantee of confidentiality for the submitted information. Data collection did not begin until participants willingly gave their consent by responding via email to indicate their agreement.

The Belmont report affirmed that the ethical principle of justice was maintained when research advantages and disadvantages were fairly allocated (Miracle, 2016). The study posed low risks to the participants, for they were not anticipated to be exposed to any higher level of danger than what they typically encounter in their daily routines. The process of using patient feedback to enhance the quality of care in healthcare settings within an integrated healthcare system has a positive impact on the well-being of patients, facilitates good societal development, and, in turn, promotes positive social change.

Summary

The present chapter offered an in-depth examination of the research design, the researcher's function, the technique and methodologies used, the data analysis strategy, the concerns regarding trustworthiness, and the ethical processes implemented in the study. The chapter commenced with providing a justification for the use of qualitative research methods in the study. A phenomenological study was chosen to explore the subjective phenomenon of healthcare leaders' lived experiences with using patient feedback to improve care quality in an integrated healthcare system, based on the perceptions of the participants.

To achieve this objective, I had to carry out interviews, gather data, and conduct analysis to discover patterns that would accurately depict the real-life experiences of the participants (Zhong, 2018). In this chapter, I recognized and elaborated on the role of the researcher. Participants were to be recruited from the facility where I am employed in the study environment. However, because I did not have a leadership role or the ability to influence the participants, my position in relation to the study may not have affected the data provided by the participants. Nevertheless, I was resolute in my efforts to uncover possible biases and reduce their frequency by employing the reflexive technique of bracketing and keeping detailed records of my actions.

A purposive nonprobability sampling strategy was suggested to enlist volunteers with specific expertise that aligned with the goals and focus of the study. Consequently, the study mandated that participants fulfill precise inclusion/exclusion criteria to qualify. Applicants must have had a mandatory minimum of 3 years of experience in a leadership

role at the chosen hospital, overseeing at least three subordinates. Additionally, they should have expertise working with patient satisfaction measurements or patient experience metrics in an integrated healthcare system. Individuals who had a personal connection with me were deliberately excluded from the study to eliminate the possibility of bias or any other factors that could distort the results. I planned to use audio semistructured interviews facilitated by the Zoom application to collect data from the participants, who were enlisted either phone or email. After obtaining the “I agree” on the informed consent, the participants were presented with a series of semistructured questions that were designed to correspond with the research objectives. The data underwent analysis using the six-step thematic analysis technique as described by Braun and Clarke (2006). This procedure involves transcribing and becoming comfortable with the data, coding, creating themes, reviewing themes, naming, and defining themes, and finally writing the report.

The study’s credibility, transferability, dependability, and confirmability were briefly established by the techniques implemented to verify the overall trustworthiness of the study. In addition, the text provided a comprehensive explanation of ethical considerations related to obtaining institutional approval, adhering to the beneficence criterion, obtaining informed consent, and ensuring the anonymity of participant data.

Chapter 4: Results

The objective of this qualitative phenomenological study was to examine the firsthand encounters of healthcare leaders regarding their use of patient input to enhance the standard of care within an integrated healthcare system. The primary research inquiry that guided this study was as follows:

RQ. What are the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system?

This chapter presents the results after having collected analyzed data described in Chapter 3, and includes the following sections: (a) setting, (b) demographics, (c) data collection, (d) data analysis, (e) evidence of trustworthiness, (f) results, which are organized by theme, and (g) a summary of the results.

Setting

The data collection was conducted using the online audio conference application Zoom. There were no personal or organizational conditions that influenced participants, or their experience at the time of study that might have influenced the interpretation of the study results.

Demographics

The participants were a purposeful sample of 10 individuals who met the following inclusion criteria: (a) holding a leadership position within the selected hospital for a minimum of 3 years, (b) supervising a minimum of three subordinates, and (c) holding experience with patient satisfaction measures or patient experience measures in

an integrated healthcare system. Individual demographic information about the participants is displayed in Table 1.

Table 1

Participant Demographics

Participant	Job title
P1	Senior Associate Vice President for Clinical Services
P2	Vice Chair for the Department of Medicine
P3	Chief Experience Officer
P4	Chief Nursing Officer
P5	Interim Medical Director, Emergency Department
P6	Director for Hospital Medicine
P7	Director of Nursing for the Medical-Surgical Division
P8	Chief Executive Officer
P9	Assistant Vice President for the Revenue Cycle
P10	Director of Clinical Operations

Data Collection

Data were collected through a one-to-one, semistructured interview with each of the 10 participants. The interviews were guided by a researcher-developed interview protocol (see Appendix D). All interviews were conducted online over Zoom and audio-recorded with the participant's consent using Zoom's integrated audio-recording feature. The average duration of the interviews was approximately 30 minutes. There were no variations from the data collection plan presented in Chapter 3, and no unusual circumstances were encountered during data collection. The following interview questions were asked:

1. What is your role as a manager?
2. What are the characteristics of the healthcare settings that may influence patient satisfaction with the care they receive?

- a. The physical environment
- b. Practitioners (nurses, physicians, others)
3. What is your experience with how patient satisfaction results identify gaps in quality of care to patients on your unit(s)?
4. What is your experience using patient satisfaction reports to develop quality improvement plans and initiatives?
 - a. What factors facilitated your use of the patient satisfaction results to effect change in your unit(s)?
 - b. What factors hindered your use of the patient satisfaction results to effect change on your unit(s)?
 - c. What is your experience implementing environmental changes based on the patients' evaluation?
5. What else would you like to add that we might not have covered?

Data Analysis

The interviews, once audio-recorded, were transcribed word-for-word into Microsoft Word documents through the use of otter.ai transcription software. These transcriptions were then uploaded into NVivo 14, a software designed for qualitative data analysis, as primary source files. The data analysis was conducted using the inductive thematic approach as suggested by Braun and Clarke (2006), which is outlined in six stages: (a) becoming thoroughly acquainted with the data, (b) generating initial codes, (c) developing themes from these codes, (d) reviewing these themes for coherence, (e) defining and naming the themes, and (f) synthesizing and presenting the findings. The

subsequent sections detail the implementation of these analytical steps on the collected data.

Step 1: Familiarization with the Data

I read and reread the data thoroughly to get more familiar with it, as Braun and Clarke (2006) recommended. This step was aimed to gain familiarity with the dataset to identify patterns of meaning within and across participant responses that could serve as the basis for code and theme formation in the following analysis steps. Handwritten notes regarding points of potential analytical interest, including repeated words, phrases, and ideas in the data were notated.

Step 2: Initial Coding

The data were divided into text segments, each conveying a single idea. An example of a text segment was the following excerpt from a response from P10: “ER, we are always open, we are always receiving, and when we reach capacity, it is tough to provide that timely care to patients when we do have a surge.” Each text segment from the participants’ responses was then assigned an initial code, and the initial codes were labeled with brief, descriptive phrases that summarized the meaning of the data assigned to them. The excerpt from P10 indicated that the ER staff could not provide timely care during a patient “surge” when the facility reached its maximum capacity for patients. The relevance of this response was that patient complaints about lack of timeliness in providing care could not always be addressed due to staff limitations, for staff were unable to provide timely care when demand exceeded their maximum capacity.

