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Strategies to Improve Patient Satisfaction and Organizational performance in Health Care

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Abstract

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Executive Masters of Arts in Leadership & Training, Royal Roads University, 2003

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

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Abstract

Hospital leaders who fail to respond to poor patient satisfaction reports may experience lower organizational performance. The purpose of this qualitative case study was to explore strategies of leaders in private health care settings to improve patient satisfaction. This study may provide strategies that health care leaders in the public setting can apply to improve patient satisfaction and organizational performance. One private health care provider operating in Vancouver, British Columbia, Calgary and Edmonton, Alberta, was selected as both private and public healthcare centers are located in these areas. Data were gathered from 12 participant interviews and from an examination of available physical artifacts such as organizational documents provided by the participants and the company website. Transformational leadership was the underlying conceptual framework for this research. Triangulation was used to ensure the rigorousness of the study. In the study, themes were identified after member checking the transcribed open-ended interview questions. The 5 themes identified were cohesive culture of employee engagement, patient-focused model of care, timely access and follow-up of results and coordination of care, continuous system quality improvement, and employee accountability. These themes underscore the importance of a culture of employee engagement; they also illuminate care that focuses on the patient-care that ensures timely access, follow-up and coordination of care, quality improvement based on patient feedback, and employee accountability. Current publicly-funded hospitals and health care centers may apply these findings to improve patient satisfaction and organizational performance.

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Dedication

I dedicate this doctoral study to my family and to my partner who listens to my ideas, challenges my thinking and never gives up on me. To all, your love and continued support has helped me to succeed in my professional, academic and personal life.

I would also like to thank Dianne Doyle for her support of my academic work.

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Section 1: Foundations of the Study

Patients view health care as much as a consumer-focused service as other service industries (Merlino, 2013). Health care from the provider perspective is disease-centered, which might have a negative impact on patient satisfaction (British Columbia Ministry of Health, 2014). Focusing on diseases and not including patients as part of the health care team may negatively impact organization performance. Health care leaders may require strategies to improve patient satisfaction to improve organizational performance.

Background of the Problem

Most measures of health care focus on objective measures of clinical outcomes of patient care and rarely seek the patient's views (Hostetter & Klein, 2011). Patient-reported outcomes are critical measures of assessing whether health care is improving the health of patients (Hostetter & Klein, 2011). Patient-reported outcomes focus on the patient's wellbeing and satisfaction of the care given (Hostetter & Klein, 2011). Understanding that patient satisfaction may improve organizational performance, The Institute for Health Care Improvement developed the Triple Aim strategy of simultaneously improving population health, the patient's experience of care, and reducing per capita costs of health care (Stiefel & Nolan, 2012). In the United States, pay-for-performance incentives reflect how well hospitals score on patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (Guadagnino, 2012). In Canada, hospitals are not incentivized for patient satisfaction scores. From a patient's perspective, health care is as much a

consumer-focused service as other service industries (Merlino, 2013). Health care is disease-centered and provider-focused, which might have a negative impact on patient satisfaction and reduce organization performance. Health care leaders may need innovative strategies to improve patient satisfaction to improve organizational performance.

Problem Statement

Leaders who do not measure patient satisfaction lack information on quality improvement, which may result in decreased organizational performance (Kleefstra, Zandbelt, de Haes, & Kool, 2015). Hospitals with the lowest satisfaction scores generate 21% more health care costs (Leber, 2014). The general business problem was that some hospital leaders who fail to respond to poor patient satisfaction reports may experience lower organizational performance (British Columbia Ministry of Health, 2014). The specific business problem was that some health care leaders lack the strategies to improve patient satisfaction to improve organizational performance.

Purpose Statement

The purpose of this qualitative case study was to explore strategies that leaders in private health care settings use to improve patient satisfaction. Learning from this study may provide strategies that health care leaders in the public setting can apply to improve patient satisfaction and organizational performance. The population for the study included nine leaders and three staff in a private health care center with offices located in Vancouver, B.C., Edmonton and Calgary, Alberta. Vancouver, B.C., Edmonton and

Calgary, Alberta were appropriate locations for the study as both private and public health care centers are in these areas. There have been a number of studies on this topic conducted in the United States, so a Canadian perspective adds a greater understanding of the phenomenon by looking at perspectives beyond the scope of the United States. The research study contributes to social change by providing strategies to improve patient satisfaction as consumers of health care. Hospital leaders who focus on patient satisfaction and performance positively contribute to the social well-being of people and communities by addressing health care needs according to patient perspectives (Merlino, 2013).

Nature of the Study

The research methods considered for this study included qualitative, quantitative, and mixed methods. Quantitative researchers seek to test theories by understanding the relationship between variables (Vance, Talley, Azuero, Pearce, & Christian, 2013). A quantitative approach incorporates data, statistical analysis, and closed-ended questions (Vance et al., 2013). I did not choose a quantitative approach as this method does not explore perceptions and experiences of people. A mixed-method research study incorporates both qualitative and quantitative methodology in data collection, analysis, and interpretation of results (Ihantola & Kihn, 2011). This type of study has the advantage of obtaining both multiple viewpoints and hard, factual data (Caruth, 2013). The disadvantage of the mixed-method approach is that it is a complicated research methodology, which may be beyond the time allocated and scope of this degree.

Qualitative research is a method that explores the meaning that individuals believe to be true about a business problem (Lee, 2014). A qualitative researcher explores business leaders' beliefs and how people understand business problem. Thus, the qualitative method was appropriate for this study, as qualitative research enabled the exploration of strategies health care leaders can use to review patient satisfaction and organizational performance.

The research designs considered for this study included phenomenological, ethnographic, narrative, and case study. Research designs vary in the variety of information collected and the scope of the data collection. Phenomenological research is an understanding of the phenomenon, in practice, in an organization (Reiter, Stewart, & Bruce, 2011). I did not select a phenomenological design because I was interested in exploring strategies to improve patient satisfaction and organizational performance. Ethnographic research can enable a better understanding of the culture, which can improve organizational practice (Shover, 2012). I did not select an ethnographic design because I was interested in exploring strategies to improve patient satisfaction and organizational performance. Narrative researchers report on stories of experiences of an individual or several individuals (Jorgensen, Dahl, Pederson, & Lomborg, 2012). I did not select a narrative design because I was interested in exploring strategies to improve patient satisfaction and organizational performance. Case study research can provide an in-depth understanding of complex social and technical phenomena related to the improved practice of an organization or business (Yin, 2014). A case study is a useful

method to evaluate the real-world phenomenon (Yin, 2014). The research design in this applied research study was a case study. Evaluating the complexity of health care using a qualitative case study design enables the exploration of innovative strategies to improve patient satisfaction and organizational performance.

Research Question

The central research question for this study was the following: What strategies do private health care centers use to improve patient satisfaction to improve organizational performance as these strategies may also be helpful in the public health care system?

Interview Questions

1. What patient satisfaction strategies specifically contribute to improved organizational performance?
2. What do you think is necessary for successful implementation of these strategies?
3. What factors in the patient experience are measurable to aid in assessing patient satisfaction?
4. What processes exist to gather patient satisfaction information?
5. What processes exist to assess patient feedback?
6. How are patient issues addressed?
7. How are changes to service delivery implemented to improve performance?
8. What steps do leaders take to collect, analyze, and apply patient

feedback to improve organizational performance?

Conceptual Framework

The conceptual framework in this qualitative case study was transformational leadership. The body of knowledge that arises from transformational leadership helped me to explain and predict phenomena related to the study. A transformational leadership framework was beneficial to explore what strategies private health care centers use to improve patient satisfaction to improve organizational performance as these strategies may also be helpful in the public health care system. Transformational leaders influence and shape culture by inspiring employees to change expectations, perceptions, and motivation to work towards a common goal (Northouse, 2013). Burns (1978) developed transformational leadership theory, and Bass and Avolio (1993) further developed key components of the theory (Northouse, 2013). The key components of transformational leadership are an individualized consideration, inspirational motivation, intellectual stimulation, and idealized influences (Northouse, 2013). Transformational leaders master the organizational rules and norms and then create new visions and strategies to improve and transform the organization (Northouse, 2013). The conceptual framework of transformational leadership grounded and complemented the business problem. In B.C. hospitals, the specific business problem is that some health care leaders lack strategies to improve organizational performance via improved patient satisfaction. Transformational leadership theory can change a culture and inspire employees to embrace a common

vision, of using patient feedback to improve patient satisfaction, and applying this new knowledge to improve business performance.

Operational Definition

Transformational leadership: Transformational leadership key components are an individualized consideration, inspirational motivation, intellectual stimulation, and idealized influences (Northouse, 2013).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are concepts believed to be true but not proven (Simon, 2011). Three assumptions affected the case study. First, participants articulated experiences related to the research questions. Second, participants responded to the research questions to the best of their knowledge. Third, themes emerged from the participant's responses that were linked to the literature and informed the research results.

Limitations

Limitations are research parameters limiting the research and context of the study (Simon, 2011). Three limitations affected the case study. First, the study was a small sample size. Second, I was a novice researcher. Third, the study results may not be generalizable to other health care organizations.

Delimitations

Delimitations are the characteristics that limit the scope and define the boundaries of the study (Simon, 2011). Two delimitations affected the study. First, the population

studied was limited to a health care organization located in Vancouver, British Columbia, Edmonton and Calgary Alberta, Canada. Second, the population included in the study was limited to health care leaders and employees employed in one private health care business.

Significance of the Study

Contribution to Business Practice

The results of the study provided strategies for improvements to patient satisfaction and organizational performance. Improving patient satisfaction and organizational performance for hospitals improves the patient experience in hospitals and positively affects organizational efficiency. Health care is disease-centered and provider-focused, which can have a negative impact on patient satisfaction (British Columbia Ministry of Health, 2014). Health care from the patient's perspective is as much a consumer-focused service as other service industries (Merlino, 2013). The results of this study may be important as the culture of health care in B.C. plans to shift from disease-centered and provider-focused to patient-centered (British Columbia Ministry of Health, 2014). The study results may also contribute to the body of knowledge on this topic. The target audience for the study findings is the senior leadership teams of hospitals to aid in the implementation of the study findings. The Ministry of Health is also a target audience with the aim of shifting from a disease-centered and provider-focused environment to one that is patient-centered (British Columbia Ministry of Health, 2014).

Implications for Social Change

The results of the study might improve patient satisfaction and organizational performance. Improving patient satisfaction and organizational performance for hospitals positively contributes to the social well-being of people and communities. Improving patient satisfaction and hospital performance in hospitals potentially improves the health of the population. Improving the health of the population decreases mortality and morbidity. Ensuring efficient, patient-centered health care for the population may improve human conditions and have a positive social impact.

Review of the Professional and Academic Literature

My main goal in conducting the literature review was to provide a review of the topic and to demonstrate a comprehensive understanding of the research topic (Doctorate of Business Administration, 2014). The topic of the study was the impact that patient satisfaction has on organizational performance. Most measures of health care focus on objective measure of clinical outcomes of patient care and rarely seek the patients' views (Hostetter & Klein, 2011). Patient-reported outcomes are critical measures of assessing whether health care is improving the health of patients and focus on the patient's well-being and satisfaction of the care given (Hostetter & Klein, 2011). Improved patient satisfaction may improve organizational performance (Stiefel & Nolan, 2012). The general business problem was that hospital leaders who fail to respond to poor patient satisfaction reports may experience lower organizational performance (British Columbia Ministry of Health, 2014). The specific business problem was that some health care

leaders lack the strategies to improve patient satisfaction to improve organizational performance. Increased longevity and complex health conditions increase health care demand, and the exponential increase in health care costs is not sustainable (Stiefel & Nolan, 2012). One strategy to address rising costs and sustainability of health care is to improve patient satisfaction to improve business performance.

In the literature review, I focus on the conceptual framework of the study. Additional literature explored pertains to strategies to improve patient satisfaction and organizational performance. A critical review of the literature provides a synopsis of previous research on the research study. I found limited research that used the conceptual framework, transformational leadership, as the focus of the research for seeking strategies to improve patient satisfaction and organizational performance.

The literature used was found in the ProQuest, EbscoHost, and Science Direct databases. The total number of references in the literature review is 101. Of the total number of references, 90 were peer-reviewed articles, and 83 of these articles were published after 2012. References in this review published before 2012 were used because they contribute directly to the research study and provided a background and foundation for the study. Keywords and phrases that guided the literature review were *patient satisfaction*, *patient-centered care*, *operational performance in hospitals*, and *transformational leadership*. In addition to the conceptual framework literature, the literature review highlighted the following categories: nursing and transformational leadership, leadership and organizational performance, patient-and family-centered care,

patient satisfaction, patient-centered care and patient outcomes, new models of care to improve performance, and the relationship between employee engagement and patient satisfaction.

Theory

The conceptual framework of the study was transformational leadership. Bass and Avolio (1993) described transformational leadership as a key to changing organizational culture. Transformational leaders are proactive and work to change the organizational culture by implementing new ideas (Northouse, 2013). The transformational leader motivates employees by encouraging them to achieve objectives through innovative ideas and creative solutions to problems (Northouse, 2013). Transformational leadership was an effective framework for this study as it takes employees and organizations beyond the status quo towards a vision for the future. Transformational leaders articulate a vision, exemplify behaviors that gain trust, challenge the status quo, and empower others to reach their goals (Northouse, 2013). Transformational leaders can enact significant changes in an organization by motivating employees to achieve results for the good of the organization (Northouse, 2013). As such, transformational leaders can improve organizational performance by influencing the culture (Northouse, 2013). The key components of transformational leadership are an individualized consideration, inspirational motivation, intellectual stimulation, and idealized influences (Northouse, 2013).

Transformational leaders positively influence employee. Wolf (2012) used transformational leadership theory to study leadership dimensions that influence followers. Intellectual stimulation, charisma, and individual consideration constitute aspects of transformational leadership that have a positive influence on employees. Improved employee satisfaction results in improved organizational performance (Wolf, 2012). Doody and Doody (2012) focused on the four dimensions of transformational leadership: idealized influence, inspirational motivation, intellectual stimulation, and individual consideration. Doody and Doody discussed how health care organizations face changes that require an increasingly adaptive and flexible leadership. Transformational leadership allows for shared responsibilities that influence new ways of leading. Transformational leaders motivate followers by appealing to higher ideals and moral values, where the leader has a deep set of internal values and ideas. The followers of transformational leaders act to sustain the greater good, rather than their interests, and supportive environments where everyone shares responsibilities (Doody & Doody, 2012).

Transformational leaders influence employee performance. Gousy and Green (2015) explored the effects of transformational leadership in bringing about service-led improvements in health care for patients with chronic pain. The goal was to develop a patient-centered approach to ensure that care treated the person, not the disease. Gousy and Green cited the key components of transformational leadership as individual consideration, intellectual stimulation, and inspirational motivation and idealized influence. Individual consideration means each member of the team received treatment

differently but equally, and the leader acts in an advisory capacity providing coaching, teaching, and mentoring (Gousy & Green, 2015). Intellectual stimulation encourages members of the team to think in new ways, create solutions, and try new ideas with the leader, empowering staff to approach problems from a new perspective (Gousy & Green, 2015). Inspirational motivation is the leader's ability to instill faith and respect and to excite and provide a shared vision (Gousy & Green, 2015). Idealized influence is the leader's ability to behave as an effective role model, providing a sense of mission and upholding high standards (Gousy & Green, 2015). Gousy and Green (2015) concluded that transformational leadership is an effective way to engage and empower nurses. Transformational leaders inspire employee to find ways to ensure patient satisfaction.

Nursing and Transformational Leadership

Leadership plays a key role in nursing practice. Denkard (2014) reviewed the issues and trends facing nursing executives and identified research gaps in personal and professional leadership that impact nursing practice. Drenkard studied key concepts of personal and professional leadership related to transformational leadership and explored them in terms of leadership of self, leadership in relation to others, and leadership in relation to the systems. Mantynen et al. (2014) conducted their study in a Finish University hospital that was working to achieve Magnet hospital standards. Magnet organizations are health care organizations that are recognized for quality patient care, nursing excellence, and innovation in professional nursing practice (Clavelle & Drenkard, 2012). Mantynen et al. described the changes in transformational leadership and

outcomes in regard to job satisfaction among nurses, patient safety culture, and patient satisfaction. These factors brought the hospital into compliance with Magnet standards. Mantynen et al. found that a more transformational approach to nursing leadership might enhance the hospital and that development of a strong patient safety culture improves quality care.