Therefore, the text segment from P10 was assigned to an initial code labeled, “staff limitations.”

When the various data segments were similar in meaning, I assigned the same initial code. For example, P2 said, “We cannot do everything our patients need.” This response from P2 and its subsequent elaboration expressed an idea similar to that expressed by the previously quoted response from P10. P2’s response was, therefore, assigned to the same initial code as P10’s response. Sixty-two data segments across the ten transcripts were assigned to 17 initial codes. Table 2 indicates the initial codes and the number of assigned text segments.

Step 3: Theming

Themes were derived inductively by organizing related codes into fewer, broader categories that encapsulate deeper meanings, as outlined by Braun and Clarke (2006). For example, the initial code, “staff limitations,” was grouped with three other codes to form a preliminary theme, including “resource constraints,” “unclear feedback,” and “unreceptive to feedback.” These four codes were identified as related and grouped to form a theme because they all indicated hindrances to using patient satisfaction results to effect change. Table 2 indicates how the 17 initial codes were grouped to form the four themes.

Table 2*Data Analysis Initial Codes*

Initial code (alphabetized)	<i>n</i> of participants contributing (<i>N</i> =10)	<i>n</i> of data segments assigned to code
Centralized reporting system	1	1
Facilitating staff engagement with patients	3	3
Identifying gaps in communication	1	1
Importance of patient-centered care	7	9
Improving cleanliness and orderliness	3	3
Improving privacy	3	3
Patient satisfaction reports only one tool used	2	4
Patients may identify gaps in care	8	8
Patients want a clean, orderly environment	3	4
Performance improvements guided by patient feedback	8	9
Reducing wait times	3	3
Resource constraints	3	3
Responsiveness to data	3	3
Staff limitations	4	4
Triaging areas for improvement	1	1
Unclear feedback	1	1
Unreceptive to feedback	2	2

Step 4: Reviewing the Themes

The themes were subjected to a review procedure to ensure that they met the criteria of internal homogeneity and exterior heterogeneity, as suggested by Braun and Clarke (2006). Internal homogeneity ensures that each theme is cohesive and focused on a singular concept, rather than being a broad concept that should be divided into multiple, more specific themes. In this case, all four themes satisfied this criterion. External heterogeneity, on the other hand, emphasizes the uniqueness of each theme, ensuring they

are sufficiently distinct to warrant presentation as separate themes rather than being combined into fewer, broader themes. All four themes met this standard as well.

Step 5: Naming the Themes

In Step 5, naming the themes involved assigning titles that reflected their relevance and contribution to answering the research question, thus highlighting their significance within the study. The data assigned to each theme were reviewed to assess its significance in the category of meaning the theme represented. For example, in the theme related to hindrances to using patient satisfaction results to effect change, the data and codes assigned to the theme were reviewed to assess the hindrances so that the theme could be named to reflect them. The theme was named accordingly. Table 3 indicates the names of the finalized themes, and the initial codes grouped to form each theme.

Evidence of Trustworthiness

To guarantee the integrity of research outcomes, a researcher needs to secure the study's reliability and validity, actions that are taken to minimize biases to the greatest extent feasible (Yin, 2014). The trustworthiness of a study refers to the degree of confidence in data, interpretation, and methods used by the researcher to ensure the quality of a study (Connelly, 2016). In terms of validity and reliability, establishing trustworthiness remains a crucial concern for the quality of qualitative research (Ang et al., 2016). The quality criteria for all qualitative research studies are credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018). To this end, I applied the criteria for measuring the quality of qualitative research methods and

specific criteria for each method. The following sections indicate the strategies used to establish this study's trustworthiness.

Credibility

The study's credibility is the confidence in the truth of the findings; in empirical research, credibility is the essential criterion (Connelly, 2016). To maintain the credibility of this study, this researcher (a) adopted a well-established data collection plan; (b) conducted the research in natural settings, where the participating healthcare leaders at the selected hospital were relevant to the phenomenon under study; (c) gave sufficient time to listen and document the data, in addition to achieving data saturation; and (d) paid due attention to researcher reflexivity, which reminded me to maintain an awareness of how the results of the research were reached and emerging patterns were documented (Korstjens & Moser, 2018; Palaganas et al., 2017).

Table 3*Data Analysis Grouping of Initial Codes to Form Finalized Themes*

Finalized theme: Initial code grouped to form theme	<i>n</i> of participants contributing (<i>N</i> =10)	<i>n</i> of data segments assigned to the theme
Theme 1: Patient satisfaction results identified gaps in quality of care and guided performance improvements Identifying gaps in communication Importance of patient-centered care Patient satisfaction reports only one tool used. Patients may identify gaps in care. Performance improvements guided by patient feedback Triaging areas for improvement	10	32
Theme 2: Patient satisfaction results guided improvements in facility cleanliness, orderliness, and privacy Improving cleanliness and orderliness Improving privacy Patients want a clean, orderly environment. Reducing wait times	9	13
Theme 3: Hindrances to the use of patient satisfaction results included staff limitations, resource constraints, and lack of receptivity to feedback Resource constraints Staff limitations Unclear feedback Unreceptive to feedback	10	10
Theme 4: Responsiveness to data and staff engagement with patients facilitated use of patient satisfaction results Centralized reporting system Facilitating staff engagement with patients Responsiveness to data	7	7

Transferability

Transferability addresses the extent to which the research findings can be applied to contexts outside of the original study sample and settings (Korstjens & Moser, 2018). To aid in assessing the transferability of the findings, I provided detailed descriptions of the healthcare leaders who participated, and the methodology used in the research. This information allows readers to determine if the outcomes of the study could be relevant to their own contexts (Korstjens & Moser, 2018). Furthermore, to support this goal, I verified that the sample size of 10 healthcare leaders was both adequate and suitable, ensuring they met the predefined eligibility criteria.

Dependability

Dependability refers to the degree to which research procedures are documented and reliable, which includes consistency (Korstjens & Moser, 2018). To enhance the dependability of this study, I assessed whether the analysis was in line with accepted standards for the selected research design. As suggested by Korstjens and Moser (2018), I employed the audit trail strategy and documented the inquiry process, developing a complete set of notes on decisions made during the research process, reflective thoughts, sampling, research instrumentation, the emergence of the findings, and details regarding data management. Such an audit trail allowed for the transparency of the research path.

Confirmability

The neutrality of the study is generally referred to as confirmability (Korstjens & Moser, 2018). Concerning this aspect of the study, I secured the inter-subjectivity of the data and ensured that the interpretation was grounded in the data, not in my own

preferences, values, or beliefs; much like the process to ensure dependability, the audit trail used maintained the study's confirmability. In addition to the audit trail, I considered researcher reflexivity to maintain awareness regarding the overall process by which the results were reached and emerging patterns were documented (Korstjens & Moser, 2018; Palaganas et al., 2017).

Results

The research question used to guide this study was: What are the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system? Four themes emerged during data analysis to address this question, as follows: (Theme 1) patient satisfaction results identified gaps in quality of care and guided performance improvements; (Theme 2) patient satisfaction results guided improvements in facility cleanliness, orderliness, and privacy; (Theme 3) hindrances to the use of patient satisfaction results included staff limitations, resource constraints, and lack of receptivity to feedback; and (Theme 4) responsiveness to data and staff engagement with patients facilitated use of patient satisfaction results. The presentation of the results is organized by theme.

Theme 1: Patient Satisfaction Results Identified Gaps in Quality of Care and Guided Performance Improvements

All 10 participants contributed data to this theme. The finding indicated that the lived experience of the participants of using patient feedback was that the feedback could identify gaps in the quality of care. When patient feedback from patient satisfaction surveys was used to identify gaps in quality of care, it could be used to guide

performance improvements. Performance improvements that participants had implemented based on patient satisfaction results included addressing gaps in provider-to-patient communication, increasing patient comfort, and reducing wait times. Most participants indicated that providing caring, patient-centered care was the factor that most strongly and positively influenced patient satisfaction.

Eight participants reported that in their experience, patients identified gaps in quality of care through patient satisfaction survey results. No participants provided discrepant data, disagreeing with this finding. P10 explained how the hospital collected patient satisfaction data: “When you leave the facility, you will get a follow-up [survey] from Press Ganey [Associates] asking you about how you were satisfied with your visit.” P2 explained that even the most well-meaning providers might have misconceptions about the quality of care they were offering and that patient satisfaction results could be valuable correctives for those misconceptions:

Patient care surveys are very, very important. Because as a doctor, I might have an opinion about myself, and I say, “I speak with you [the patient] in certain terms that are easy for you to understand. The responses I give you are quite appropriate.” However, that is just my opinion. Patients can provide feedback and say, “Hey, doctor, what are you saying? You rushed me because you had to go to an appointment, you did not give me the time. You were quick, and you answered medically using complex terminologies. I did not understand. However, I was embarrassed to tell you that I did not know what you were talking about” . . . [This is] something I might not have recognized, but my patients can tell me

exactly what they think I need to do to be better. Moreover, there is no replacement for this.

Speaking from a systemic perspective, P3 corroborated P2's response, saying that when healthcare leaders reviewed patient satisfaction results, those results often led them to identify gaps in care: "It is so often that when we see a trend identified by our patients, and we look into it, we investigate, we find breakdowns in those very systems and processes that they are complaining about." P6 described patient reports of dissatisfaction as an opportunity to identify areas for improvement: "Some complaints are legitimate, some are not. However, [even] when they are not, it is complaining about something that did not go correctly. So, there is an opportunity to try to fix an interaction or fix something in our system."

P8 noted that there were limitations to the improvements that could be made to address patient feedback (a finding that will be explored further under Theme 3), but P8 added that they made efforts to address gaps in care that patient feedback identified: "I cannot fix what the hospital looks like. I cannot fix the semiprivate rooms. However, to the extent of how we deliver care and treat patients, we do try to respond to the input from patients." P9 agreed, saying that their team attempted to address "every negative response that has some substance to it, where they can specifically point out certain things that should be taken into consideration and can be looked at." Thus, almost all participants reported that they had experience using patient satisfaction results to identify gaps in the quality of care.

All 10 participants indicated that they had experience using patient satisfaction results to guide performance improvements in areas where gaps in quality of care had been identified. P1 reported improving patients' waiting times based on patient satisfaction results: "I tried to address any delays or inefficiencies that lengthen a patient's total length of stay or waiting time. Time waiting to be seen, time waiting for CT scan, our initiatives to improve door-to-doctor time." P1 provided the following example of one such initiative:

It used to be that they [the patient] signed in, were triaged, got vitals, and saw a provider. So, the new system is nonlinear. So, once the patient signs in and gets an ID band, whether it be the nurse to triage, the tech to do vitals, or the physician to do the eval, it can happen in any order. They will get all the components, but it does not have to be a linear process so that if someone is available sooner than the other, they can get the patient started.

P2 reported that patients expressed in patient satisfaction results that they had trouble sleeping in the hospital at night. The resulting performance improvement was that staff were instructed not to wake patients to administer medication unless necessary: "If their [prescriptions are] written for once a day, or twice a day, we scheduled them so that they can be given during the times when the patients are awake, rather than having to wake them up at night." As a further measure to help patients get adequate sleep, P2 said, "We have also created ways to decrease the noise level at night so that patients are not awakened by overhead announcements in the unit, the operators and the doctors talking loud, and so forth." Overhead lights were lowered at night, and reminders were posted to

remind staff to keep their voices low. P7 reported that their team had received feedback that no one checked in with patients to ensure their needs were met. To address this feedback, P7's team issued iPads to nurse managers to ensure that rounds were completed and logged so that a record was created of the nurse manager's interaction with each patient and of the patient's condition at the time of the interaction:

There are questions [for the patient to answer, and the nurse manager to log the answers on the iPad] about if the staff introduced their names, if the doctor visited them, or if the nurse or the nursing staff responded to their call right away, is it within 10 minutes? 20 minutes? How many times did they press the call bell? Do they have any questions about their medications or side effects? And then if they have any questions about their condition right now. It is just like a yes or no thing . . . there is also a part there, like, say, when a patient has like, oh my gosh, nobody cleaned my bathroom. So, you put in the information there.

P10 reported that in the emergency room, patient feedback indicated that wait times were too long and that no one was checking in with waiting patients to update them on their care status. To address this feedback, P10 implemented a system involving student-nurse volunteers who would circulate to check in with waiting patients and update them:

One of the most significant feedback items I have gotten from the data I have collected from Press Ganey is the need for more information and waiting time. Moreover, when I dive more deeply, as I do my rounding with the patients in the ER, it is not just the waiting time; no one informs me what is going on, and no

one keeps me updated. I have been sitting here for XYZ amount of time, and no one has told me what is happening. One of the pilots I have implemented within this ER is to use volunteer student nurses to assist people with our electronic check-in system inside the waiting room. Also, there appears to be an extension to help keep the patients updated as to what processes are happening.