Transformational leaders impact employee engagement. Gillet, Fouquereau, Bonnaud-Antignac, Mokounkolo, and Colombat (2013) investigated the psychological mechanisms that impact the relationship between transformational leadership and a nurse's quality of life and engagement in work. In particular, Gillet et al. studied organizational justice in two forms, distributive and interactional justice, to determine if they mediated the relationship. Data analysis showed that transformational leadership of supervisors correlated with distributive and interactional justice ($p < 0.001$; Gillet et al., 2013). Similarly, the two facets of organizational justice were also positively associated to the quality of work life ($p < 0.001$; Gillet et al., 2013). Lastly, the quality of work life correlated with the level of engagement at work ($p < 0.001$; Gillet et al., 2013). All relationships were significant. Gillet et al. found that through distributive and interactional justice, transformational leadership may be a powerful tool in changing the quality of work life for nurses and as a result, work engagement increases. Top, Tarcan, Tekinqunduz, and Hikmet (2013) sought to determine the linkages between an employee's perception of the transformational leadership of a supervisor, job satisfaction, organizational trust, and organizational commitment. The quantitative, cross-sectional

study measured six transformational leadership dimensions: articulating a vision, providing an appropriate model, fostering the acceptance of group goals, high-performance expectations, providing individualized support, and intellectual stimulation (Top et al., 2013). Top et al. found correlations amongst all measured variables. Significant relationships were observed between transformational leadership and organizational commitment ($r = 0.285$), organizational trust ($r = 0.424$), and job satisfaction ($r = 0.229$; Top et al., 2013). Job satisfaction correlated with organizational trust ($r = 0.363$) and organizational commitment ($r = 0.385$), and organizational commitment was significantly associated with trust ($r = 0.428$; Top et al., 2013). Transformational leadership had the strongest relationship with organizational trust (Top et al., 2013). Top et al. encouraged administrations of hospitals and other health care facilities to recognize the value in transformational leadership, organizational commitment, organizational trust, and job satisfaction for increasing productivity, effectiveness, and quality of performance.

Transformational leaders influence employee satisfaction. Wang, Chontawan, and Nantsupawat (2012) examined the relationship between the transformational leadership of nurse managers and job satisfaction as perceived by registered nurses. The population was a voluntary sample of registered nurses, ages 20-30 years, from nine clinical departments at a tertiary care hospital in China. There were 238 surveys completed in the correlation study. Wang et al. measured the transformational leadership of the nurse managers with practices such as challenging the process, inspiring a shared vision,

enabling others to act, modeling the way, and encouraging the heart. Employee satisfaction levels were measured based on professional development opportunities, recognition and praise, achievement and responsibility, salary and compensation, scheduling and work conditions, work, supervision and hospital policy, interpersonal relationships, and the balance of family and work (Wang et al., 2012). Transformational leadership was correlated to job satisfaction of clinical nurses ($p < 0.001$). Through encouragement and praise for performance, innovation and problem solving, trust and confidence in employees, practicing organizational values, and behaving as a role model, nurse managers enhance the job satisfaction of clinical registered nurses. Transformational leaders positively impact employee satisfaction. Satisfied employees may improve organizational performance.

Transformational leaders can achieve Magnet status for organizations. Clavelle and Drenkard (2012) highlighted several transformational leadership practices of chief nursing officers (CNO), which stimulated their achievement of Magnet organization status. Clavelle and Drenkard sent invitations to 384 members of the Magnet Recognition Program CNO list of the American Nurses Credentialing Center. Clavelle and Drenkard received responses from 206 female and 17 male CNOs of Magnet organizations. Clavelle and Drenkard described the results from a questionnaire based on five leadership practices: enabling others to act, encouraging the heart, inspiring a shared vision, challenging the process, and modeling the way. The two most important practices of Magnet CNOs were enabling others to act and modeling the way. Enabling others to act

was significantly higher than all other components of the leadership practices ($p < 0.001$). There was a significant association between the total number of years of experience as a CNO and the total scores on the leadership inventory ($p = 0.029$), the importance of inspiring a shared vision ($p = 0.001$), and the number of beds in the organization ($p = 0.029$). Results indicate that CNOs who have experience, education, and practice in health care for long periods may have elevated transformational leadership skills (Clavelle & Drenkard, 2012). Transformational leadership behaviors of CNOs have positive relationships with job satisfaction and productivity.

Transformational leaders can improve organizational performance. Thompson (2012) used a transformational leadership model to demonstrate how managers can improve workforce competencies. Leaders who challenge budgets, consider new ways of working, and engage effectively with staff can improve productivity and care, and those who invest in appropriate learning will have a highly trained workforce. Thompson discussed how problems arise because of poor delegation skills or failure of a leader to respond appropriately to economic factors and patient demographics. Groves and LaRocca (2012) studied whether personal values that facilitate transformational leadership characteristics generate follower beliefs concerning corporate social responsibility. Five hundred and eighty-two participants were surveyed from a combined 110 publicly, private, and government organizations in the Southern California area (Groves & LaRocca, 2012). Groves and LaRocca e-mailed Likert-type scale surveys to participants with instructions to participate. Groves and LaRocca found that follower

corporate social responsibility beliefs strongly mediated the relationship between transformational leadership and employees' beliefs of leadership effectiveness. There is a relationship between leadership, employees' beliefs and the organization.

Transformational leaders influence employee productivity. Breevaart, Bakker, Demerouti, Sleebos, and Maduro (2015) described the mechanisms through which transformational leadership operates to optimize follower task completion and evaluated employee work engagement and job performance. Over 200 pairs of leaders and employees provided data through anonymous, online questionnaires. Questionnaires had 14 items that evaluated transformational leadership; job resources; basic need fulfillment; and a need for leadership, work engagement, and in-role task performance (Breevaart et al., 2015). Transformational leadership was associated with the fulfillment of employees' needs ($p < 0.001$). There was a greater amount of job resources available and fulfillment of employees' needs when leaders demonstrated transformational leadership qualities, and increased work engagement was also observed (Breevaart et al., 2015). Breevaart et al. suggested that transformational leaders are able to facilitate advancements in their followers' task performance through enhancement of the work environment. Concurrently, the fulfillment of employees' needs prompts them to respond with increased engagement, which increases job performance. Additional benefits of elevated engagement include job satisfaction, feelings of competence, and a sense of relatedness (Breevaart et al., 2015). Breevaart et al. built upon previous research in the field but instead of working to find an association between variables, Breevaart et al. provided a

descriptive account of the mechanisms of transformational leadership that can influence employees. Lievens and Vlerick (2013) sought to determine the influence of transformational leadership on the safety performance of nurses. Specifically, safety compliance and safety participation were the two aspects of safety performance considered and the mediating role of knowledge-related job characteristics in the relationship between transformational leadership and safety practices (Lievens & Vlerick, 2013). Although all 498 nurses at a Belgian hospital were invited to participate in the study, there were 152 completed questionnaires. The mean age was 40.1-years-old, and 127 were female. This cross-sectional study was composed of a self-administered questionnaire. Lievens and Vlerick measured transformational leadership practices and collected data on knowledge-related job characteristics and safety performance. There was a significant and positive association between transformational leadership and both facets of safety performance (safety compliance, $p = 0.002$, safety participation, $p < 0.01$). Knowledge-related job characteristics also partially mediated the relationship between transformational leadership and safety performance (Lievens & Vlerick, 2013). There was more compliance with safety rules in those who had a greater perception of knowledge-related job characteristics. Lievens and Vlerick found that the behavior of head nurses and other leaders increase the safety practices of nurses. Management can also impact an employee's perception of their job-related knowledge, which is responsible for part of the relationship between transformational leadership and following

safety guidelines. The leadership style of nurse managers may influence employees to promote and follow safety guidelines in the workplace (Lievens & Vlerick, 2013).

Transformational leaders impact employee satisfaction. Munir, Nielsen, Garde, Albertsen, and Carneiro (2012) investigated if work-life conflict levels could explain part of the relationship between transformational leadership, job satisfaction, and psychological well-being, and found that transformational leadership demonstrated a direct relationship with work-life conflict, job satisfaction, and psychological well-being. The amount of work-life conflict mediated the association between transformational leadership and perceived well-being, but not the association between transformational leadership and job satisfaction (Munir et al., 2012). Munir et al. determined that managers with a transformational leadership style may be able to enhance an employee's perception of work-life balance and well-being. Weng, Huang, Chen, and Chang (2015) investigated the effect of transformational leadership on innovation behavior of nurses, looking at whether the established organizational climate had any impact on the relationship. A group of nurses from three regional Taiwan hospitals were included in the study, and the researchers obtained 439 valid responses from 450 distributed questionnaires. This cross-sectional study consisted of an anonymous, self-reported questionnaire. Weng et al. (2015) measured transformational leadership with questions that focused on individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence. Measurements of innovation behavior reflected transformational leadership had a significant and positive relationship with nurse

innovation behavior (Weng et al., 2015). Two factors, patient safety, climate, and innovative climate, showed full mediating roles in the relationship between transformational leadership and innovation behavior (Weng et al., 2015). Innovation behavior, an activity that may improve nursing quality care, is an important outcome that leaders consistently work to increase. Prior to this study, there were few published articles emphasizing the significance of nurse leaders' transformational leadership behaviors on innovation behaviors among nurses (Weng et al., 2015).

Transformational leaders influence employee turnover. Green, Miller, and Aarons (2013) investigated the relationship between transformational leadership, emotional exhaustion, and turnover intention. A total of 72 public sector programs for mental health for children, adolescents, and families were asked to participate. From the 64 programs that responded, a voluntary sample of 316 females and 72 male community mental health providers agreed to take part in the study (Green et al., 2013). The Emotional Exhaustion subscale, based on the Maslach Burnout Inventory, measured emotional exhaustion. The Multifactor Leadership Questionnaire quantified the supervisor's leadership practices. The intention of turnover was assessed with five questionnaire items that were established in a past study. Emotional exhaustion positively correlated with the turnover intention (Green et al., 2013). Transformational leadership negatively correlated with both emotional exhaustion and turnover intention. Leaders who interact with followers with a transformational leadership style may be capable of reducing the emotional exhaustion and intention of turnover in community mental health providers. Lin,

MacLennan, Hunt, and Cox (2015) sought to determine the effect of transformational leadership qualities of nurse leaders on the perceived quality of nurses' working lives in Taiwan. Eight hundred and seven nurses from four private, four public, and four religious hospitals were invited to participate (Lin et al., 2015). A voluntary sample of 651 nurses provided valid responses to the questionnaires. Nurses had at least one year's work experience at a hospital. The design was a cross-sectional quantitative study, where self-administered questionnaires aided in the collection of work experience. The questionnaire included the Multifactor Leadership questionnaire to measure idealized influence, inspiration motivation, intellectual stimulation, and individualized consideration of leaders. Karasek's Job Content Questionnaire, the Occupational Stress Indicator, the Organizational Commitment Questionnaire, and the General Health Questionnaire were also used (Lin et al., 2015). The perceived support of the supervisor was significantly influenced by transformational leadership. A larger amount of transformational leadership practices related to greater supervisor support, which in turn, increased levels of job satisfaction. Lin et al. (2015) showed that workplace support was a core mediator in the association between transformational leadership and job satisfaction. Nurse leaders who exercise leadership styles to create a transformational culture may be able to positively change nurses' perceptions of their quality of work lives and levels of job satisfaction, in three different hospital settings (Lin et al., 2015). Transformational leaders can help reduce employee stress in the workplace.

The aim of Roberts-Turner et al. (2014) study was to compare the pediatric registered nurses' (RN) ratings of the transactional and transformational leadership behaviors of their nurse leaders. The association between the ratings and reported RN job satisfaction was also examined (Roberts-Turner et al., 2014). Through the Children's National Health System, 1,223 eligible nurses were invited to participate. Of this number, 935 nurses from the Children's National Medical Center in Washington, D.C. participated. Using their employee numbers, nurses were able to access an online survey. Upon completion of the survey, an external consultant reviewed the responses. The Healthcare Environment Survey was the instrument used to evaluate distributive justice, autonomy, and job satisfaction (Roberts-Turner et al., 2014). Autonomy and distributive justice applied as proxies for transformational leadership and transactional leadership, respectively. Although both autonomy and distributive justice had significant and positive associations with job satisfaction ($p < 0.001$), autonomy had a stronger relationship. Interestingly, the relationship between the role of management or leadership and job satisfaction was insignificant. However, job satisfaction did significantly influence autonomy ($p = 0.002$) and distributive justice ($p < 0.001$). Results suggest that management may indirectly affect job satisfaction through the perceived autonomy and distributive justice in pediatric RNs (Roberts-Turner et al., 2014).

Ross, Fitzpatrick, Click, Krouse, and Clavelle (2014) examined trends in the practice of transformational leadership of nurse leaders in professional nursing associations (PNA). The population studied consisted of nurse leaders with positions such

as president, vice president, past president, and various members of boards of directors, from PNAs (Ross et al., 2014). A group of 448 nurse leaders participated in an online questionnaire. From this group, 20 male and 113 female nurse leaders from 37 states in the U.S. completed the survey and provided data for the research. This qualitative study was comprised of an email questionnaire, based on the Leadership Practices Inventory. Data collection continued for six weeks. The two most important transformational leadership practices in nurse leaders from PNAs were enabling others to act and encouraging the heart. There was a significant, positive association between the amount of leadership training and frequency of transformational leadership. In the population of nurse leaders from PNAs, the transformational leadership style was widely employed (Ross et al., 2014). Shi, Zhang, Xu, Liu, and Miao (2014) proposed that perceptions of transformational leadership may mediate the relationship between regulatory focus and burnout in Chinese nurses. The sample consisted of 5,456 practical and registered nurses from three large, established hospitals in western China. Of this number, the random selection provided 620 nurses working in internal medicine, surgery, pediatrics, and intensive care for greater than six months. There were 242 nurses who were excluded due to incomplete questionnaires. This correlational study administered three separate, anonymous questionnaires to participants in a counterbalanced order during a single sitting (Shi et al., 2014). The regulatory focus is determined using the dominant regulatory focus measurement method, which subtracts the promotional focus subscale score from the prevention focus subscale. The validated Transformational Leadership

Inventory evaluated the following topics: articulating a vision, providing an appropriate model, fostering the acceptance of group goals, high-performance expectations, individualized support, and intellectual stimulation. The specific type of regulatory focus predicted burnout. Perceived transformational leadership practices partially mediated the relationship between regulated focus and burnout. Promotional focus enabled a greater perception of transformational leadership, and those with a prevention focus perceived lower levels of transformational leadership (Shi et al., 2014). Shi et al. (2014) demonstrated that regulatory focus may reduce burnout, due to the amount of perceived transformational leader. The data suggested that although perceived transformational leadership of a leader can be effective at improving a nurse's mental health outcomes, the focus style of a nurse may be able to influence this relationship (Shi et al., 2014). Individuals may be more or less susceptible to burnout depending on their type of focus.

Leadership styles impact employee learning. Raes et al. (2013) compared the effectiveness of different leadership styles and their ability to facilitate team learning behaviors in groups of nurses. Twenty-eight nursing teams were randomly selected from a university hospital in Flanders, Belgium and each team leader identified team members, which resulted in a population of 605 nurses. The qualitative study consisted of an anonymous and confidential questionnaire with five parts, through which transformational leadership styles, laissez-faire leadership styles, social cohesion, team psychological safety, and team learning beliefs was measured (Raes et al., 2013). The Multifactor Leadership Questionnaire evaluated leadership styles and specific questions

regarding conversational actions, partnerships, shared knowledge and coordinated team activities were asked to study team learning behaviors. Transformational leadership was a significant predictor of team learning behaviors ($p < 0.001$) and laissez-faire leadership was also positively associated ($p < 0.05$). Team psychological safety mediated the association between leadership and team learning behaviors, but social cohesion did not. Although laissez-faire leadership influenced team learning behaviors positively, transformational leadership was seen to have a much stronger impact affecting the team learning behaviors of nurses (Raes et al., 2013).