P5 reported using patient satisfaction results to identify gaps in physician communication. They indicated that physicians sometimes failed to manage patient expectations appropriately: “We, as doctors, do a terrible job communicating.” P5 indicated that when a patient presented with potentially worrisome symptoms. The doctor ordered a series of tests to rule out the worst possible explanations, “I would not find anything. And I would be like, ‘This is great!’ And like, ‘Everything is negative. You get to go home.’ [But] patients would be so angry,” because they still had no explanation of the symptoms that were troubling them. P5 learned from patient satisfaction survey results that they needed to manage expectations by conveying at the outset that their goal was not to test all possible explanations but only to ensure that the patient was safe:

My job is to . . . think about . . . the things that if I do not diagnose today, it could kill you tomorrow, and to prove that none of those things are happening to you. Moreover, when I do that, I feel great because I know you do not have one of these life-threatening problems. However, you might be frustrated because I have not answered why you came. Moreover, managing the expectations of the patients is crucial. Thus, all participants reported experience using patient satisfaction survey results to guide performance improvements in quality of care.

Seven participants expressed the perception that the aspect of care that most significantly influenced patient satisfaction was patient-centered care in the form of caring interactions between providers and patients. No participants provided discrepant data, disagreeing with this finding. P2 noted, “Patients are nervous, they are worried about their health,” and that, in consequence, they wanted to be treated with attention, care, and respect: “They just want to make sure that the person they are interacting with is honest, is paying attention to them, is responsive, that they are getting appropriate, truthful responses.”

P4 cited the importance of caring for and about patients: “We are caring, we are providing a caring environment, that human-to-human communication, I think, are the major factors in patient satisfaction.” P5 spoke of the need to be attentive to patients and think deeply about their needs and for providers to be “Open and receptive to hearing what it is that the patient needs or wants, able to hear those things that are maybe not spoken, but to see the nonverbals, and to get at the heart of the thing.” P10 spoke of welcoming the patient as necessary: “Our patients coming in through the ER are coming in under extreme stress and pain, and being welcoming is probably one of the biggest factors that will influence that relationship that we start with that patient.” Thus, most participants believed that providing caring interactions was the factor that had the most substantial positive influence on patient satisfaction.

Theme 2: Patient Satisfaction Results Guided Improvements in Facility Cleanliness, Orderliness, and Privacy

Nine of the participants contributed data to Theme 2. Whereas Theme 1 indicated improvements that participants had implemented to quality of care based on patient satisfaction survey results, the present theme indicates improvements to medical facilities based on patient satisfaction survey results. Improvements to medical facilities included increased orderliness, cleanliness, and privacy.

Three participants indicated that a clean, orderly hospital environment was the factor that most strongly and positively influenced patient satisfaction. Concerning having an orderly or disorderly environment, P6 said that noise in the hospital bothered patients, particularly at night: “Their impression is level of noise, which I know patients always complain about, especially at night when they are trying to rest, and many activities are happening in the hallways.” P6 suggested that an older facility might also negatively impact patients: “We are dealing with an older building. Moreover, I think that may sometimes affect patients’ impressions. I think [patients prefer] the shinier new rooms, which we do not have.” P8 cited several aspects of the older facility that they believed contributed to patient dissatisfaction: “We have issues with controlling the temperature, we do not have [individual] bathrooms, individual showers or patient rooms, these rooms are small and crowded, our clinic spaces are relatively small and crowded.” P9 explained that the physical appearance of a hospital was the first impression that set the tone of a patient’s later impressions of the facility and the care they received there:

For someone walking into a healthcare setting, it will be what the appearance is, influencing all our opinions about things. That has nothing to do with the care there directly. However, it will shape their opinion of the organization and the type of people that work there. So, hospitals must maintain a clean, safe environment. These three participants, therefore, indicated that in their experience, the physical condition and appearance of the hospital played a significant role in determining patient satisfaction results.

Three participants reported that they had experience using patient satisfaction survey results to guide improvements to facility orderliness and cleanliness. P10 spoke of cleaning up and decluttering the waiting area in the emergency room: “One of the things that that I did was declutter that area because that is another thing that could affect your satisfaction level if you are in an environment where you feel it is cluttered or claustrophobic.” P4 reported that patient satisfaction survey results indicated that garbage cans were too small or emptied too infrequently, so they overflowed frequently. P4’s team replaced the small garbage pails with larger ones and implemented “more frequent rounding by our environmental services people to ensure it is empty.”

P4 also said that the bathrooms in the older hospital facility appeared dirty because they were old, so patients often complained that the bathrooms were unsanitary. P4, therefore, ensured that bathroom cleaning occurred when patients would see it being done: “It is not that they are [bathrooms are] dirty, but they are just old, and just making sure that it is cleaned, and the patients see that cleaning, that they are reassured that they are in a safe environment.” P8 said, “On the postpartum unit, we are building showers

and bathrooms connected to the rooms to address patient complaints about not having individual bathrooms. So, we consider patient complaints and issues as much as possible.” P8 added that the hospital was upgrading its HVAC system and renovating its operating rooms at the time of the study.

Three participants reported that they had experience using patient satisfaction survey results to guide facility improvements to address patient concerns about privacy. P1 indicated that in the emergency rooms, technicians were taking patient vitals in the waiting room, and patients had complained about the lack of privacy. P1 said that to address that patient’s concern,

We made some minor changes and cleared out two of the three cubicles where the registrars used to sit, put up curtains that made it more spacious, and put a chair so that patients could be called behind the door and into a cubicle to have vitals with some semblance of privacy.

P5 reported that patients had been lying on stretchers in the hallways without privacy. To gain privacy, these patients were moved into rooms separated from their incumbent occupants by temporary partitions. P5 said, “If you are in a room, even if a curtain or screen separates a person next to you, it still feels more private than lying in a hallway where people are walking back and forth.” P9 indicated that the registration desk was too close to the waiting area in the outpatient lab, and patients complained about a lack of privacy when they provided their confidential information during registration. The registration desk was moved during remodeling in response to those complaints; P9 said: “In that remodeling of areas that we were going to do, we needed to consider separating

the registration desk, moving away from where the waiting area was, at least providing some privacy.” Therefore, these three participants indicated that changes were made to facility layouts or patient placements to address patient concerns about privacy.

Theme 3: Hindrances to the Use of Patient Satisfaction Results Included Staff Limitations, Resource Constraints, and Lack of Receptivity to Feedback

All 10 participants contributed data to Theme 3. The findings indicated four hindrances to using patient feedback to identify gaps in quality of care and guide improvements to quality of care. The most frequently cited hindrance was staff limitations, or limitations in the capabilities of staff to implement the changes that patient feedback requested. Resource constraints, including budgetary constraints, were the second most frequently cited hindrance. Lack of receptivity to feedback and unclear feedback were hindrances cited by a small minority of participants.

Four participants referred to staff limitations as barriers to implementing improvements based on patient feedback. P2 raised the example of being unable to turn off monitoring equipment that made noises that providers relied upon, but that might disturb some patients:

We cannot do everything that our patients need . . . we still cannot turn off the alarms and bells from the monitors because you are in the emergency. You always hear beep, beep, beep, beep, beep, beep, beep, beep, beep, beep, beep, beep, beep. It is an emergency room, everybody is running around, trying to do what they need to do to protect our patients and care for them. So, the beeps are essential. It

is a reminder for clinicians. However, if these beeps bother someone, I cannot just turn them off because somebody says, “Oh, is it so noisy here.”

P10 noted that personnel could always provide timely service when the emergency room’s capacity was reached or exceeded:

In the ER, we are always open and receiving, and when we reach capacity, it is challenging to provide timely care to patients when we do have a surge. I may need more resources to update patients as quickly as possible when we do not have that type of surge. Therefore, staff limitations made addressing some patient concerns unfeasible, such as when patients wanted short wait times when the emergency room was experiencing high demand or when patients wanted quiet when staff depended on audio feedback from monitoring equipment.

Three participants spoke of resource constraints as hindrances to implementing performance improvements guided by patient feedback. P1 acknowledged, “It is easy to fix things, sometimes, not everything, but easier to fix things if you have enough money.” P3 spoke more specifically about resource limitations confronting the hospital:

We always have short resources, particularly downstate. Moreover, we are a state-run urban center or inner-city hospital with limited resources and funding and limited development opportunities for donations from large corporations. So, we only sometimes have the resources we need to get things done.

P8 provided some corroboration about funding limitations, saying, “Changing the physical infrastructure is something we need support from the state to do. So, those are

things we cannot readily address.” Thus, funding constraints, like staff limitations, made addressing some patient complaints unfeasible.

Two participants described a need for receptivity to patient feedback by healthcare providers as a barrier to making improvements. P5 said, “I think many people are biased against it [patient feedback] because they have a healthcare bias, meaning they think there is a doctor, and they know best, and the patient just did not understand.” P9 also cited lack of receptivity to patient feedback as a danger, saying that too often, “We just push it [patient complaints] off as, ‘This patient is just being difficult.’” P9 said that instead, “We just need people to be receptive . . . Even when patients can be difficult, there is substantial truth to their concerns.”

P6 cited as an additional hindrance that, sometimes, patient feedback needed to be more precise to act upon. P6 said, “Sometimes, the feedback is not specific enough. Then you try to investigate and cannot figure out what went wrong. Thus, you cannot make change.” Thus, according to P6, patient feedback needed to be sufficiently clear and specific to be usable as a guide for identifying gaps in care.

Theme 4: Responsiveness to Data and Staff Engagement with Patients Facilitated Use of Patient Satisfaction Results

Seven participants contributed data to Theme 4. The remaining three participants should have addressed the findings. This theme indicated facilitators using patient satisfaction survey results to identify gaps in the quality of care and implement performance improvements. The two most frequently attested facilitators were responsiveness by hospital administrators and leaders to patient satisfaction survey data

and staff engagement with patients. One participant also referred to a centralized reporting system as a facilitator.

Three participants answered what facilitated their use of patient satisfaction data by indicating they responded to the data. P5 spoke of why specific improvements were made in the radiology department by saying that the data from patient satisfaction surveys appeared to demand those improvements:

Those things fall in line because if you look at the Press Ganey survey in the radiology domain, there is a specific question about how long it took to get the test done. Like, did you have radiology tests? Yes or No? Were you satisfied with how long it took to get the test? Thus, there are some things you need data to prove.

P8 agreed, saying, “We are driving change and how we care for patients on the unit by our satisfaction scores.” P9 also stated that responsiveness to the data was a facilitator of using the data to implement change: “Some of those changes were a direct result of the patient satisfaction surveys, and also the complaints that you would get when patients were sitting there waiting.” Thus, these participants noted that using patient satisfaction results in implementing improvements, which requires being receptive to that data and willing and ready to respond to it through appropriate initiatives.

Three participants indicated that staff engagement with patients facilitated using patient satisfaction results to improve the quality of care. Engagement with patients enabled staff to learn patient opinions, these participants indicated. P4 reported implementing multiple levels of rounding to garner patient feedback: “Besides the staff

rounding on the floors, the hourly rounding, there is also leadership rounding to get the true sense, so they know that there is someone beyond the level of the unit that they can reach out to.” P7 indicated that patient satisfaction depended on staff engagement: “Staff engagement is significant because patient experience is always congruent with staff engagement. If your staff does not engage, your patient experience will not be good.”

P6 referenced a centralized patient complaint reporting system as a facilitator of acting on patient feedback. P6 said, “There is a centralized system now where these complaints go through. Furthermore, a lot of that is through the incident reporting system...So that makes it easier for us to address it.” P6, therefore, found patient complaints easier to address when they were funneled through the centralized incident reporting system.

Summary

The research question used to guide this study was: What are the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system? Four themes emerged during data analysis to address this question. The first theme was patient satisfaction results, which identified gaps in quality of care and guided performance improvements. All 10 participants contributed data to this theme. The finding indicated that the lived experience of the participants of using patient feedback was that the feedback could identify gaps in the quality of care. When patient feedback from patient satisfaction surveys was used to identify gaps in quality of care, it could be used to guide performance improvements. Performance improvements that participants had implemented based on patient

satisfaction results included addressing gaps in provider-to-patient communication, increasing patient comfort, and reducing wait times. Most participants indicated that providing caring, patient-centered care was the factor that most strongly and positively influenced patient satisfaction.

The second theme was that patient satisfaction improves facility cleanliness, orderliness, and privacy. Nine of the participants contributed data to this theme. The remaining participants should have addressed the findings. Whereas Theme 1 indicated improvements that participants had implemented to quality of care based on patient satisfaction survey results, the present theme indicates improvements to medical facilities based on patient satisfaction survey results. Improvements to medical facilities included increased orderliness, cleanliness, and privacy.

The third theme was hindrances to patient satisfaction results, including staff limitations, resource constraints, and lack of receptivity to feedback. All 10 participants contributed data to this theme. The findings indicated four hindrances to using patient feedback to identify gaps in quality of care and guide improvements to quality of care. The most frequently cited hindrance was staff limitations, or limitations in the capabilities of staff to implement the changes that patient feedback requested. Resource constraints, including budgetary constraints, were the second most frequently cited hindrance. Lack of receptivity to feedback and unclear feedback were hindrances cited by a small minority of participants.

The fourth theme was responsiveness to data and staff engagement with patients, which facilitated the use of patient satisfaction results. Seven participants contributed

data to this theme. The remaining three participants should have addressed the findings. This theme indicated facilitators using patient satisfaction survey results to identify gaps in the quality of care and implement performance improvements. The two most frequently attested facilitators were responsiveness by hospital administrators and leaders to patient satisfaction survey data and staff engagement with patients. One participant also referred to a centralized reporting system as a facilitator. Chapter 5 includes discussion, interpretations, recommendations, and implications based on these themes.

Chapter 5: Discussion, Conclusions, and Recommendations

The problem addressed in this study was that it was unknown how healthcare leaders translate patient feedback to improve the quality of care in an integrated healthcare system. To address this study problem, the purpose of this qualitative phenomenological study was to explore the lived experiences of healthcare leaders about their use of patient feedback to improve the quality of care in an integrated healthcare system. A qualitative phenomenological design was used in this study, which can facilitate obtaining information directly about the experiences of healthcare leaders regarding the phenomenon (Bradshaw et al., 2017).