Leadership and Organizational Performance

Leadership influences organizational performance. Lega, Prenestini, and Spurgeon (2013) provided insight on the importance of strong management in healthcare practices and conducted a literature search to review the relationship between the performance of healthcare organizations and management leadership, practices, and characteristics. Following a systematic literature search, Lega et al. (2013) extracted and analyzed 37 articles with the keywords of management, management practice, management impact, healthcare services, quality, healthcare organizations, and healthcare performance. The articles were divided into four areas of study: the impact of management practices on performance, the impact of managers' characteristics on performance, the influence of acquiring professionals in management on performance, and the effects of organizational culture and management styles on performance. Academic scholars suggested that strong management was associated with decreased risk

of mortality and increased financial performance (Lega et al., 2013). Lega et al. (2013) made a distinction between management and leadership; management includes planning, budgeting, organizing, staffing, and controlling, while leadership practices involved guidance, direction, motivation, and alignment of people. The second research area revealed commonalities with chief executive officers who either had notable experience with the healthcare system or were clinically qualified. The third classification of studies primarily report correlations between doctor engagement in management and organizational performance (Lega et al., 2013). The researchers identified a causal relationship between management styles and organizational culture, and performance. In the healthcare sector, the growth of sustainability is evident and systems are continually undergoing restructuring and shifting governance. To improve value and cost efficiency of care, Lega et al. suggested that management leadership, practices, characteristics, styles, and cultures closely related to indicators of performance. Increased involvement of doctors in management to lead changes in service and innovation may improve overall productivity and quality. There is a positive effect of strong management on healthcare performance (Lega et al., 2013). Metcalf and Benn (2013) examined leadership characteristics related to the successful implementation of corporate sustainability. Leadership for sustainability requires leaders of extraordinary abilities who can read and predict through complexity in dynamic organizational change and have high emotional intelligence. Leadership moves from the concept of leadership as a relationship to the concept of leadership as a social process that contains complex relationships. Metcalf

and Benn (2013) conducted a literature review on the different styles of leadership to uncover what characteristics would be necessary for a leader. Researchers found that emotion intelligence seems a likely contributor to the human capacity to lead through complexity. Three types of leadership style drive organizational performance and sustainability, authentic leadership, ethical leadership, and transformational leadership (Metcalf & Benn, 2013).

Tideman, Arts, and Zandee (2013) suggested a new type of leadership style may be valuable to encompass sustainability necessary for creating a sustainable organization. The new world-view of organizations is where business, the economy, the environment, and society are inseparable and interconnected. Therefore, a new paradigm for business leadership needs to emerge. Tideman et al. (2013) conducted a literature review comparing previous work on leadership styles against the attributes needed for sustainable leadership and uncovered six required attributes for a person to be considered a sustainable leader. The six elements are context, consciousness, continuity, connectedness, creativity, and collectiveness. Tideman et al. (2013) found that transformational leadership already contains four of the elements required, which are consciousness, continuity, creativity, and connectedness.

Patient and Family Centered Care

Researchers suggested that patient-and-family-centered care improves organizational efficiency (Groene, 2011; Mirzaei et al., 2013). The definition of patient-and-family-centered care cited the most frequently in the literature comes from the

Institute for Patient and Family-Centered care (2013): an approach to the planning, delivery, and evaluation of health care. Patient-and-family-centered-care is a mutually beneficial partnerships with healthcare providers, patients, and families (The Institute for Patient and Family-Centered Care, 2013).

Patient Satisfaction

Heidenreich (2013) described patient-centered care as patient satisfaction. Many hospitals and healthcare systems reward providers who obtain high rates of patient satisfaction as an award for quality. Heidenreich (2013) proposed that patient-centered care is not always evidence-based; however, non-evidence-based care should occasionally trump evidence-based care if that is what the patient wants. Patient-centered care gains attention in both the United States and in Canada. Many healthcare facilities are looking to the retail industry for guidance on patient-centered care. The ultimate measure of healthcare performance is whether it helps people recover from an acute illness, live with chronic disease, and face end of life with dignity (Hostetter & Klein, 2011). Lieber (2014) reinforced the importance of high patient satisfaction scores for financial rewards in the United States. The Centers for Medicare and Medicaid (CMS) are developing patient experience surveys for hospital outpatient surgery departments and ambulatory care surgical centers. The surveys contain such topics as communication between providers and patients, patient satisfaction with the experience, care coordination, assessment of pain, other outcome measures, and the decision to return and/or recommend the hospital to others. Lieber (2014) reviewed the literature and

sought to find innovative strategies that nurses and leaders could implement to improve patient satisfaction scores.

There is a relationship between patient satisfaction and quality care. Arshad, Shamila, Jabeen, and Fazli (2012) investigated the effect of patient satisfaction measures on the quality of care at a tertiary care hospital, Sher-I-Kashmir Institute of Medical Sciences (SKIMS), in Srinagar, India. The population included 400 middle aged patients (204 males and 196 females) in the outpatient department (OPD) at a tertiary care hospital in Srinagar, India. A close-ended questionnaire was developed, pre-tested and administered in the Department of Community Medicine on outpatients to determine patients' perceptions on quality of care. Data collection continued for two months, and statistical analysis proceeded. For a majority of patients, 61.25% reported the main reason for choosing the hospital was the skillfulness of the doctors. Patients were also highly satisfied with the availability of facilities at the hospital (70.5%) and the behavior of the medical care staff (66.75%). The authors, implied there may be a relationship between patient satisfaction and the quality of care received at a hospital (Arshad et al., 2012). This information is valuable in developing plans to improve the quality of care, as a high-level of patient satisfaction is characteristic of high-quality organizations. The perception of care impacts patient satisfaction. Zendjidjian et al. (2014) identified patient and care-related factors associated with patient satisfaction with psychiatric hospital care using the Satisfaction with Psychiatric Care Questionnaire-22 (STISPSY-22), based on the patient's point of view. Zendjidjian et al. (2014) conducted a cross-sectional study in

psychiatric departments of two French university teaching hospitals. Zendjidjian et al. (2014) found that the therapeutic relationship and seclusion were the most important features associated with patient satisfaction. These factors may be amendable through intervention, which would improve patient satisfaction and health outcomes for psychiatric hospitals.

Gebhardt, Wolak, and Huber (2013) identified clinical variables related to patient's treatment satisfaction. In this qualitative research study, questionnaires including the Global Assessment of Functioning scale (GAF) at admission and discharge and Student t-test and Pearson correlations were performed (Gebhardt et al., 2013). Patient satisfaction is dependent on symptom severity and global functioning at discharge, on pharmacologic disturbances during treatment, and on the discharge group (Gebhardt et al., 2013). Therefore, the researchers concluded that the primary aim of an inpatient treatment should be a focus on symptom relief and reduction of adverse side effects and improved patient satisfaction improves employee performance (Gebhardt et al., 2013).

The Patient-Centered Care and Quality Improvement Outcomes

Locock et al. (2014) identified improvement activities stimulated by an accelerated form of an experience-based co-design (EBCD). An EBCD is a form of participatory action research where patients and staff collaborate over a period of 12 months to improve the quality of health services. A secondary objective was to determine the influence of nationally, rather than locally, filmed personal narratives on the quality

of staff engagement in the performance improvement initiatives. Two English National Health Service (NHS) hospitals offering 96 staff members and 63 patients and family members participated in the study. Films from Oxford University collections of patient experience interviews demonstrated the patients, their families, and staff. Staff and patients attended a workshop to review the films, discuss their feedback, and establish priorities for quality improvement. Following over 155 hours of facilitator training, workshops, and meetings, Locock et al. (2014) conducted interviews with the sample to evaluate involvement in the project, service delivery, and project sustainability. All participants also completed a self-evaluation questionnaire. The sample accepted the accelerated format of the EBCD. There were no adverse effects of using national patient narratives in place of local patient narratives. The patient participants reported that the national films reflected themes similar to their own experiences. The accelerated EBCD was less costly and produced improvement activities faster than a traditional EBCD (Locock et al., 2014). Locock et al. provided evidence for the use of EBCD, as a performance improvement method. The accelerated format may be able to provide similar results to a regular EBCD, in a timelier and less costly manner. Locock et al. suggest that the national patient narratives of experiences in NHS hospitals are able to stimulate quality improvement initiatives through workshops, discussions, and collaboration of patients and staff. Manary, Boulding, Staelin, and Glickman (2013) performed a comprehensive literature review to examine the value in using patient-reported experiences as measures of quality of care. Manary et al. (2013) began with

identifying three integral problems surrounding the idea of patient satisfaction as a reported measure. Manary et al. (2013) investigated contrasting studies, which highlighted potential reasons for the inconsistent research that have been published regarding the association between patient-reported experiences and patient outcomes. Manary et al. (2013) first argued that patients do not possess the formal medical training and, therefore, patient feedback on the quality of care is not a valid measure. Instead, patients' perceptions of satisfaction may be associated with factors unrelated to care, which may possess a larger influence on their levels of satisfaction. Secondly, Manary et al. (2013) stated that healthcare is a service and instruments used to measure patient satisfaction may not be reflective of technical care. Furthermore, the last concern pertaining to patient satisfaction is validity. Thirdly, Manary et al. (2013) explained that patients may base their assessments on the fulfillment of their personal desires, regardless of the whether or not the service is truly required for their care. In the latter portion of the paper, possible explanations for the inconsistencies in the current body of literature on patient experience measures and health outcomes are noted. Patients could focus on specific events or visits when reporting their experiences and they may be more inclined to describe patient-provider interactions. Additionally, the timeliness of data collection after a patient's visit, additional confounding factors, and the unclear definition of patient satisfaction may relate to the contrasting results. Patient-reported experiences offer important feedback and opportunities for improvement in health care.

Reeves, West, and Barron (2013) sought to determine the effectiveness of ward-level surveys, meetings to discuss survey results and plans, and provision of data on the quality improvement efforts of nurses. The sample included 18 adult, non-maternity wards from two Acute Hospital National Health Service Trusts in London, England. Reeves et al. (2013) randomly selected nine wards from each trust. Every four months over a period of two years, the most recent 160 patients from each ward received questionnaires to measure the quality of nursing care. In total, 5,329 surveys encompassed the study (Reeves et al., 2013). The researchers used the Care Quality Commission's Inpatient Questionnaire to collected patient information on nursing care. The wards were randomly assigned to the basic feedback group (distribution of printed patient survey results and written comments), the feedback plus group (printed patient survey results, comments, and regular ward meetings to discuss responses and plans for improvement), or the control group. Reeves et al. (2013) calculated nursing care scores based on the patient survey results. The nursing care scores did not demonstrate any change in practice or specific actions for improvement in the basic feedback groups (Reeves et al., 2013). Suggestions for improvement and encouragement of ward nurses to implement changes became apparent at meetings in the feedback plus group, which facilitated nurse engagement. There was a statistically significant improvement in the feedback plus group's nursing care scores in comparison to the control group over the 18 months ($p = 0.02$). Delivering printed copies of ward-specific patient survey results are not effective for improving nursing care, however continuous ward meetings may be able

to increase nurse engagement, provide support and encourage for improvement, and facilitate quality care (Reeves et al., 2013).

Tsianakas et al. (2012) examined surveys and patient narratives to establish the aspects of breast cancer care that possess the greatest need for quality improvement initiatives. Tsianakas et al. (2012) selected patients from two teaching hospitals that were part of an Integrated Cancer Centre in the United Kingdom. Narrative interviews with 13 breast cancer patients and unstructured interviews conducted between the clinical nurse specialist and the breast cancer patient at each hospital provided insight on the crucial moments of a patient's overall care, beginning at diagnosis. Interviews were filmed and transcribed for analysis. Eighty-two patient experience surveys out of the 164 distributed were sent back to the researchers (Tsianakas et al., 2012). From each approach, there were similarities and differences in improvement priorities. The patients providing narrative responses in the interview expressed relational aspects of patient care as a priority. The patient responses focused on functional aspects of care as priorities for improvement. The surveys were not descriptive enough to identify what specific areas required improvement, indicating that survey data may not be an adequate source of information for performance improvement due to the lack of detail and constricting nature of a questionnaire. As Tsianakas et al. (2012) used patient satisfaction surveys as measurement these findings present a reason to reassess the value in utilizing patient satisfaction data as a predictor of successful quality improvement (Tsianakas et al., 2012). Rathert, Wyrwich, and Boren (2012) searched 40 articles in three databases to

examine the results of involving patients in their care, and the effect this had on health outcomes of patients. Rathert et al. (2012) found strong evidence that patient-centered care is a positive influence on patient satisfaction and self-management.

Patient satisfaction is a good measure of quality care. Wen and Schulman (2014) described team-based care as inpatient care management teams or multidisciplinary teams that are important for improvements in care delivery, especially for patients with complicated medical conditions. Team-based care is an important attribute of patient-centered care and patient satisfaction has become an important and commonly used indicator to measure the quality of care. Wen and Schulman (2014) reported on a systemic review of the relationship between team-based care and patient satisfaction using 26 trials with a total of 15,526 participants and found that team-based care had a positive effect on patient satisfaction. Zendjidjian et al. (2014) identified patient-and-care-related factors that are associated with patient satisfaction in psychiatric care using the SATISPSY-22 questionnaire. The researchers used a sample size of 270 patients and conducted the study in two public academic teaching hospitals in France. The method was a multivariate analysis using multiple linear regressions and results showed that the most important relationship between patient satisfactions was with the therapeutic relationship and seclusion practices (Zendjidjian et al., 2014).

Guadagnino (2012) explored whether patient satisfaction scores are appropriate for pay-for-performance incentives. The Centers for Medicare & Medicaid Services (CMS) began withholding 1% of hospitals' Medicare reimbursement as part of its

Hospital Values-Based Purchasing Program, restoring it to institutions based upon their quality performance (Guadagnino, 2012). Thirty percent of the program's financial incentive surfaces from how well hospitals score on patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Guadagnino (2012) demonstrated that some hospitals that score high on patient satisfaction surveys have a higher mortality rate and poorer patient outcomes. As well, some hospitals with low satisfaction survey scores have low mortality rates and, therefore, better patient outcomes (Guadagnino, 2012).

Moreau et al. (2012), identified, an integrated healthcare model improved patient care and operational performance by supporting patient choices. Patient-and-family-centered-care empowers individuals to be autonomous and take charge of their health care (Morgan & Yoder, 2012). Traditional healthcare settings are systems of efficiency and architectural design and organized around care providers rather than around patients (Morgan & Yoder, 2012). Dokken et al. (2015) produced a descriptive report to highlight a campaign to put policies in place to recognize patients as partners in care. One of the strategies to reinforce patients as partners is to change policy and culture to accept families as partners of care instead of visitors to hospitals (Dokken et al., 2015). Changing the concept of families as visitors to families as partners in care, based on the patient's preference, is fundamental to building a safe, high-quality, cost-effective system of care. Recognizing patients and families as partners improves efficiency and performance in hospitals (Dokken et al., 2015). Many families are restricted from the

bedsides of loved ones because of hospital visiting policies based on long-held beliefs that families interfere with care and exhaust patients (Lui, Read, Scruth, & Cheng, 2013). Isolating patients at their most vulnerable time from families, who know them best, puts them at risk for medical error, emotional harm, and inconsistency of care and lack of preparation for discharge home (Lui et al., 2013).

Using the Evidence in the Learning Organization (ELO) model, which describes the learning processes of healthcare organizations through inquiring, deciding, relating, and interpreting, Hovlid et al. (2012) evaluated the Førde Hospital in Norway and the redesign of their elective surgery pathway to determine how sustainability improvements are achievable. A strategic, purposive sample of 10 male and 10 female employees at Førde Hospital was suitable for the study. Hovlid et al. (2012) intended to gather an organizational perspective rather than individual perspectives, and thus subjects from varied professional backgrounds, work experience, and positions within the hospital participated. The qualitative case studies involved in-depth interviews lasting 20-70 minutes. In accordance with the theoretical framework of the ELO model, interviewees responded to questions relating to the identification of a need to change, planning change, actions taken, outcomes of change, and adaptations to interventions. In the inquiring phase, four multidisciplinary groups evolved to brainstorm ideas regarding the improvement and redesign of the elective surgery pathway. Top management as well as frontline professionals and staff were included in the decision-making process and supported the interventions (Hovlid et al., 2012). Though clinicians reported information,

reflected on it, and related the findings amidst their respective groups, communication was not limited to the four multidisciplinary groups. Clinicians interacted outside of the project groups, and this is how information was transmitted throughout the entire organization. During the interpretation stage, groups identified the need to collaborate to improve overall system performance. Clinicians recognized the interdependence in the hospital and how smaller individual tasks were vital to the optimal pathway. By studying the redesign of the elective surgery pathway at Førde Hospital with detailed interviews with staff, Hovlid et al. (2012) demonstrated that employees develop a deeper understanding of systemic interdependence through viewing the system as a whole. Ikkersheim and Koolman (2012) investigated the impact of public reporting and competition on the patient experience measured by the Consumer Quality Index (CQI). The population included 24,246 randomly sampled patients in 2006, 2007, and 2009 in 94 Dutch hospitals. The CQI evolved from questionnaires partially based on the HCAHPS that were administered to patients. Comparisons surfaced between hospitals that were forced to publish their CQI scores and those that were not, and the Herfindahl-Hirschman Index was used to compute the level of competition between hospitals. A CQI improvement of 0.034 ($p < 0.05$) to 0.06 ($p < 0.01$) was observed for all hospitals from 2006 to 2009. Hospitals that had published CQI scores exhibited a greater improvement of 0.027 ($p < 0.01$) and hospitals that faced more competition showed an improvement of 0.004 to 0.5 in CQI scores. Patient reports on quality care and satisfaction improved experiences measured by the CQI in Dutch hospitals between 2006 and 2009 (Ikkersheim

& Koolman, 2012). Mandatory publication and increased competition of hospitals prompted further improvements in CQI scores and an enhanced patient experience (Ikkersheim & Koolman, 2012).

Patient satisfaction impacts organizational performance. Al-Abri and Al-Balushi (2014) analyzed research studies that evaluated specific characteristics of overall patient satisfaction and attempted to identify how this data influenced performance enhancement processes. Studies published within the past 15 years and contained keywords (patient satisfaction surveys, quality improvement, patient feedback, hospitals, and patient satisfaction measurement) were selected. Of the 29 acquired articles, there was a lack of consensus on the definition of the concept of patient satisfaction in health care. Researchers agreed that measuring patient satisfaction has a clear impact on quality improvement, and there were several approaches to collecting patient satisfaction data. Qualitative or quantitative information from a large variation of standardized, vendor-created, or internally developed questionnaires is in use today. There was consistent evidence that supported that nursing care significantly impacted patient satisfaction, and physician communication needed improvement (Al-Abri & Al-Balushi, 2014). Despite the attention that patient satisfaction surveys have garnered over the past few decades, little research focuses on improvements due to the feedback of patient satisfaction surveys. Patient evaluation and feedback create opportunities for improvement in the healthcare system (Al-Abri & Al-Balushi, 2014). Although surveys on patient satisfaction are important quality outcome indicators in health care, there lacks a clear definition, a

standardized tool to gather data and systematic processes to develop improvement initiatives. The review by Al-Abri and Al-Balushi (2014) effectively combined the findings of past studies to critically interpret the use of patient satisfaction surveys as a tool for quality improvement. Al-Abri and Al-Balushi (2014) used evidence from multiple articles to prove that in the current body of literature, inconsistencies are present in the concept, measurement, determinants and impacts of patient satisfaction. Junewicz and Youngner (2015) critically evaluated the validity of utilizing patient-satisfaction surveys as a means to improve medical treatment. They further argue that the pressure exerted on physicians to acquire positive ratings may drive poor clinical practices. Junewicz and Youngner (2015) discussed several concepts concerning the idea of patient satisfaction. Attention focuses on the multiple definitions of patient satisfaction, discussion of surveys as indicators of health care quality, and the impacts of survey results on healthcare professionals. There are three themes that definitions of patient satisfaction fall under the provision of medically necessary care to improve the patient's health outcome, completion of medical interventions that patient's desire, and a humanistic aspect of care. Junewicz and Youngner (2015) argued that there is a lack of an established definition of patient satisfaction because it means something different to everyone. Moreover, although patient-satisfaction data incorporates performance measurement, surveys implicitly presume that patients are capable of evaluating the technical quality of health care. Surveys measure patient perceptions, and are manipulated, and items can focus on poorly related measures of the health care provided,

or its quality. Finally, in confirmation of other studies, Junewicz and Youngner (2015) insisted that the emphasis on patient satisfaction as an indicator of healthcare quality may inappropriately emphasize catering to patients' wishes. Clinicians experience to provide unnecessary care or tell patients what they want to hear. Although patient satisfaction surveys can be valuable in evaluating health care and ensuring patients receive respect, they may create problematic effects.

Kleefstra et al. (2015) compiled patient satisfaction data from four large-scale comparative studies from 2003-2009, to examine national patient satisfaction trends and if the quality improvement was achievable. All of the university medical centers in the Netherlands (n = 8) used the Core Questionnaire for the assessment of patient satisfaction (COPS) in four past studies. The data included 58,055 inpatients and 79,498 outpatients. The data showed a significant, positive trend line in patient satisfaction in the Dutch university medical centers. Kleefstra et al. (2015) observed the strongest trend with outpatient data. Healthcare facilities with low starting scores and high starting scores saw improvement (Kleefstra et al., 2015). The researchers suggest that patient satisfaction data may correlate positively with hospital improvement. As healthcare facilities with high patient satisfaction scores can continue to see improvement, monitoring of the patient perspective applies to interventions to increase performance. Continual assessment of intervention effectiveness provides useful information for improving patient care. Kleefstra et al. (2015) study results are very generalizable because of the extremely large sample size. Also, factors such as a patient's age, gender, education, and

health status were accounted for. Zgierska, Rabago, and Miller (2014) investigated the perceived consequences of patient satisfaction ratings on physician or clinician job satisfaction and the quality of clinical care. Physicians who were a part of a U.S. state-level medical society received invitations to participate in the study. Out of this group of approximately 4,000 physicians, there were 132 male and 23 female physicians who responded to the survey. Almost half of the respondents practiced in a hospital. Questions evaluated the effect of patient satisfaction ratings on physician job satisfaction and perception of clinical care. Theme analysis occurred to identify central ideas in the qualitative data. Job satisfaction moderately or severely gained influenced by patient satisfaction ratings for 78% of physicians (Zgierska et al., 2014). Contemplation of quitting or leaving the medical profession due to poor scores illuminated from 28%. Nearly half of the sample reported that the pressure to improve on their score promoted behaviors of inappropriate care. These included unnecessary antibiotic and opioid prescriptions, tests, procedures, and hospital admissions. The major theme identified was that patient satisfaction ratings were a poor way to evaluate the quality of medical care (Zgierska et al., 2014). Despite reports on the casual relationship between patient satisfaction and improved performance, potentially negative consequences such as decreased job satisfaction, a perception of compromised clinical care, and attrition of physicians may occur.

New Care Models to Improve Performance

Research studies in the literature explore new, innovative strategies to improve organizational performance in hospitals. New models of care are part of innovative strategies to improve organizational performance. There is an awareness, that increased longevity and complex health conditions have increased healthcare demand and that the exponential increase in healthcare costs is not sustainable. Stiefel and Nolan (2012) outlined the triple aim strategy that incorporates the patient experience, improved population health, and lower costs to the system. Ridic, Gleason, and Ridic (2012) explored the need for equity and efficiency in healthcare. Hawks (2012) proposed the need to rethink operational strategy from fee-for-service models in healthcare to volume-based modules focused on prevention and good value. Increased longevity and complex health conditions have exponentially increased healthcare costs and demand (Reinhardt, 2012). Healthcare needs to find ways of improving organizational efficiencies in order to contain costs. The cost of delivering health care has been rising exponentially, and governments around the world are searching for alternative mechanisms to reduce costs. Sustainability of the healthcare system is in jeopardy in British Columbia, given the exponential increase in healthcare costs and demand (Wilson, Whittaker, & Whitford, 2012). The government funds health care in Canada and the B.C. healthcare system consumes 40% of the total provincial budget (B.C. Medical Journal, 2012). A significant cost to healthcare is the maintenance of infrastructure, thus public-private partnerships are an innovative strategy to reduce the burden of spending money on infrastructure

renewal (Barrow et al., 2012). Lafontaine (2014) proposed that rising healthcare costs are due to controllable costs, such as prescriptions, new technology, and medical imaging and improved organizational performance requires an innovative plan.

Waite (2014) found that leadership development is pivotal towards organizational sustainability and servant leadership was the closest leadership style that captures the global mindset and concern for others. The characteristics of servant leadership include empowering and developing people, humility, authenticity, interpersonal acceptance, providing direction, and stewardship which when compared to corporate social responsibility that focuses on the broader view and on others in a firm, the community, and the environment, suggest that servant leadership style is in alignment with sustainability and innovation (Waite, 2014). Scott, Duncan, and Siren (2014) explained how a company can build an innovation function in 90 days. In the first 30 days, define the gaps between the organization's goals and current operations and then identify innovated ideas to fill the gaps. In the next 30 days, meet with at least 12 customers to identify unmet needs and hold workshops for leaders to prioritize two to three initiatives on which to focus. In the remaining 30 days, assign dedicated people to work on the priority initiatives and develop a concrete action plan and senior leadership to monitor progress. Scott et al. (2014) used their experiences of a financial services firm, a water utility, and a hospital to build systems that ensure that good ideas are encouraged, prioritized, resourced, and developed to improve efficiencies. Wong, Tong, and Wong (2014) conducted a quantitative study on the healthcare insurance industry in Hong Kong

using a questionnaire survey of over 500 participants. Customer satisfaction has a positive effect on customer loyalty and provides insights into how hospital branding influences the public's perceptions of hospitals and patient satisfaction (Wong et al., 2014). The American Geriatrics Society (2013) initiated a program called Choosing Wisely, which engages patients, healthcare professionals, and family caregivers in discussions about the safety and appropriateness of medical tests, medications, and procedures. These discussions examine whether the tests and procedures are evidence-based, the potential benefits versus risks, and whether tests are necessary.

Burns and Pauly (2012) analyzed Accountable Care Organizations (ACO) and the similarity to Integrated Delivery Networks of the 1990s. Burns and Pauly (2012) noted two assumptions regarding ACOs, better care coordination improves quality at any given cost and ACOs lower Medicare's rate of spending. Burns and Pauly highlighted the provider capabilities needed for success including which capabilities make a difference, physician-hospital alignment, care coordination, disease management, patient-centered medical homes, health information technology (clinical decision support systems, computerized physician order entry, and electronic health records), and pay-for-performance and shared savings. Burns and Pauly commented on the Achilles heel of ACOs: focus on primary care physicians, physician practice organizations, out-of-network utilization, and disruptive innovation. Finally, Burns and Pauly (2012) commented on the trade-offs between cost, quality, and access (the iron triangle) and the

desire to turn it into the Triple Aim, which provided an interesting and thoughtful account of a different model of care that meets the needs of the patients at a lower cost.

Christensen, Flier, and Vijayaraghan (2013) discussed their belief in the coming failure of Accountable Care. The Accountable Care Organization (ACO) concept evolved from assumptions about personal and economic behavior that is not realistic. The three untenable assumptions are that ACOs can be a success without major changes in doctor's behavior, that ACOs can be a success without changing patient behavior, and that ACOs save money. Christensen et al. (2013) provided a different model of care that meets the needs of the patients at a lower cost. Cook et al. (2014) described their study examining a 'focused factory' model within a 'solution shop' model. Cook et al. (2014) described their large academic hospital (solution shop structured to diagnose and recommend solutions to unstructured problems) and an introduction of a new model within that structure (focused factory characterized by a uniform approach to delivering a limited set of high-quality problems). Specifically, they detailed three parallel efforts, stakeholder analysis, practice, and application of management tools, as they rolled out their program in cardiac surgery. Cook et al. (2014) indicated that the approach resulted in reduced resources in all care environments, better patient outcomes, and lower costs. In other words, they achieved better quality at a lower cost in a hybrid model.

Cosgrov et al. (2012, 2013) described four elements that must become part of a healthcare organization. The foundational elements included governance priority (visible and determined leadership by the CEO and Board) and a culture of continuous

improvement (commitment to on-going, real-time learning). The infrastructural elements consisted of information technological best practices (automated, reliable information to and from the point of care), evidence protocols (effective, efficient, and consistent care), and resource utilization (optimal use of personnel, physical space, and other resources). The care delivery priorities included integrated care (right care, right setting, right providers, right teamwork), shared decision-making (patient-clinician collaboration on care plans), and targeted services (tailored community and clinical interventions for resource-intensive patients). The final category was reliability and feedback, which consisted of embedded safeguards (support and prompts to reduce injury and infection) and internal transparency (visible progress in performance, outcomes, and costs). The checklist reflects core elements for the healthcare transformation needed to deliver high-quality care that meets the needs of the patients. Cosgrove et al. (2012) interviewed CEOs of healthcare organizations in an attempt to answer the question of how to build a patient-centered healthcare system and deliver high-quality care that benefits patients and the bottom line. Specifically, Cosgrove et al. (2012) found that delivering evidence-based care, team-based approaches and shared decision-making, making care delivery more efficient, providing care in new ways, and targeting care to patient and community needs were critical to the success of the organization. Ridic, Gleason, and Ridic (2012) compared the health systems of the United States, Germany, and Canada; they highlighted the differences and similarities of the three countries healthcare structures and systems and found that the three counties face similar challenges with healthcare

equity and lack of efficiency. Lasater, Sloane, and Aiken (2015) used cross-sectional survey data from nurses in 427 hospitals linked to the American Hospital Association data and patient data from the Hospital Consumer Assessment of Healthcare Providers and System survey. They showed that utilization of supplementary nurses did not detract from patients' overall satisfaction; however, there was not significant evidence that the use of supplementary nurses improved patient satisfaction (Lasater et al., 2015).

Employee Engagement and Patient Satisfaction

Some research studies in the literature explore the relationship between employee engagement and patient satisfaction to improve organizational performance in hospitals. Employee engagement can improve patient satisfaction. Christiansen, Sliter, and Frost (2014) utilized a quantitative study to investigate effects of similarity between personality and task demands on job satisfaction based on the idea that employees become distressed when asked to perform activities that require trait elevations inconsistent with their own. In addition, Christiansen et al. (2014) employed this study to gather an understanding of the impact of personality-based job fit on satisfaction by expanding the Trait Activation Theory conceptualization to include the proposition that misfit with tasks will result in distress, and that task-based distress will lead to less satisfaction with the job. They found tasks associated with agreeableness and conscientiousness were perceived as more distressing when workers were low on those traits, and increased distress was related to less satisfaction across task domains. In addition, Christiansen et al. (2014) determined individuals high in neuroticism tended to evaluate all tasks as distressing.

Ferrara, Converso, and Viotti (2013) studied the relationship between patient perceived quality of care in terms of satisfaction with respect to accessibility, organizational efficiency, humaneness of care, and workers' perceived quality of organizational life. Workers' perceived quality of organizational life was studied in terms of organizational support and availability of resources and rewards, quality of relationship in the work-unit (supervisor and coworker), and quality of relationship with patients (disproportionate client expectations and customer verbal aggression and depersonalization, job satisfaction). Accessibility and humaneness of care were negatively associated with disproportionate patient expectations, patient verbal aggression, and emotional exhaustion, and positively associated with the availability of material resources (Ferrara et al., 2013). Accessibility was also positively associated with the organizational efficiency with support from colleagues. Staff wellbeing is an essential aspect of the patient perception of the quality of care and supporting the assumption that health organizations improve the wellbeing of their workers, their organizational performance, and the quality of their service at the same time (Ferrara et al., 2013). Hesselgreaves and Scholarios' (2014) quantitative study examined the effect of the supervisor–subordinate relationship, conceptualized as leader–member exchange (LMX), on employees' experiences of job strain within nursing. Hesselgreaves and Scholarios (2014) indicated the member exchange (LMX) can either reduce or intensify subordinates' job strain and highlighted the gap between LMX relationships and the effects on job strain for two different nursing roles (junior and senior) that represent

contrasting job demands and supervisory challenges. In conclusion, Hesselgreaves and Scholarios (2014) found LMX reduced job demands and strain for junior subordinates, but for senior subordinates both low- and high-quality LMX led to greater strain, indicating a curvilinear relationship between LMX and strain.