Data for the research were gathered from healthcare leaders working in an integrated healthcare system responsible for improving the quality of care in the facility. The primary mode of data collection was through in-depth interviews via Zoom. In this study, 10 participants were interviewed with a list of interview questions developed based on the literature review and the specific problem under study. Braun and Clarke's (2006) thematic analysis approach was adopted in the data analysis process. The significance of this research was that the findings of this study could help improve the performance of the healthcare system and provide valuable insights to healthcare leaders, who could translate patient feedback to develop care practices and enhance the quality of care. In turn, this improvement in care quality could benefit the well-being of patients in an integrated healthcare system and help promote positive social change.

The findings revealed that feedback from patients could identify gaps in the quality of care provided in healthcare facilities, resulting in improvement of services

based on the feedback. The performance improvement in healthcare services was to address the gaps in provider-to-patient communication, increase patient comfort, and reduce wait times. The findings from the participants' responses suggest that providing caring, patient-centered care was the factor that most strongly and positively influenced patient satisfaction. Research data showed that patient satisfaction outcomes led to improvement in facility cleanliness, orderliness, and privacy.

The study outcomes outlined hindrances to the use of patient feedback to identify gaps in the quality of care and guide improvement in care quality. The hindrances include staff limitations, resource constraints, including budgetary constraints, lack of receptivity to feedback, and unclear feedback. The patient satisfaction survey results can be used to identify gaps in the quality of care and implement performance improvements. Responsiveness on the part of hospital administrators and leaders to patient satisfaction survey data and staff engagement with patients are key facilitators of using patient feedback for improvement. Chapter 5 presents the interpretation of findings, limitations, recommendations, implications, and conclusion.

Interpretation of Findings

The overarching research question used to guide this study was: What are the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system? The interpretation of the findings was based on the themes discussed in the following subsections.

Patient Satisfaction Results Identified Gaps in Quality of Care and Guided Performance Improvements

The study findings indicate the importance of patient satisfaction outcomes in guiding performance improvement in healthcare facilities. When healthcare facilities use feedback from the patients, they can understand areas of improvement to ensure quality healthcare services for the patients. This study has provided great insight into the need to embrace and positively accept patient feedback regarding the quality of services, for it will help to identify areas of improvement in providing quality care. Participants indicated that using patient feedback could identify gaps in the quality of care. According to Lloyd et al. (2018), current health and social care policy increasingly advocates using patient-reported measure questionnaires for embedding the patient voice into service redesign through new models of care such as person-centered coordinated care (P3C). If chosen carefully and used efficiently, these tools can help improve care delivery in novel ways, including system-level feedback for healthcare management and commissioning (Lloyd et al., 2018). Consistent with the current research findings, patient satisfaction feedback provides insight to healthcare management regarding how to redesign services to suit patient satisfaction requirements, leading to improvement in healthcare service delivery.

Current study findings provide important information by indicating that when patient feedback from patient satisfaction surveys was used to identify gaps in quality of care, it could be used to guide performance improvements in healthcare facilities. Performance improvements could be based on patient satisfaction results, such as

addressing gaps in provider-to-patient communication, increasing patient comfort, and reducing wait times. Fatima et al. (2018) confirmed that better quality of healthcare services builds satisfaction and loyalty among patients. Fatima et al. suggested that the healthcare service quality aspects, such as physical environment, customer-friendly environment, responsiveness, communication, privacy, and safety were positively related to patient loyalty and mediated through patient satisfaction feedback.

However, the findings support the Fatima et al. (2018) study outcomes. Current study results added to the previous research by indicating the need for increasing patient comfort and reducing wait times. Employing various participant groups, methodologies, and settings might lead to variations in research outcomes. Current research findings have addressed the purpose of this study by highlighting the need for patient satisfaction feedback, including performance improvement and high-quality healthcare services.

Patient Satisfaction Results Guided Improvements in Facility Cleanliness, Orderliness, and Privacy

Receiving patient satisfaction feedback could contribute to improvements in facility cleanliness, orderliness, and privacy of patient data. Patient feedback concerning healthcare facilities could help healthcare facility management to enhance medical facility's increased orderliness, cleanliness, and privacy of patient data, which would improve patient satisfaction with the services received at the facility. The findings show the need for a clean, orderly hospital environment to positively influence patient satisfaction, concerning having an orderly, or disorderly, environment. Patients like an orderly and clean healthcare environment, which they believe is commensurate to the

quality of care provided at the healthcare facility. Similar findings to the current study were partly observed in Fatima et al. (2018), who highlighted the need for healthcare service quality aspects such as a clean physical environment, customer-friendly environment, responsiveness, communication, privacy of patient data, and patient safety impacted patient satisfaction.

Still, Santana et al. (2018) highlighted the importance of establishing a person-centered care culture throughout the entire healthcare journey, the joint creation of educational and health promotion and prevention programs with patients, fostering a supportive and welcoming environment, and the development and integration of infrastructures to facilitate health information technology alongside the measurement and monitoring of person-centered care outcomes. According to Santana et al., these practices could enhance patient satisfaction and yield positive perceptions regarding the healthcare facility and the quality of care delivered. The discrepancies observed between the findings of the current study and those from earlier research might stem from variations in the research environments, methodologies, participant groups, and the specific populations targeted. The findings have provided insight that has addressed the purpose of this study regarding the lived experiences of healthcare leaders about their use of patient feedback to improve the quality of care in an integrated healthcare system. The study has also contributed to the previous literature by establishing the need for a clean, orderly hospital environment to influence patient satisfaction positively.

Hindrances to the Use of Patient Satisfaction Results Included Staff Limitations, Resource Constraints, and Lack of Receptivity to Feedback

While the findings have provided strategies to enhance patient satisfaction in an integrated healthcare system, the research data also provided factors hindering the use of patient satisfaction feedback, such as staff limitations, limited resources, and lack of receptive feedback. The study outcomes demonstrate staff limitations contributing to the lack of use of patient satisfaction results as limitations in the abilities of staff to implement the changes that patient feedback requested. The findings concur with past research, which indicated that healthcare staff often find it difficult to act on patient satisfaction feedback to improve services (Sheard et al., 2017).

Patient engagement can also influence the outcomes of implementing patient feedback (Bombard et al., 2018). Current study findings have added to Bombard et al.'s (2018) and Sheard et al.'s (2017) findings by revealing that lack of receptivity to feedback and unclear feedback were hindrances to the use of patient satisfaction feedback. Consistent findings of current research can be found in previous literature, which revealed that patients are increasingly being asked for feedback about their healthcare experiences; however, healthcare staff often find it difficult to act on this feedback for improved services (Sheard et al., 2017).