Kane-Frieder, Hochwarter, and Ferris (2014) utilized a quantitative study to examine how engaged individuals respond to one specific source of workplace stress; namely, organizational politics perceptions. Kane-Frieder et al. (2014) developed a four-sample investigation to examine the role of perceived politics on employee work engagement and work outcomes relationships. From the multi-study investigation, Kane-Frieder et al. (2014) concluded when political perceptions were low, individual work outcomes were consistent across engaged and less engaged/non-engaged individuals. On the other hand, employees' attitudes and behaviors of less engaged employees experienced adverse effects when work environments were perceived as political. Salanova, Llorens, Cifre, and Martinez (2012), conducted a study to validate the Healthy and Resilient Organization (HERO) model. The study involved 14 CEOs, 710 employees, 84 managers, and 860 customers. Healthy employees fully mediate the positive relationship between healthy organizational resources and practices, and healthy organizational outcomes, and employees' excellent performance positively predicts customer loyalty and satisfaction with the company (Salanova et al., 2012).

Transition

In Section 1, I discussed the: (a) foundations of the study, (b) the problem and purpose statements, (c) research questions, (d) the conceptual framework, (e) operational terms, (f) the significance of the study, and (g) review of the literature. I also explored how the transformational leadership framework assisted in understanding the impact of patient satisfaction on organizational performance. In Section 2, I expand on the: (a) role of the researcher, (b) the qualitative method of a single-site case study research design, (c) population and sampling, (d) ethical research, (e) validity and reliability, (f) data collection, (g) analysis, and (h) organization.

Section 2: The Project

For this qualitative case study, I explored strategies that leaders in a private health care center with offices in Vancouver, B.C., Edmonton and Calgary, Alberta use to improve patient satisfaction to improve organizational performance. In addition to interviews, I used additional organizational documents. The results of this study could provide strategies that health care leaders in the public setting can apply to improve patient satisfaction and organizational performance.

Purpose Statement

The purpose of this qualitative case study was to explore strategies that leaders in private health care settings use to improve patient satisfaction. Learning from this study may provide strategies that health care leaders in the public setting can apply to improve patient satisfaction and organizational performance. The population for the study was nine leaders and three staff members working in a private health care center with offices located in Vancouver, B.C., Edmonton and Calgary, Alberta. Yin (2014) suggested that a sample of between three and eight is suitable for a case study. Vancouver, B.C., Edmonton and Calgary Alberta were appropriate locations for the study as both private and public health care centers are located in these areas. There have been a number of studies on this topic conducted in the United States, so a Canadian perspective adds a greater understanding of the phenomenon by looking at perspectives beyond the scope of the U.S. The study contributes to social change by providing strategies to improve patient satisfaction as consumers of health care. Hospital leaders who focus on patient

satisfaction and performance positively contribute to the social well-being of people and communities by addressing health care needs according to patient perspectives (Merlino, 2013).

Role of the Researcher

The role of the researcher is to collect and analyze data, report findings accurately, maintain the confidentiality of the study participants, and conduct research within ethical boundaries. In qualitative studies, the researcher, in the data collection process, acts as an instrument (Pezalla, Pettigrew, & Miller-Day, 2012). The quality of data relies on my expertise as an instrument in gathering data (Pezalla et al., 2012). I have interviewing experience from completing other academic research studies, which facilitated the collection of data from the participants. I did not have any personal or business relationship with the participants of the study.

A research study must conform to an acceptable code of conduct, social adaptability, and legal requirements (Yin, 2014). I adhered to the Institute Review Board (IRB) ethical and legal requirements to ensure no harm or foreseeable risks were experienced by the participants in the study. I also adhered to the Belmont Report's (1979) moral framework for regulations on the use of humans in experimental research. I ensured the core principles of respect for persons, beneficence, and justice and ensured diligence in informed consent, assessment of risks and benefits, and selection of subjects.

To mitigate bias in qualitative research, an interactive process between the researcher, the research participants, and the data collected is needed to achieve a higher

level of accuracy and consensus (Koelsch, 2013). The researcher mitigates bias by revisiting facts, feelings, experiences, and values or beliefs collected and interpreted. Koelsch (2013) focused on member checking interviews, where participants review sections of the research and comment on the accuracy of the report. I used member checking as this process helped mitigate bias and helped me to view data from the participant's personal view.

I collected data from face-to-face interviews asking open-ended, semistructured questions. A semistructured interview technique is a secondary instrument (Pezalla et al., 2012). I adhered to an interview protocol (see Appendix B) and asked the same questions to each respondent. According to Xu and Storr (2012), asking the same questions to each participant in an interview will minimize the variation in the responses. The interview protocol for the face-to-face interviews commenced with introductions, an overview of the research topic, and a reminder that the interview will be recorded, as per the consent agreement, and the conversation will remain confidential (see Appendix A). For each interview, I recorded the participant's identifying code, date, and the time of the interview. The interviews were approximately 30 minutes long to obtain responses to the eight questions. I explained the concept of member checking and each participant verified the interview summary sent to them.

Participants

Study participants included nine business leaders and three staff from the private health care center. The sample size was appropriate (Suresh & Chandrashekara, 2012),

and enabled an understanding of how business leaders use information about the impact of patient satisfaction on organizational performance. Participants in the qualitative case study were leaders and employees from a private health care facility with offices in Vancouver, B.C., Edmonton and Calgary, Alberta. The face-to-face interviews took approximately 30 minutes each. My experience with face-to-face interviews made this an ideal data collection process.

Purposeful sampling adds credibility and certainty in participant selection (Lee, 2014). The use of purposeful sampling will ensure that participants have the appropriate knowledge to provide information on the research topic (Yin, 2014). Establishing a comfortable relationship with participants is essential to obtaining meaningful information during the face-to-face interviews (Yin, 2014). I established a working relationship by welcoming participants to the interview, explaining the objectives and purpose of my research, and encouraging questions before starting the interview. I scheduled the interviews to allow enough time after e-mail contact for participants to consider and sign their agreement on the consent forms. I also ensured that the participants had a copy of the consent form at the time of the interview. The participants aligned with the overarching research questions as I explored strategies that leaders in private health care centers use to improve patient satisfaction to improve organizational performance, as these strategies may also work with leaders in the public setting.

Research Method and Design

Research Method

Researchers determine the best study method to explore information about a particular problem (Yin, 2014). The research methods considered to conduct this study included qualitative, quantitative, and mixed methods. Quantitative researchers seek to test theories by understanding the relationship between variables (Vance et al., 2013). A quantitative approach incorporates data, statistical analysis, and closed-ended questions (Vance et al., 2013). I did not choose a quantitative approach as this method does not explore the perceptions and experiences of people. A mixed-method research study incorporates both qualitative and quantitative methodology and has the advantage of obtaining both multiple viewpoints and hard factual data (Caruth, 2013). The disadvantage of the mixed-method approach is that it is a complicated research method, which may be beyond the time allocated and scope of this degree. Qualitative research is a method that explores the meaning that individuals believe to be true about a business problem (Lee, 2014). A qualitative researcher explores business leaders' beliefs and how people make sense of the business problem. Thus, the qualitative method was appropriate for this study, as qualitative research enabled the exploration of strategies health care leaders can use to review patient satisfaction and organizational performance.

Research Design

Researchers conduct a review of methods to determine the fit between the research questions, method, and design (Yin, 2014). A researcher choosing to conduct a

qualitative research study will choose the design that best fits the purpose of the study (Yin, 2014). The research designs considered for this study included phenomenological, ethnographic, narrative, and case study. Research designs vary in the variety of information collected and the scope of the data collection. Phenomenological researchers obtain an understanding of the phenomenon and explain how practice in an organization improves (Reiter et al., 2011). I did not select a phenomenological design because I was interested in exploring strategies to improve patient satisfaction and organizational performance. Ethnographic research can enable a better understanding of the culture, which can improve organizational practice (Shover, 2012). I did not select an ethnographic design because I was interested in exploring strategies to improve patient satisfaction and organizational performance. Narrative researchers report on stories of experiences of an individual or several individuals (Jorgensen et al., 2012). I did not select a narrative design because I was interested in exploring strategies to improve patient satisfaction and organizational performance.

Researchers who use a case study design can provide an in-depth understanding of complex social and technical phenomena related to the improved practice of an organization or business (Yin, 2014). Case study researchers focus on obtaining answers using how and why questions and it is a useful method to evaluate the real-world phenomenon (Yin, 2014). The research design in this research study was a case study. Evaluating the complexity of health care using a qualitative case study design enabled an

exploration of innovative strategies to improve patient satisfaction and organizational performance.

Population and Sampling

The population consisted of leaders and staff of a private health care facility with offices in Vancouver, B.C., Edmonton and Calgary, Alberta, Canada. I accessed the leaders' contact information through the facility's website to obtain confirmation of interest to participate in the study from the organization. Study participants were nine business leaders and three staff, chosen by the business leaders. The number of participants in a study needs to ensure enough data are obtainable to understand the research problem (Suresh & Chandrashekara, 2012; Yin, 2014). The sample size was appropriate to understand how business leaders use information about the impact of patient satisfaction on organizational performance. The leaders and employees met the criteria for participation indicated on the consent form (see Appendix A). The perspectives of the leaders and the employees, combined with the secondary materials from the organization and my observations during the interviews, provided a triangulation of data to gain a deeper understanding of innovative strategies to improve patient satisfaction and organizational performance.

I conducted face-to-face interviews using a tape recorder, with permission from the participants, to recall information correctly. I used purposeful sampling to ensure that participants had the experience and knowledge to provide meaningful input into the interview questions. A sample size of nine business leaders and three employees offered

a range of experiences, perceptions, and knowledge of strategies to improve patient satisfaction and organizational performance. A semistructured interview with eight questions provided participants the opportunity to elaborate on their responses to the questions. According to Yin (2014), semistructured interviews increase reliability and validity by allowing more depth and meaning to responses.

Ethical Research

A research study must conform to an acceptable code of conduct, social adaptability, and legal requirements (Yin, 2014). I completed the training for Protecting Human Subject Research Participants by the National Institutes of Health Training on Human Participants and received the ethical approval number 1547206, to conduct my research. I adhered to the IRB ethical and legal requirements to ensure no harm or foreseeable risks to participants in the study. I obtained approval, and then contacted the organization, to obtain consent to participate in the study. Participants received a consent form (see Appendix A) inviting them to participate, which explained the purpose of the study and the role of the researcher. The informed consent form also included the central research question, sample research questions, and the procedures of the study, including the need for participants to send a *statement of consent* by e-mail, agreeing to participate in the 30-minute study. Participants consented to an audio recording of the interview, which included detailed information about the voluntary nature of the study, and the right to withdraw at any time. The consent form also included a list of potential risks from participating in the study, such as fatigue or stress, and

benefits from the study, such as the potential for positive social change. In addition, participants were informed that no compensation would be received. I informed participants of their privacy and that information would be kept confidential by the assignment of unique identifying codes in place of names to ensure participant anonymity. Participants were also informed that data would be stored in a safe place and destroyed after 5 years and those they have access to my e-mail address and phone number, a Walden University representative and a copy of my study IRB approval number with the expiry date.

Before making contact with participants, I (a) obtained approval to conduct research from the IRB, (b) contacted the private health care facility to introduce myself and the study and determine interest from the facility to participate in the study, and (c) explored the facility's related documents from their website. After securing interest from the facility, employee e-mail addresses were provided. I then e-mailed the potential participants to provide information about the problem requiring investigated and the purpose of the study. I also explained the interview process, confidentiality, and consent to participate in the study. I ensured a signed consent form was completed including the time commitment required to complete the interview, the rights of participants to answer some or none of the questions, the right to withdraw from the study at any time, and the storage process for securing information confidentiality.

In addition to the informed consent, I took additional measures to assure the ethical protection of the participant's confidentiality. Study participants received a unique

identifier to distinguish participants and to ensure anonymity (Pezalla et al., 2012). Protecting the anonymity of participants is critical to maintaining the integrity of the study (Lee, 2014). To ensure confidentiality, I first assigned a unique identifier and did not use participants' names with the data collected during the interview process. Data are kept in a locked drawer to ensure participant confidentiality, and I will be the only person to access the data and will destroy the data after 5 years. Secondly, I explained in the consent form my plan to care for the confidential information, the participant's right to answer none of the questions, and their right to withdraw from the study at any time without consequences. Thirdly, I explained to the participants that the notes that I took during the interview will remain confidential.

Data Collection Instruments

The goal of the qualitative research was to explore strategies that leaders in private health care settings use to improve patient satisfaction. Learning from this study may provide strategies that health care leaders in the public setting can apply to improve patient satisfaction and organizational performance. In qualitative studies, the researcher, in the data collection process, acts as an instrument (Pezalla et al., 2012). The data collection instrument that I used in this study was open-ended interviews in a semistructured format. I used open-ended interviews in a semistructured format to allow participants to speak freely regarding strategies leaders use to improve patient satisfaction to improve organizational performance (Lee, 2014).

I used the data collection instruments and followed the interview protocol (see Appendix B) to ask eight interview questions. The interview protocol begins with introductions and an overview of the research topic. Once the participants granted permission, I recorded the face-to-face interviews and then transcribed the data. As part of the interview protocol, I used unique identifiers to ensure that participants were not identifiable. Furthermore, I explained the concept of member checking and ensured consent of the participants to verify accuracy of the transcribed interview. Checking the transcription of the data adds reliability and validity of the information (Mero-Jaffe, 2011).

At the time of the interviews, I also asked the participants for organizational documents, such as strategic planning documents, that articulated the mission of the organization and services offered. I used the interviews, notes taken at the interview sessions, my observations, organizational documents, and website to triangulate the data in the study. Triangulation is a method to gather information from multiple sources to add validity of the study (Yin, 2014).

Data Collection Techniques

I conducted a qualitative case study to explore what strategies private healthcare organizations use to improve patient satisfaction to improve organizational performance that may be helpful in the public healthcare setting. I collected data from face-to-face interviews asking eight open-ended semi structured questions (see Appendix C). The advantage of using open-ended questions is to minimize the variation in the responses, as

I asked the same questions to each respondent (Xu & Storr, 2012). The advantage of using a semistructured approach is flexibility to explore questions in greater depth to enrich the responses (Xu & Storr, 2012). The disadvantage of using a semistructured approach is that it can be time consuming and resource intensive (Xu & Storr, 2012). As well, skill is required to analyze the data obtained from a semistructured interview to prevent construing too much by the researcher (Xu & Storr, 2012).

A number of techniques apply to maintain structure and focus of my qualitative research study and thematic analysis. Bredart, Marrel, Abetz-Webb, Lasch, and Acquadro (2014) presented a comprehensive guide on optimal interviewing practices that researchers use to achieve quality results. In particular, Bredart et al. (2014) outlined the importance of preparing for interviews; the researcher's choice of the interview environment, the researcher's interviewing skills, and interviewing training. Bredart et al. (2014) defined a qualitative research interview as a scientific research process, communicated verbally, that collects information with regard to a specific aim. They also found that a researcher's specific listening skills positively impacted the information provided by the interviewee. Other instruments required to conduct the interviews were a conference rooms or office, a watch to monitor the time, a tape recorder, notepad, pencil, and paper. I am storing all collected information in a locked cupboard, only accessible by me and I will destroy all data, in 5 years.

After receiving approval from the IRB and Walden University to conduct my research study, I scheduled the interviews with study participants. I contacted participants

the day before to confirm the interview appointment, the intent of my research study and interview process, and the participant's right to confidentiality and to withdraw from the study and any given time.

Strategies to ensure the validity of the study findings are member checking and triangulation of the data. Koelsch (2013) described member checking as an interactive process between the researcher, and that the collected data aims to achieve a relatively higher level of accuracy and consensus by means of revisiting facts, feelings, experiences, and values or beliefs. Koelsch (2013) focused on member check interviews, where participants are able to review sections of the research and comment on the accuracy of the report. Archibald (2015) defined triangulation as a collaborative strategy to ensure validation of data results. I used interviews, organizational documents, and the literature to ensure validation of the study through multiple lenses. Rather than conducting a pilot study, I encouraged participants to seek clarity of the questions throughout the interview process.

Data Organization Techniques

I organized the data to ensure ease of interpretation and confidentiality. I collected data using a voice recorder to record responses to the interview questions, took notes to document my observations, and reviewed the organizations documents. Data organization is important when multiple data sources are used (Lee, 2014). Study participants were each assigned a unique code, and data was analyzed for themes and the relationship to the conceptual framework and literature review. A system to organize data is important for

ease of interpretation (Bloomberg & Volpe, 2012). Data will remain in a secure locked cabinet and will be destroyed after 5 years.

Data Analysis

The sample size of nine business leaders and three staff members provided sufficient data and provided saturation (Yin, 2014). According to Yin (2014), using multiple sources of data and data analysis increases the accuracy of the data interpretation. I used multiple sources of data including interview questions, note-taking, and a review of organizational documents. I also used multiple sources to analyze the data including methodological triangulation of the data, member checking, identifying theme, and applying a conceptual framework (Bloomberg & Volpe, 2012). According to Bloomberg and Volpe (2012), the data from the interviews require analysis and coding to determine if themes emerge between the study participants experience and the research study. The themes may contribute to a better understanding of the specific business problem that some healthcare leaders in B.C. public hospitals lack strategies to improve patient satisfaction to improve organizational performance.

The transcription of information is vital to reduce problems with accuracy, fidelity, and interpretation (Fade & Swift, 2011). According to Yin (2014), using multiple sources of data and data analysis increases the accuracy of the data interpretation. Bloomberg and Volpe (2012) stated that the data from the interviews require analysis and coding to determine if themes emerge between the study participants experience and the research study.

Stringer (2014) noted that the researcher is required to categorize and code the data in a way that reflects the perspectives of the participants. I used text analysis to interpret the meaning of the data as opposed to a software program. I first reviewed the data obtained from the interview questions to look for similar words, phrases, and themes. I then assigned codes to the themes that arose from the data. I also assigned each study participant a unique identifier to ensure ease of interpretation and confidentiality. The final step was to review the themes according to the conceptual framework, the literature review, and documents collected from the organization. Reviewing the results through different lenses supports the identification of concepts and themes that are reflective of participants' experiences in relation to the organizational framework and the literature (Bloomberg & Volpe, 2012). The coding, themes, interpretation, and explanation of the data support the central research question for this study of strategies that private healthcare centers use to improve patient satisfaction to improve organizational performance as these strategies may also be helpful in the public healthcare system.

Reliability and Validity

Brutus, Aguinis, and Wassmer (2013) suggested that there is a greater emphasis on reliability and validity of research studies. Reliability is the ability for other researchers to repeat the study and obtain similar results (Brutus et al., 2013). Bekhet and Zausniewski (2012) proposed that to achieve validity, the study must measure what it is intended to measure.

Reliability

Reliability is the ability for other researchers to repeat the study and obtain similar results (Brutus et al., 2013). The design of the study enabled dependability of duplicating results. The design of the study included outlining the purpose of the study, process for selecting study participants, describing the data collection process and tools, a description of how the data is interpreted, articulation of research findings, and attention to reliability and validity of the research study. Reliability of the study was ensured by aligning interview questions with the central research question, aligning interview questions with the conceptual framework and utilizing standard processes for a qualitative case study. Additional strategies to ensure reliability included, securing and storing data in a locked cupboard and destroying data after five years.

Validity

Bekhet and Zausniewski (2012) proposed that to achieve validity, the study must measure what it is intended to measure. They identified a need for objective measures, transferability, and external applicability through saturation of qualitative data, and consistency. Strategies to ensure the validity of the study findings were member checking and triangulation of the data.

Member checking is conducted after the interview where the researcher shares a briefing of the data collected with the participant to validate the data (Fusch & Ness, 2015). Koelsch (2013) described member checking as an interactive process between the researcher and the collected data that aims to achieve a relatively higher level of accuracy

and consensus by means of revisiting facts, feelings, experiences, and values or beliefs collected and interpreted. Koelsch (2013) focused on member check interviews, where participants are able to review sections of the research and comment on the accuracy of the report. Harper and Cole (2012) defined member checking as a qualitative inquiry methodology where the researcher attempts to improve accuracy, credibility, and validity about recorded contents of an interview. Xu and Storr (2012) explored the experiential knowledge of qualitative research and the researcher as an instrument in qualitative research. Pezalla et al. (2012) investigated the concept of the researcher as an instrument, where the unique qualities of a researcher have the potential to impact the data collection process in an empirical study. I ensured that the participants of the study had a chance to review my interpretation of the data gathered during the interviews.

Bekhet and Zauszniewski (2012) proposed that triangulation may be able to ensure the thoroughness of data and aid in finding similarities and differences in results. I used the data collected from the interviews, my observations, and the organizational website and documents to triangulate the study. Archibald (2015) defined triangulation as a collaborative strategy to ensure validation of data results. My research study goal was to gain an understanding of strategies to improve patient satisfaction and improved organizational performance from business leaders and employees that work in a private healthcare organization. The understanding of the strategies has come from finding patterns and identifying themes that emerged from the data sources. I used interviews,

organizational documents, and the literature to ensure validation of the study through multiple lenses.

Transition and Summary

In Section 2, I introduced several phases and aspects of the research project including the purpose of the study, the research method, research design, data collection technique, and analysis. In the study, I used a qualitative case study to explore strategies used by private healthcare facilities to improve patient satisfaction and organizational performance as these strategies may also be helpful in the public healthcare system. Regarding the data collection, I used face-to-face semi-structured interviews with participants who have signed a consent form and analyzed the data for common themes and this will be presented in the next section. In section 3, I present the findings from the study and summarized the common themes from the data collected. I also describe the implications of the findings to the business world and for social change and discussed the recommendation for future research.

Section 3: Applications to Professional Practice and Implications for Change

Introductions

The purpose of conducting this qualitative case study was to explore strategies that leaders in private health care settings employ to improve patient satisfaction. The results of this study may provide strategies that health care leaders in the public setting can use to improve patient satisfaction and organizational performance. The population of this study included leaders and staff in a private health care center with offices in Vancouver, B.C., Edmonton and Calgary, Alberta. I used a purposeful sampling method to choose the private health care center and collected data using purposeful selection of the participants who answered semistructured interview questions. I recorded, transcribed, and analyzed all of the questions and identified common themes. I used the organization's website to review the programs and collected business artifacts from the participants that outline the key services of the organization. One of the study participants gave me a package prepared by the organization for patients including a newly developed booklet that was a step- by-step guide to the business program that was designed to help clarify patient's expectations and improve patient satisfaction.

The findings of this study revealed five distinct themes: (a) cohesive culture of employee engagement, (b) patient-focused model of care, (c) timely access and follow-up of results and coordination of care, (d) continuous system quality improvement, and (e) employee accountability. First, all 12/12 (100%) participants stated that the culture of the organization focused on customer service and that leadership treats the employees well.

Three participants said that "happy staff means happy clients." Second, all members mentioned that the clinic is patient-centered and provides compassionate care to their clients. One participant said that patient satisfaction is how the client describes satisfaction. Two participants mentioned that successful care gives clients a wow experience. One of the senior leaders described the clinic as a primary health care home for clients and that care meets the individual needs of each client. Third, all participants mentioned that the clinic offers specialized and timely access to a team of health care experts. All members mentioned that the clinic helps clients navigate and coordinate both the public and private health care system to ensure proactive primary health care and access to an extensive specialist referral network as needed. All participants mentioned that follow-up of results and client progress is convenient as clients can communicate with the health care team at clinic visits and through telephone and e-mail. Fourth, all study participants stressed the importance, and explained the process, for addressing clinical and systems' issues individually and as a team. Four (25%) of the participants mentioned that a net promoter score, (NPS), which is if clients recommend the clinic to friends and families, determines the ultimate measure of success. All participants described the team approach to care and follow-up to address clinical or system issues. Fifth, participants stated that each team member is accountable and empowered to follow-up issues and concerns when they happen. All participants talked about their accountability and commitment to the patient experience. In the next section, I will present a detailed analysis of each theme.

Presentation of Findings

The central research question for this study was the following: What strategies do private health care centers use to improve patient satisfaction to improve organizational performance as these strategies may also be helpful in the public health care system? From the central research question of inquiry, the interview questions are below:

1. What patient satisfaction strategies specifically contribute to improved organizational performance?
2. What do you think is necessary for successful implementation of these strategies?
3. What factors in the patient experience are measurable to aid in assessing patient satisfaction?
4. What processes exist to gather patient satisfaction information?
5. What processes exist to assess patient feedback?
6. How are patient issues addressed?
7. How are changes to service delivery implemented to improve performance?
8. What steps do leaders take to collect, analyze, and apply patient feedback to improve organizational performance?

After receiving IRB approval, I contacted the private health care facility vice president and obtained the e-mail addresses of the study participants. I sent participants a consent form (see Appendix A) inviting them to participate that explained the purpose of

the study and the role of the researcher. The informed consent form also included the central research question, sample research questions, and the procedures of the study. For those agreeing to participate, I requested each participant to read and send a statement of consent by e-mail to indicate that they understood the scope of the project, their rights, and the protection of their personal information. This study included nine leaders and three employees. Before conducting the interviews, I confirmed agreement of participants to an audio recording for transcription purposes and ensured that they had a copy of the consent form (see Appendix A) before starting the interview. I collected business physical artifacts from the website and during the interviews.

For the interviews, I used opened-ended questions to gather information from the leaders and employees of the private health care facility. Because the interviews were semistructured, I asked additional questions based on the participants' responses. I recorded, transcribed, and analyzed the interviews. As a follow up to the interview, I used member checking to confirm the participants' answers to improve the quality of the data. Member checking after the interview is where the researcher shares a briefing of the data collected with the participant to validate the data (Fusch & Ness, 2015). I used pen and paper to code the transcripts to find themes and examined the physical artifacts of the business, such as the websites and company documents.

All data collected for this research study are confidential. The data collected are in a locked storage cupboard and, after 5 years, will be destroyed. To ensure high quality of the data, I used triangulation. Bekhet and Zauszniewski (2012) proposed that

triangulation may be able to ensure the thoroughness of data and aid in finding similarities and differences in results. I used the data collected from the interviews, my observations, and the organizational documents and website to triangulate the study.

After analyzing the collected data, which included the interview transcripts and the physical artifacts, I identified five distinct themes: (a) cohesive culture of employee engagement, (b) patient-focused model of a care, (c) timely access and follow-up of results and coordination of care, (d) continuous system of quality improvement, and (e) employee accountability. I will discuss each theme in the following subsections.

Theme 1: Cohesive Culture of Employee Engagement

The first theme emphasized the cohesive culture and employee engagement. All of the participants stated that the culture of the organization is focused on excellent customer service. The leaders of the organization commented that client satisfaction is all about the team. Salanova et al. (2012) found that employees' excellent performance positively predicts customer loyalty and satisfaction with the company. All participants mentioned that leadership treats the employees well. Three participants stated, "happy staff means happy clients." Bass and Avolio (1993) described transformational leadership as a key to changing organizational culture. Wolf (2012) used transformational leadership theory to study leadership dimensions that influence followers. Intellectual stimulation, charisma, and individual consideration constitute aspects of transformational leadership that have a positive influence on employees. Wolf found that improved employee satisfaction results in improved organizational performance. Metcalf and Benn (2013)

examined leadership characteristics related to the successful implementation of corporate sustainability. Leadership for sustainability requires leaders of extraordinary abilities who can read and predict through complexity in dynamic organizational change and have high emotional intelligence. The following Table 1 includes comments from the participants regarding a cohesive culture of employee engagement.

Table 1

Theme 1: Cohesive Culture of Employee Engagement

Participant	Participant's Comments
P1	…the company really takes care of the staff…I think that translates into good customer care…when someone appreciates you and values you it makes it easier to go the extra mile…it is drilled into us that we want clients to have a 5-star experience and so they treat their staff like 5-star employees
P2	…we have to design interventions that have all employees involved to create an improved patient experience
P3	…the key to patient satisfaction is the culture of the employees…the culture of the clinic…if we have a culture of care, compassion and happiness we will be able to succeed in implementing any strategic change for the client experience. From a cultural perspective, we provide care and really go above and beyond to wow the client
P4	…something that I think is very important are we included all of the employees, not just the leaders in process improvements.
P5	…in our team meetings we brainstorm what needs to be changed to improve
P6	…the results of the survey get reviewed by the team…we have a continuous monitoring and feedback process to improve processes and the system
P7	…we are all very receptive to client feedback
P8	…the key is a strong culture…you have to be deliberate about building your culture…it starts with the team and making sure that they understand our mantra when they engage with clients and understanding that every interaction with a client counts…the key is commitment at every level of the organization
P9	…I think it really comes down to team engagement
P10	…we work well as a team…we like to hear if we are meeting the clients expectations
P11	…patient satisfaction is part of our culture…we are very customer satisfaction orientated
P12	…are patients are our clients…they need to be happy in order to come back…it's how you treat people, being present in the conversation and being compassionate. We make sure that the client knows that we care and have listened…I think that is the best thing

Theme 2: Patient-Focused Model of Care

All participants mentioned that the clinic is patient-centered. The definition of patient-and family-centered care cited the most frequently in the literature comes from the Institute for Patient and Family-Centered care (2013): an approach to the planning, delivery, and evaluation of health care. Patient-and family-centered-care is a mutually beneficial partnerships with health care providers, patients, and families (The Institute for Patient and Family-Centered Care, 2013). All participants said that patient satisfaction is how the client describes satisfaction. Two participants mentioned that successful care gives clients the wow experience. Heidenreich (2013) described patient-centered care as patient satisfaction. Patient-and family-centered care empowers individuals to be autonomous and take charge of their health care (Morgan & Yoder, 2012). Dokken et al. (2015) produced a descriptive report to highlight a campaign to put policies in place to recognize patients as partners in care. Rathert et al. (2012) found that patient-centered care is a positive influence on patient satisfaction. Table 2 includes comments from the participants regarding a patient-focused model of care.

Table 2

Theme 2: Patient-Focused Model of Care

Participant	Participant's Comments
P1	…we take patient satisfaction very seriously
P2	…is finding out what is the patient experience from the patient's perspective and have the patient inform any improvement activities that need to happen
P3	…to me the focus is client experience
P4	…the focus group is an opportunity for the team to hear what the expectations are of the clients
P5	…we have a survey…to find out how their experience was…
P6	…we have a survey loop at the point of care to determine what went well and to determine if we have solved their problems
P7	…at every interaction we do quality checks to see if clients are satisfied and that their needs are met
P8	…it is really all about the giving amazing experiences, wow moments to our clients…there needs to be spirit and sincerity especially when you walk into the clinic as a client and you are greeted by name and are talked to people by the front desk
P9	…for patient satisfaction…I would say that is how we run…
P10	…we like to hear about if we are meeting client's expectations…
P11	…patient surveys provides immediate feedback to us as to how clients feel about their experience
P12	…it starts with employees being open to the patient's feedback…every encounter gives us an opportunity to understand where the patient is at…checking-in on an ongoing bases

Theme 3: Timely Access, and Coordination of Care and Follow-Up of Results

All participants mentioned that the clinic offers specialized and timely access to a team of health care experts. According to Moreau et al. (2012), an integrated health care model improved patient care and operational performance by supporting patient choices. Three members mentioned that the team of experts navigate and coordinate both the public and private health care system to ensure proactive primary health care and access to an extensive specialist referral network as needed. Traditional health care settings are systems of efficiency and architectural design and are organized around care providers rather than around patients (Morgan & Yoder, 2012). One of the senior leaders described the clinic as a primary health care home for clients and that care meets the individual needs of each client. All participants mentioned that follow up is convenient as clients can communicate with the health care team through telephone and e-mail. The following Table 3 includes comments from the participants regarding timely access, coordination of care and follow-up of results.