The study findings indicated that limited resources, including budgetary constraints, were the second most frequently cited hindrance to the use of patient feedback in healthcare facilities to improve the quality of care. Øvretveit et al. (2017) recommended the use and value of patient-reported outcome measures in quality

improvement and gave practical guidance and resources. On the other hand, other studies also indicated that segmented health care, coupled with poor planning and inadequate resource distribution, fails to provide essential life-saving treatment, leading to negative feedback from patients (Barnea et al., 2021). This study has provided significant information concerning barriers to using patient satisfaction feedback for performance improvement in healthcare, including quality of care.

Responsiveness to Data and Staff Engagement with Patients Facilitated Use of Patient Satisfaction Results

Enhanced responsiveness to data and staff engagement with patients can promote the use of patient satisfaction feedback. The findings indicated that the facilitators used patient satisfaction survey feedback to identify gaps in the quality of care and implementation of performance improvements. These facilitators included responsiveness on the part of hospital administrators and leaders to patient satisfaction survey data and staff engagement with patients.

Creating a centralized reporting system can also help enhance the use of patient satisfaction feedback. Bombard et al. (2018) suggested that patient engagement can influence the outcomes of implementing patient feedback as staff can understand the needs of the patients and provide information for improvement through redesign of services. Responsiveness and engagement were also reported by Baines et al. (2021), who revealed the implementation of online feedback as an opportunity to learn, change, and improve, including the factors that could facilitate the implementation of feedback, such as engagement, support, and promotion.

The findings also revealed that staff engagement with patients can help in using patient satisfaction feedback to improve the quality of care. Engagement with patients enabled staff to learn patient opinions and experiences with the quality of care. McGowan and Reid (2018) suggested that the level of engagement influenced the outcomes of service redesign-discrete products primarily derived from low-level engagement. Bombard et al. (2018) highlighted that patient engagement could inform patient and provider education and policies and enhance service delivery and governance. The study findings have addressed the purpose of this research by establishing the factors influencing the use of patient satisfaction feedback for performance improvement and healthcare quality.

Limitations of the Study

One limitation of this study was the challenge of scheduling meetings with the healthcare leaders who voluntarily participated in the study. Another limitation was participant recruitment, which was based on the consent of the selected research site and the willingness of the healthcare leaders to participate in the study. Further, because of the COVID-19 pandemic and social distance measures, all interviews were conducted online via Zoom, which made it difficult to understand non-verbal communication, such as body movements that may suggest important information.

Data were gathered from healthcare leaders working in an integrated healthcare system in the United States Northeast region responsible for improving the quality of care in the facility. Restricting data collection to healthcare leaders from a singular region

could impede the generalizability of the research outcomes to various locales and demographic groups, including patients and healthcare workers.

The selection of a qualitative phenomenological design delimits the study. All data collected were qualitative, relying on texts and narratives to generate the needed data for this study. The consequence of this scope and delimitation is that no statistical findings were reported. Moreover, this study is delimited to healthcare leaders working in an integrated system in the United States. The consequence of this delimitation is that transferability and generalizability are only intended within the same sample and geographic groups.

Recommendations

Recommendations for Future Research

Future research should be conducted on the same topic but with patients, nurses, and participants to enhance the applicability of the findings to diverse healthcare facilities and locations. This set of participants may have different perceptions regarding patient satisfaction feedback and challenges encountered when collecting feedback from patients. McGowan and Reid (2018) identified specific difficulties in gathering feedback from older adults, attributed to chronic conditions affecting vision, hearing, speech, and cognitive processing. Additionally, they observed that nurses faced challenges in using this feedback data to enhance quality of care.

Due to the challenges of the COVID-19 pandemic and social distance measures, all interviews were conducted online via Zoom, which made it difficult to understand nonverbal communication, such as body movements that may suggest important

information. In this regard, future research can be carried out during this time without the COVID-19 pandemic to compare the research outcomes. The researcher highlighted that the current COVID-19 pandemic challenged face-to-face interviews. Also, limiting data to healthcare leaders from one specific region of the United States Northeast region may hinder the transferability of research findings to different locations and populations, such as patients and healthcare professionals. Based on this limitation, it is recommended that further research should be conducted in different settings to enhance the generalizability and transferability of research findings.

Recommendations for Practice

There is a need for implementing training and development programs regarding patient satisfaction feedback and staff engagement, which would help staff improve on the use of patient feedback for performance improvement. Baines et al. (2021) indicated barriers to implementation included staff anxieties about time pressures, moderation processes, and responding responsibilities, though they were less frequently described. Baines et al. further found that activities, including providing evidence-based responder training, often addressed such anxieties.

Healthcare facilities should implement staff-patient engagement programs to promote online feedback responses from the patients to facilitate its use in improving the quality of healthcare. Staff engagement, support, and promotion could lead to improvement in the use of patient satisfaction feedback for performance improvement in an integrated healthcare system. In implementing patient feedback for improving

healthcare quality, challenges occur from both healthcare professionals and patient engagement perspectives (Bombard et al., 2018; Sheard et al., 2017).

Healthcare organizations should adopt online feedback programs to improve the efficiency of feedback responsiveness through timely patient engagement in obtaining adequate feedback. Boylan et al. (2020) stated that online feedback, such as social media and blogs, from patients, careers, or the public about healthcare providers, individuals, services, or organizations could help facilitate performance improvement.

Implications

Implications for Positive Social Change

In this study, I sought to understand processes used to improve the quality of care in integrated healthcare systems based on self-reported patient satisfaction. This study provides insight into how integrated healthcare facilities translate patients' perceptions of the quality of care they receive into quality improvement programs. The study builds on improving healthcare systems' performance by implementing a person-centered healthcare model (Santana et al., 2018). There is a lack of evidence on how patient feedback could be translated to policies and procedures to improve the quality of care by healthcare facilities. Thus, this study's findings could help policymakers implement patient feedback use policies to enhance the quality of care. Furthermore, Ramsey et al. (2019) suggested that future studies should investigate the connections among the type of responses, organizational culture, and the practical application of feedback.

Focusing on this research problem from the perspectives of healthcare leaders has addressed the gaps by indicating that patient satisfaction results can help identify a quality gap in healthcare (Bombard et al., 2018; Greenhalgh et al., 2018; Ramsey et al., 2019). The findings of this study can benefit researchers and scholars in the fields of patient experience and quality of health care, make practical implications, and promote positive social change.

Healthcare facilities should take the initiative from this study's findings to create feedback responsiveness programs to collect data from patients concerning the quality of care received at the facility, which can be achieved through online feedback programs. Healthcare professionals must exhibit normative legitimacy, have structural legitimacy in place, and facilitate ownership and resources to enact change (Greenhalgh et al., 2018). Such improvements require the existence of the hospital's organizational readiness for inter-departmental cooperation or high-level assistance to achieve change, which will facilitate staff members to be engaged and supported with opportunities to respond and invite patients for feedback (Baines et al., 2021). Therefore, the findings of this study would help improve the performance of the healthcare system and provide valuable insights to healthcare leaders, who could translate patient feedback to develop care practices and enhance the quality of care. In turn, this improvement in care quality could benefit the well-being of patients in an integrated healthcare system and help promote positive social change.