Table 3

Theme 3: Timely Access, and Coordination of Care and Follow-Up of Results

Participant	Participant's Comments
P1	… timely communication is important and so we get back to the clients right away. I think the biggest thing is follow-up…I worked with a doctor who emailed a client her results while he was on vacation in Africa. We keep track of what doctors and clinics have the fastest response times and the least wait times for the patient to access
P2	…in the private sector we get things done…we can move quickly because there is less bureaucracy…we also provide timely follow-up communication through email which improves response times to patients
P3	…we provide timely follow-up communication…communicating through email improves the response time back to patients
P4	…we have created a step by step guide of our programs to help clients know what to expect from the moment they walk into the client to when they leave
P5	…we use a company that provides the most recommended specialist and best access times
P6	…we check in with clients at the point of care…if they don't see the value of our services they leave
P7	…we try to address issues right then at the moment
P8	…every interaction with the client matters…
P9	…the patient journey booklet is very clear on what we do or do not do and what team member is responsible for each part of the journey…as a doctor in the private system we are paid differently, and so I am not whipping through 40 people in one day…
P10	…the keys are the timeliness of follow-ups and the access to services
P11	…I would like to say we just do it...surveys measure if clients have timely access and if their questions are answered
P12	…there is time to spend with the patient…Doctors have the time to address all of the multiple issues that clients come in with vs. having to make multiple visits to get their issues addressed

Theme 4: Continuous Quality Improvement

Leaders that do not measure patient satisfaction lack information on quality improvement resulting in decreased organizational performance (Kleefstra, Zandbelt, de Haes, & Kool, 2015). All of the participants communicated that they continuously evaluate the patients experience and have good processes to make quality improvements. Transformational leadership is proactive and changes the organizational culture by implementing new ideas (Northouse, 2013). The transformational leader motivates employees by encouraging them to achieve objectives through innovative ideas and creative solutions to problems (Northouse, 2013). Transformational leadership is an effective framework as it takes employees and organizations beyond the status quo towards a vision for the future. Transformational leaders articulate a vision, exemplify behaviors that gain trust, challenge the status quo, and empower others to reach their goals (Northouse, 2013. The review by Al-Abri and Al-Balushi (2014) effectively combined the findings of past studies to critically interpret the use of patient satisfaction surveys as a tool for quality improvement. According to Arshad et al. (2012) there may be a relationship between patient satisfaction and the quality of care received at a hospital. Improved patient satisfaction may improve organizational performance (Stiefel & Nolan, 2012). This information is valuable in developing plans to improve the quality of care, as a high-level of patient satisfaction is characteristic of high-quality organizations. The following Table 4 includes comments from the participants regarding continuous quality improvement.

Table 4

Theme 4: Continuous Quality Improvement

Participant	Participant's Comments
P1	…the team lead, and team review feedback in order to see what processes can be changes to improve patient satisfaction…Anytime we have something that did not go well for the client our team tries to change the process to work better…
P2	…I think the connection between the patients experience from the patient perspective are critical in improvements that you can make to that experience…we have intentional strategies to measure the client experience and want to capture the clients while they are here…we use a table to measure client satisfaction at the time of the visit and calculate the NPS to measure if the client would recommend our service to family and friends
P3	…we do customer satisfaction surveys to improve the client experience…
P4	…we created a patient journey booklet which is a step-by-step pathway of all programs and teams….we use patient focus groups, interviews…and connected with successful companies to see what they used for client surveys
P5	…we will call them or email them to ask, how their appointment was... …we ask if there are improvements that we can do to make our service better...
P6	…we do a feedback loop at the point of care to determine what went well and what do not go well and to determine if we solved their problems
P7	…at every interaction, every point of care encounter, for quality assurance, we check if clients are satisfied and that their needs are met…we use this as an opportunity to see if there is anything else that needs to be follow-up on
P8	…we have a good process for quality improvement and utilizing the feedback back into the system…our new idea is to give patients a tablet right after their interaction with us and then in 30 seconds or less we have feedback at the individual level and that will go to a server and populate a dashboard
P9	…we use touch points and evaluate…
P10	…we do things like health checks to check in with our clients throughout the year…we like to hear if we are meeting their expectations...after every encounter we ask if there is anything else that we can do to help them
P11	…we make sure the right person knows what the problem is…
P12	…we use the NPS that encourages feedback at every step of the interaction

Theme 5: Employee Accountability

All participants stated that each team member is accountable and empowered to follow-up of issues and concerns when they happen. To improve value and cost efficiency of care, researchers suggested that management leadership, practices, characteristics, styles, and cultures closely related to indicators of performance (Lega et al., 2013). All participants described the team approach to care and follow-up and the systems designed to address clinical or system issues. Top et al. (2013), in their study, demonstrated the relationship amongst transformational leadership, organizational commitment, organizational trust, and job satisfaction for increasing productivity, effectiveness, and quality of performance. Transformational leaders can enact significant changes in an organization by motivating employees to achieve results for the good of the organization (Northouse, 2013).The following Table 5 includes comments from the participants regarding employee accountability.

Table 5

Theme 5: Employee Accountability

Participant	Participant's Comments
P1	…we try to keep the customers happy…if I have made a mistake I follow-up to say I am sorry. We give gift cards if we screw up
P2	…we handle complaints at all levels of the organization…we take complaints very seriously and believe complaints are an opportunity.
P3	…we have a lot of brainpower at our level and from our higher management levels to implement change
P4	…the key is addressing issues both positive and negative feedback…it is important to empower care givers and leaders to be accountable for process improvement
P5	…at our meetings…we are all active participants, we are vocal and we like to brainstorm ideas to improve customer service
P6	…every team member is responsible for finding ways to make process improvements
P7	…we are all very receptive to feedback…we try to address issues right then at the moment…if you can intervene and remedy the problem at your level then you do this
P8	…the key is to respond to clients in a timely fashion and we expect everyone to respond in a timely fashion…I think you need to walk the talk…it is important that leadership and every employee is responsible for an amazing wow patient experience
P9	…patient satisfaction really comes down to how we run…it really comes down to team engagement
P10	…we pride ourselves on timely feedback
P11	…we let clients know that we will make things better for them, whatever that means to them…we take issues and questions seriously and we do not leave anything just hanging there…leadership has to lead by example, be visible, be out and about with clients
P12	…we have changed processes very often based on feedback from our clients

Research Questions

The central research question for this study was what strategies do private healthcare centers use to improve patient satisfaction to improve organizational performance as these strategies may also be helpful in the public healthcare system. In qualitative studies, the researcher, in the data collection process, acts as an instrument (Pezalla et al., 2012). The data collection instrument that I used in this study was open-ended interviews in a semistructured format. Open-ended interviews in a semistructured format allowed participants to speak freely (Lee, 2014). In this section, I will analyze the answers to each strategy question.

Question 1: What patient satisfaction strategies specifically contribute to improved organizational performance?

The research participants provided several strategies they believed contributed to patient satisfaction and organizational performance. All participants believe that care needed to be patient-focused. Researchers suggested that patient-and-family-centered care improves organizational efficiency (Groene, 2011; Mirzaei et al., 2013). P1 shared that the organization takes patient satisfaction very seriously and timely communication to the client is critical. P2 stated "the number one strategy to ensure patient satisfaction is to make improvements based on the patient's perception of their experience." P3 specified that "we have to understand what the client is experiencing truly from their perspective so that we can be more intentional about making sure we are doing our due diligence from a customer service perspective." All participants expressed that they have

a continuous quality improvement process to improve client experience. P4 expressed that the goal of patient focus groups, interviews, and surveys are to understand patient satisfaction. P5 stated that clients are asked questions about their experience such as "how was the setting?", "were you seen on time?", "what was the bedside manner of the team and Doctor?", "is there anything we can do to improve our service?" and "would you recommend us to a friend or family member?" P6 stated "we do a short survey at the point of care to determine what went well and what did not go well and to determine if we have solved their problems." P7 stated that "at every interaction we do a point of care encounters for quality assurance to check to see if clients are satisfied and that their needs are met." All participants stated that they provide timely access and follow-up and coordination of care to the clients. P5 explained that access to care was important to clients and so they use specialist that are experts in their field with short waitlists and diagnostic facilities that offer timely tests to clients. All participants stated that the clinic has a cohesive culture of employee engagement. P8, a senior leader explained that "patient satisfaction starts with people and having a genuine focus on the team as happy employees mean happy clients, if employees think everything I do today will have an impact and people are happy then that is 99% of what we need to do." Gousy and Green (2015) described the key components of transformational leadership as individual consideration, intellectual stimulation, inspirational motivation, and idealized influence. Individual consideration means each member of the team received treatment differently but equally and the leader acts in an advisory capacity providing coaching, teaching, and

mentoring. Intellectual stimulation encourages members of the team to think in new ways, create solutions and try new ideas with the leader, empowering staff to approach problems from a new perspective. Inspirational motivation is the leader's ability to instill faith and respect and to excite and provide a shared vision. Idealized influence is the leader's ability to behave as an effective role model, providing a sense of mission and upholding high standards. All employees and leaders commented on their commitment and accountability. P8 stressed that "staff, have to want to do it and so obviously you have to get the right people on the bus." P8 also stated that "promoting staff health company culture absolutely critical and being deliberate about building your culture." P9 stated that "for patient satisfaction it really comes down to team engagement, our clients know who is on their team and they get frequent touch points with their team members." P10 stated "we like to hear if we are meeting their expectations." P11 stated "it is just part of our culture, we are very customer satisfaction orientated, you need to really put yourself in their shoes and so culturally we train all of our new staff and even our experienced staff on an ongoing bases that it is not just about great clinical care, but it is about good customer service." P12 stated it starts with the patients and clinicians being open to the patient's feedback and utilizing every encounter with the patient as an opportunity to understand where the patient is at.

Question 2: What do you think is necessary for successful implementation of these strategies?

The research participants provided several factors necessary for successful implementation of strategies. All participants stressed the importance of timely communication and follow-up, and that patient feedback guides improvements. P1 stated "I think the biggest thing is follow-up, we are always looking for ways for things to work better for our clients." P 2 stated "first of all you have to define what the client experience is by having our clients define it and then number two we have to design an intervention that has all players across the continuum involved in creating that improvement experience." P2 also stated that "it has to be intentional, it has to be designed, it has to be measured, and it has to be tracked and there has to be some type of surveillance to make sure whatever changes you put in place actually happen and actually creating that improvement that you trying to design." P3 stated "I think the key is the culture of the employees, the culture of the clinic, we have a culture of care, compassion and happiness and so we succeed in implementing any strategic change around the customer service piece or the client experience piece." P4 indicated "I think it is necessary to involve all stakeholders, not just people in leadership positions, but especially those people that are in direct contact with the patients." Doody and Doody (2012) proposed transformational leadership allows for shared responsibilities that influence new ways of leading. Transformational leaders motivate followers by appealing to higher ideals and moral values, where the leader has a deep set of internal values and ideas. The followers of transformational leaders act to sustain the greater good, rather than their interests, and supportive environments where everyone shares responsibilities (Doody & Doody, 2012).

P5 stated that it was important to implement strategies at all sites in both provinces and that the teams needed to develop a process to make the strategy work. P6 added that managing the feedback at the point of care encounter requires the will and desire to do it. P7 explained "the clients see many different people so we need to check at each step of the appointment to make sure the client's needs are being met." P8 said "it goes back to the cohesive culture, if someone is not really aligned or part of that cohesive culture then it is important that we invite them to pursue external opportunities." P8 also stated "once you get the information from the clients you need to have a good process for quality improvement and utilizing the feedback back into the system". P9 explained that they have automated check back systems to prevent people from slipping through the crack that lets the healthcare team know when a client needs to come back to the clinic to have their health care goals reviewed. P10 said it was important to make sure feedback is timely and to respond to the actual need, and to not make assumptions. P10 stated that "we collect feedback from clients and we talk about it, we meet as a team to talk about it and listen to what it is that clients are really saying and how can we show that we have heard their concerns and taken some action to address it." P11 said that the "number one I think our leadership has to lead by example and be visible." P12 stated "the key is to empower staff as nothing changes unless people are empowered to provide the service and the care and to ask those questions of the clients."

Question 3: What factors in the patient experience are measurable to aid in assessing patient satisfaction?

The research participants provided data on what they believed contributed to be measureable in the patient experience to aid in assessing patient satisfaction. Most measures of healthcare focus on objective measure of clinical outcomes of patient care and rarely seek the patient's views (Hostetter & Klein, 2011). All participants reported on the importance of patient satisfaction measures. Patient-reported outcomes are critical measures of assessing whether healthcare is improving the health of patients (Hostetter & Klein, 2011). Patient-reported outcomes focus on the patient's wellbeing and satisfaction of the care given (Hostetter & Klein, 2011). P1 stated "we measure a lot, for example we measure the time it takes to return patient calls and how courteous staff is to the clients." P2 added that "we use satisfaction surveys to monitor our wait times, access, experience of the interaction with the care team and we measure how likely the patient/client is to recommend the clinic to your family and friends." P3 stated "I think creating alignment and having the understanding of what the client experience is and being able to match those with measures is important, it is how the patient perceives their care and what their experience is." P4 stated the measures need to be both qualitative and quantitative to assess patient satisfaction, and quality of services received and things like wait times." P5 said "we use surveys for measurement of our patient satisfaction and we continuously work on strategies to improve customer service." P6 stated "the most important question to measure is if the client would recommend the clinic to their family and friends." P7 stated "we monitor if clients are satisfied with the quality of care." P8 explained that "we looked around the world at patient satisfaction questions that we could benchmark

ourselves against and came up with the NPS "how willing are you to refer us to your friends and family?" P9 said that "touch points with the clients are good." P10 added that "we base patient satisfaction on retention of the clients, we get weekly or monthly reports on the number of clients we see and the feedback we receive and if they are happy with the services that we are providing." P11 stated, "we measure patient satisfaction by fewer complaints, and if the client would refer family or friends." P12 explained "you measure patient satisfaction by the client's perspective."

Question 4: What processes exist to gather patient satisfaction information?

The research participants provided information on the processes to gather patient satisfaction information. All participants reported that patient satisfaction surveys are used and that every interaction with a client is an opportunity for feedback. P1 stated "we use surveys, and we have a customer complaint process, we have dedicated staff that deal with the customer complaints and we get back to the client quickly, we take complaints seriously." P2 we are using tablet survey which will measure patient satisfaction at the time of the visit and allow us to calculate the NPS score and we also provide timely follow-up communicate through email which improves the response time to patients." P3, P4 and P5 commented that the organization does patient satisfaction surveys. P6 explained that "there is continuous monitoring of patient feedback with an automated short survey to patients right after their visit." P7 stated "we do regular surveys, email and phone follow-ups." P8 stated we have multiple strategies including surveys. P9 stated "we actually book ten minutes in the patients schedule to answer a short survey on a

tablet." P10 stated "every team member does regular check-ins with the clients, and we also do seminars and patient surveys." P11 stated "it is making sure that the right person knows about the problem, as a team we do an analysis of what are the critical issues and what can be done to change our processes." P12 "We are moving towards implementing what the hospitality business does which rates each of the clinician interactions with the client and a Net Promoter Score (NPS) is used for that."

Question 5: What processes exist to assess patient feedback?

The research participants involved provided information on the processes for assessing patient feedback. All participants reported that there are individual and team processes to assess patient satisfaction surveys and system process to make changes in all clinics. P1 stated "we have surveys and also communicates through email which improves the response time to patients." P2 said "we need to capture the clients while they are here and so the survey is done on a Tablet at the point of care right at the end of the patient's visit." P3 stated "we use surveys and we also provide timely follow-up communicate through email which improves the response time to patients." P4 said "patients can go to our website and there is a patient feedback process there." P5 stated the organization conducts surveys. P 6 explained that there are team reviews to follow-up on all issues. P7, P8 and P9 stressed the importance of addressing the issue right then at the moment it occurs. P10 stated "we take the time to listen to our clients and have a patient journey document which shared with each client." P11 and 12 stressed the importance of taking the opportunity to get feedback with every client encounter.

Question 6: How are patient issues addressed?

All 12/12 (100%) of participants stressed the importance of addressing patient issues quickly. P1 stated that "patient issues are addressed quickly, and front line staffs are empowered to deal with issue right away either by email or in person." P2 added that "complaints are dealt with by the front-line staff and are escalated to the manager and vice president if necessary." P3 commented that "when feedback positive or negative comes in about an issue it is triaged directly to team lead and the issue is typically dealt with right away." P4 said "when we have a complain the complaint is send to the most appropriate team leader depending on the nature of the complaint and that the target is to have the complaint addressed within 24 hours by the most appropriate person." P5 reported that "the referral team sends an email to patients about a week or two after the specialist appointment to capture as much customer feedback as possible." P 6 stated "issues are to be addressed at the point of care and team reviews are done." P7 said "we are always looking for ways to improve or change processes to help prevent incidents." P8 stated "the key thing is to respond in a timely fashion and we expect everyone in the organization to respond in a timely fashion." P9 stated "we have a very good complaint and follow-up process." P10 reported "when we get feedback from our clients we always talk to our team and look into the system to see what happened, we collect the facts and own our mistakes, we are definitely upfront and honest about that and we make sure we do everything we can to rectify the mistake." P11 reported "we explore what the issues means to the patient and conduct a root cause analysis." P12 added "we then take the

issue and investigation findings to the team and use it as an opportunity for learning and or improvement of a process and then we get back to the patient to let them know what we have learned from the investigation and what processes we are putting in place to prevent reoccurrence of the issues to make things better for them…whatever that means to them."

Question 7: How are changes to service delivery implemented to improve performance?

All participants reported that there is a structure and process to improve performance. P1 stated "we always try to make the process more streamlined and faster and we ensure staffs are trained, and processes are good." P2 shared that "at our regular monthly meetings we review the results of the surveys and complaints and use the feedback to brainstorm new processes to improve the old processes with clear action plans and measures." P3 stated "I get the feedback and then share it with my team and we examine the process to see if we can make it better, to improve the client experience." P4 shared "the key is taking issues down to the department to address the feedback…positive or negative." P5 explained "we all have team meetings and at our meeting we brainstorm suggestions on how to improve customer service." P 6 stated that "there is a continuous monitoring and feedback process to improve processes and systems." P7 added "we are all very receptive to all feedback." P8 stated "it is the responsibility of the local management team if it is local issues, and cross site committee's address systemic and/or process type issues impacting all sites so we can also make improvements across the

system." P9 stated "when an error is found or a patient complains we review the issue and change processes." P10 added "a lot of our systems involve double checking making sure we have all the information and don't drop the ball…we always think perhaps we can tweak to make improvements." P11 added "we write practice standards and vet these though the appropriate committee, and then communicate to all staff, across all sites." P12 added "we have changed processes many times based on feedback from our clients."

Question 8: What steps do leaders take to collect, analyze, and apply patient feedback to improve organizational performance?

The research participants provided feedback on the steps that leaders take to collect, analyze and apply patient feedback to improve organizational performance. All participants outlined the continuous quality improvement steps to enhance the patient experience and stressed the importance of timely access. Most of the steps are included in the answers to previous questions. P1 stated "patients are surveyed and the results are given to the staff and teams…we have a small structure so it makes follow up easier." P1 also stated "the company really takes care of us as staff…I think that translates into good customer care…when someone appreciates you and values you it just makes it a lot easier to go the extra mile to help people…the company strives to give patients a 5-star experience and so they treat their staff like 5-star employees." Transformational leaders improve organizational performance by influencing the culture (Northouse, 2013). Transformational leaders influence and shape culture by inspiring employees to change expectations, perceptions, and motivation to work towards a common goal (Northouse,

2013). P2 stated “we use an electronic survey at the point of care for timely improvements and a step by step guide (Patient Journey Booklet) that helps clarify for the patient what the organization offers for care.” P3 stated “we are a private company and so performance is important…each set goals that are cascaded down from the organizations goals of the senior team and we use these to keep accountable.” P4 stated “I think it is very important to include all of the employees in the process improvement process not just the leaders…it is important to empower the front line care givers and leaders to be accountable for process improvement.” P5 stated “after a patient’s appointment, we ask them or call them or send them an email to ask “how was your appointment?, were you seen on time?, were the preparation instructions clear?, is there room for improvement?...we use these strategies at our team meetings to brainstorm what needs to be changed to improve our quality and we escalate our ideas to the operational leaders for consideration of implementation to improve processes…we also ensure that whatever we do in Vancouver and North Vancouver is done in our offices in Calgary and Edmonton.” P6 stated “we have a feedback loop at the point of care and we also will survey a sample of approximately 100 clients each year.” P7 stated “we use client surveys and feedback at our point of care encounters and our electronic chart is helpful to be able to investigate client issues at the time the issues are raised.” P8 stated “I think the key thing is to walk the talk.” P 9 stated “the key steps are the timeliness of following-up and the access to service and communication.” P 10 stated “we have to remember when we work in health care that it can be intimidating and the client may not be feeling well or they may be

concerned about what is wrong with them and so we have to listen to them and show that compassion and take the time to educate what is going to happen next and when to expect the results or when to expect an appointment for something…that's what we find our client's need, they don't necessary know the clinical side of things but they know good customer service…the key is customer service and hospitality…making sure that the person gets good eye contact, body language and tone of voice, these things all makes a difference to the experience." P11 stated "I would say we work hard to keep all of the staff motivated and when staff are motivated it reflects on the care to the clients…I think the key is good culture and relationships between the employees and leadership." P12 stated "I think it is about spending more time with our patients, our clients need to be happy in order to come back…it is how you treat people, being present in the conversation and being compassionate…we make sure that the client know that we care and have listened…I think that is the best thing."

Examination of the Physical Artifacts

Another source of data for this research was the examination of physical artifacts. At the time of the interviews, I obtained organizational business documents, outlining the mission of the organization and the services offered, and examined the website. Discussion of the business physical artifacts is below.

The Business Documents and Website

The private health care facility had business documents and a web site outlining their services. The documents and websites include high quality photos and easy to understand documentation of the programs and services offered. A newly developed booklet provided a step by step guide to the business program that was designed to help clarify patient's expectations and improve patient satisfaction.

Applications to Professional Practice

The results of this study might prove valuable to healthcare leaders working in the public sector. Public healthcare leaders may find the strategies that private healthcare facilities use to improve patient satisfaction to improve organizational performance useful. The study findings included five distinctive themes: (a) cohesive culture of employee engagement (b) patient-focused model of care, (c) timely access, and follow-up of results, and coordination of care, (d) continuous system quality improvement, and (e) employee accountability.

The results of the study might provide strategies for improvements to patient satisfaction and organizational performance. Improving patient satisfaction and organizational performance for hospitals into the future improves the patient experience in hospitals and positively affects organizational efficiency. Healthcare is disease-centered and provider-focused, which can have a negative impact on patient satisfaction (British Columbia Ministry of Health, 2014). Healthcare from the patient's perspective is as much a consumer-focused service as other service industries (Merlino, 2013).
The results of this study may be important as the culture of healthcare in B.C. plans to

shift from disease-centered and provider-focused to patient-centered (British Columbia Ministry of Health, 2014). The study results may also contribute to the body of knowledge on this topic. The target audience for the study findings is the senior leadership teams of hospitals to aid implementation of the study findings. The Ministry of Health is also a target audience given the need to shift from a disease-centered and provider-focused environment to one that is patient-centered (British Columbia Ministry of Health, 2014).

Implications for Social Change

The research study contributes to social change by providing strategies to improve patient satisfaction as consumers of healthcare. Hospital leaders that focus on patient satisfaction and performance positively contribute to the social well-being of people and communities by addressing healthcare needs according to patient perspectives (Merlino, 2013). The results of the study might improve patient satisfaction and organizational performance. Improving patient satisfaction and organizational performance for hospitals into the future positively contribute to the social well-being of people and communities. Improving patient satisfaction and hospital performance in hospitals potentially improve the health of the population. Improving the health of the population decreases mortality and morbidity. Ensuring efficient, patient-centered health care for the population may improve human conditions and have a positive social impact. Positive social change to people and communities may result from strategies to improve patient satisfaction as

consumers of health care. As well, healthcare leaders that focus on patient satisfaction and performance may provide a better health care experience for patients and families.

Recommendations for Action

The results of this study might prove valuable to healthcare leaders working in the public sector. Public healthcare leaders may find the strategies that private healthcare facilities use to improve patient satisfaction to improve organizational performance useful. The study findings included five distinctive themes: (a) cohesive culture of employee engagement (b) patient-focused model of care, (c) timely access, and follow-up of results, and coordination of care, (d) continuous system quality improvement, and (e) employee accountability. First, health care leaders in the public sector should strive for a culture of employee engagement to patient satisfaction by investing in customer service training for employees. When the front desk recognizes a patient immediately and the doctor and the nurse interact with the patient and not the chart it sets a tone for a more human patient-focused experience. Leaders may need to work on building employee engagement by ensuring a culture of trust and commitment between employees and administration. Second, health care leaders in the public sector should support a focus on the patient experience, starting with communication that reflects compassion for the patient and the family. Communication to patients and families must be timely, and understandable with built in mechanisms to ensure continuity and that nothing gets missed. Patients and families need to be part of the healthcare team as they provide valuable information to the medical team and this connection adds to patient satisfaction

and organizational efficiencies. Third, health care leaders in the public sector should strive for patients to experience timely access and coordination of care across the continuum. This may involve coordination of both public and private health care resources to expand the availability of resources. In addition, patients need timely follow-up of results. This may require different processes for follow-up of such as the utilization of telephone, and email in order to meet patient needs. Fourth, health care leaders in the public sector should develop a system of continuous quality improvement that is based on the patient's perspective instead of the systems perspective. Health care providers in the public system need to eliminate duplication and overly-complicated administrative processes and make quality changes based on what is important to the patient. The public system may consider measuring performance with the net promoter score, (NPS), to determine if the patient would recommend the hospital to friends and family. Fifth, health care leaders in the public sector should build on employee accountable and commitment to the patient experience, this may involve a process for hiring and retaining all staff including physicians based on evaluations designed by patients.

Recommendations for Further Research

In this study, I collected data from one private health care facility with offices in Vancouver, B.C., Edmonton and Calgary, Alberta. I interviewed nine leaders and three employees at the private health care facility. The small sample size is one limitation of the study. Moreover, the study was limited to one private health care organization. Therefore, to generalize the findings, future researchers can expand to different public

health care facilities. Further researchers can use quantitative research to test the five themes found from this study on a larger set of data. As well future studies may consider interviewing patients and families.

Reflections

In this study, I explored strategies that leaders in private healthcare settings use to improve patient satisfaction and organizational performance. Learning from this study are to provide strategies that healthcare leaders in the public setting can apply to improve patient satisfaction and organizational performance. I had a good opportunity to learn and conduct research to solve this business problem. I also gained more knowledge from interacting with the research participants. I was fortunate to receive timely consent from twelve study participants. I was impressed with the willingness of the participants to answer the interview questions and the relatively fast turn-around of the member checked transcriptions. The study helped me to better understand the research process and the time it takes to interview and transcribe the interview results. The experience with conducting this research study will help in my future academic and professional career.

Summary and Study Conclusions

The purpose of this qualitative case study was to explore strategies that leaders in private healthcare settings use to improve patient satisfaction. Learning from this study were to provide strategies that healthcare leaders in the public setting can apply to improve patient satisfaction and organizational performance. To explore the strategies used by a private health organization, I conducted research using a semi-structured

interview technique and examination of physical artifacts including business documents and the website. I recorded the interviews, coded and analyzed the data to identify common themes. The study results included five distinctive themes: (a) cohesive culture of employee engagement (b) patient-focused model of care, (c) timely access, and follow-up of results, and coordination of care, (d) continuous system quality improvement, (e) employee accountability. From this study healthcare leaders in the public setting can apply five strategies to improve patient satisfaction and organizational performance. Ensuring efficient, patient-centered health care for the population may improve human conditions and have a positive social impact. Positive social change to people and communities may result from strategies to improve patient satisfaction as consumers of health care. As well, healthcare leaders that focus on patient satisfaction and performance may provide a better health care experience for patients and families. I would recommend future research to expand the study to different types of private health care facilities in different locations.

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Appendix A: Consent Form

Consent Form

You are invited to take part in a research study of Strategies to Improve Patient Satisfaction and Organizational Performance in Health Care. The researcher is interested in strategies used by private healthcare facilities to improve patient satisfaction and organizational performance as these strategies may also be helpful in the public healthcare system. The researcher is inviting leaders and staff who work in the private healthcare sector who are available for a face-to-face interview to participate in the study. This form is part of a process called "informed consent" to allow you to understand the study before deciding to take part.

This study is being conducted by, Leanne Heppell, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to explore strategies that leaders in private healthcare settings use to improve patient satisfaction.

Procedures:

If you agree to be in the study, you will be asked to:

- reply with the words "I Consent"
- agree to an audio recording of the interview for transcription purposes, where participants are identified on the audio by P1, P2, and so forth

- answer question regarding patient satisfaction and organizational performance
- allow approximately 30 minutes to complete the interview process
- review my initial interpretations of your interview to ensure I accurately reflect what you meant to say, this will take approximately 15 minute

Here are some of the sample questions:

- What patient satisfaction strategies specifically contribute to improved organizational performance?
- What do you think is necessary for successful implementation of these strategies?
- What factors in the patient experience are measurable to aid in assessing patient satisfaction?
- What processes exist to gather patient satisfaction information?

Voluntary Nature of the Study:

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind and withdraw from the study. You may stop participating at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress or becoming upset. Being in this study

would not pose any risk to your safety or wellbeing. Positive social change to people and communities may result from strategies to improve patient satisfaction as consumers of health care. As well, Health care leaders that focus on patient satisfaction and performance may provide a better health care experience for patients and families.

Payment:

No compensation is available for participating in this study.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of the research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure on an external drive locked in a fire-protected safe accessible only by me, and destroyed after five years as required by Walden University. If a participant reports criminal activity, the researcher must report the activity to the study organization, and appropriate authorities.

Contracts and Questions:

You may ask any questions you have now. Of if you have questions later, you may contact the researcher via phone or by email leanne.heppell@waldenu.edu. If you wish to talk privately about your rights as a participant, you can call Dr. Leilani Endicott.

She is a Walden University representative who can discuss this with you. Her phone number is 001-612-312-1210.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand my legal rights and the study well enough to make a decision about my involvement. By replying to this email with the words 'I Consent', I understand that I am agreeing to the terms described above.

Appendix B: Interview Protocol

Interview: Strategies to Improve Patient Satisfaction to Improve Organizational Performance in Hospitals in British Columbia, Canada.

A. The face-to-face interviews will begin with introductions and an overview of the topic.

B. I will advise the participants I am sensitive of their time and thank them for agreeing to participate in the study.

C. I will remind the participants of the recorded interview and the conversation we are about to have will remain strictly confidential.

D. I will turn on the recorder and I will announce the participant's identifying code, as well as the date and time of the interview.

E. The interview will last approximately 30 minutes to obtain responses for eight interview questions and follow-up questions.

F. I will also explain the concept and plan for member checking, by contracting participants with transcribed data, and request verification of the accuracy of collected information as soon as possible.

G. After confirming answers recorded to the satisfaction of the participants, the interview will conclude with a sincere thank you for participating in the study.

Appendix C: Interview Questions

The following research question will guide the research: What strategies might healthcare leaders in B.C. hospitals, use to improve patient satisfaction to improve organizational performance.

1. What patient satisfaction strategies specifically contribute to improved organizational performance?
2. What do you think is necessary for successful implementation of these strategies?
3. What factors in the patient experience are measurable to aid in assessing patient satisfaction?
4. What processes exist to gather patient satisfaction information?
5. What processes exist to assess patient feedback?
6. How are patient issues addressed?
7. How are changes to service delivery implemented to improve performance?
8. What steps do leaders take to collect, analyze, and apply patient feedback to improve organizational performance?