Theoretical Implications

The patient feedback response framework (PFRF) was used as the conceptual framework for this study (Sheard et al., 2017). The PFRF explains the factors that influence the ability of healthcare staff to use patient feedback effectively for quality improvement. The current study has also provided factors that can help healthcare professionals use patient feedback for performance and healthcare quality improvement. The PFRF indicates that only when appropriate levels of individual and organizational capacity to change exist can patient feedback be acted upon to improve services (Sheard et al., 2017). The implication is that the current research findings support the PFRF by highlighting the need to use patient satisfaction feedback to make changes in healthcare quality provision.

In the PFRF, Sheard et al. (2017) assumed actions to improve services based on patient feedback were more likely with the appropriate combination of three factors: (a) normative legitimacy (NL), (b) structural legitimacy (SL), and (c) organizational readiness (OR). Specifically, NL refers to the willingness of staff to acknowledge and respond to patient feedback. The findings support this component of PFRF by revealing the need for responsiveness to patient feedback to make changes to existing healthcare policies. The PFRF also strengthened this study's findings by asserting the need for responsiveness for patient satisfaction results. Another element of PFRF was structural legitimacy (SL), which refers to the resources staff must have to respond to patient concerns and feedback regarding healthcare service quality. This study's findings also highlighted this element by revealing the need for resources to enhance the use of patient

feedback for performance improvement. SL consists of three interrelated concepts, namely, autonomy, ownership, and resources, which Sheard et al. believed staff must have so that they could respond to an issue.

The element of organizational readiness (OR) refers to how staff believes inter-departmental and high-level system support can facilitate the change implemented (Sheard et al., 2017). The results showed that organizations welcome all kinds of feedback, especially online feedback, viewing it as a chance to evaluate the quality of care provided. The current study findings indicated that staff engagement with patients can help in using patient satisfaction feedback for improved care quality, which is because enhanced engagement with patients provides healthcare staff with knowledge, patient opinions, and experiences with the healthcare services offered and the areas that need improvement. Baines et al. (2021) highlighted the difficulties of implementing patient feedback and proposed that staff members be engaged and supported with opportunities to respond and invite patients for feedback. Therefore, Sheard et al.'s (2017) PFRF was the appropriate conceptual framework for grounding this study because of its high relevancy and wide applications to researching patient feedback and the role it plays in improving the quality of care in an integrated healthcare system (Baines et al., 2021; Maxwell, 2020; Ramsey et al., 2019; Sheard et al., 2017).

Using this study's findings and the PFRF information, healthcare leaders would improve services based on patient feedback by combining three factors: NL, SL, and OR, as suggested by Sheard et al. (2017). During the NL phase, staff should acknowledge and respond to patient feedback. In the next phase, staff will have autonomy, ownership, and

resources for them to respond to an issue. Last, in the final phase of OR, staff should believe inter-departmental and high-level system support can facilitate the change implemented. It can be of great importance to healthcare facilities that decide to apply this study's findings to implement patient satisfaction feedback for performance improvement.

Conclusion

The present study aimed to explore the lived experiences of healthcare leaders on their use of patient feedback to improve the quality of care in an integrated healthcare system. Healthcare organizations require improvement in patient care, and this study would help them make informed decisions regarding the areas of improvement and how patient satisfaction feedback is crucial for their success in the healthcare sector. The importance of this study was to help improve the performance of the healthcare system and provide valuable intuitions to healthcare leaders who could translate patient feedback to develop care practices and enhance the quality of care. In turn, this improvement in care quality could benefit the well-being of patients in an integrated healthcare system and help promote positive social change. The research findings have provided insight that feedback from patients could identify gaps in the quality of care provided in healthcare facilities, resulting in improvement of services based on the feedback. This information can be used for performance improvement in healthcare services.

Research findings indicate various gaps to be addressed, including provider-to-patient communication, increasing patient comfort, and reducing wait times. Further, improvement in facility orderliness, cleanliness, and privacy of patient-sensitive data can

be important information that promotes improved patient satisfaction with healthcare facilities and quality of care. Therefore, an integrated healthcare system can be promoted through various factors, as indicated in this study's findings. Healthcare organizations can learn from this study the various hindrances that can prevent the use of patient satisfaction feed for performance improvement, including staff limitations, resource constraints, lack of receptivity to feedback, and unclear feedback. Further research may be conducted to explore the need for responsiveness by administrators and its impact on performance improvement in integrated healthcare systems.

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Appendix A: Institutional Review Boards (IRB) Approval

Dear Michele Adams,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Healthcare Leaders' Translation of Patient Feedback to Quality Improvement in Integrated Care," conditional upon the approval of the research partner, as documented in the site IRB's notification of approval or exemption (depending on their policies), which will need to be submitted to the Walden IRB once obtained. You may not commence the study until the Walden IRB confirms receipt of that site IRB notification of approval or exemption.

Your approval # is 12-15-22-0316749. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on December 14, 2023 (or when your student status ends, whichever occurs first). One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Dear Michele Adams,

This e-mail serves to inform you that your request for a change in procedures, submitted on 7/31/23 has been approved. You may implement the requested changes effective immediately. The approval number and expiration date for this study will remain the same.

This email also confirms receipt of the documentation for the partner organization and also serves as your notification that Walden University has approved BOTH your doctoral study proposal and your application to the Institutional Review Board. As such, you are approved by Walden University to conduct research with this site.

Appendix B: Interview Protocol

Interview: Exploring the lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system.

1. I will start with greetings and a brief introduction.
2. I will thank each participant for accepting my invitation to participate in the interview.
3. I will ensure that participants have read and understood the key elements of the informed consent form before signing it.
4. I will inform participants that the interview will last approximately 30–45 minutes, and the interviews will be audio recorded.
5. I will begin interviewing.
6. I will conclude the interview, stop the audio recording, and thank each interviewee again for taking part in the interview.

Appendix C: Interview Questions

Purpose of the study: To explore lived experiences of healthcare leaders about using patient feedback to improve the quality of care in an integrated healthcare system.

6. What is your role as a manager?
7. What are the characteristics of the healthcare settings that may influence patient satisfaction with the care they receive?
 - a. The physical environment
 - b. Practitioners (nurses, physicians, others)
8. What is your experience with how patient satisfaction results identify gaps in quality of care to patients on your unit(s)?
9. What is your experience using patient satisfaction reports to develop quality improvement plans and initiatives?
 - a. What factors facilitated your use of the patient satisfaction results to effect change in your unit(s)?
 - b. What factors hindered your use of the patient satisfaction results to effect change on your unit(s)?
 - c. What is your experience implementing environmental changes based on the patients' evaluation?
10. What else would you like to add that we might not have covered?